The *Professional Counselor*™

About *The Professional Counselor*

Editorial Staff

Senior Advisory Board

Editorial Review Board 2020

National Board for Certified Counselors
3 Terrace Way, Greensboro, NC 27403-3660

In This Issue
Contents

The Professional Counselor ®

In This Issue
Contents

The Professional Counselor ®

"Take Your Kung-Flu Back to Wuhan": Counseling Asians, Asian Americans, and Pacific Islanders With Race-Based Trauma Related to COVID-19

Stacey Diane A. Litam

Following the outbreak of COVID-19, reports of discrimination and violence against Asians and Asian Americans and Pacific Islanders (AAPIs) have increased substantially. The present article offers a timely conceptualization of how public and societal fears related to COVID-19 may contribute to unique mental health disparities and the presence of race-based trauma among AAPIs residing in the United States. The relationships between media, increasing rates of xenophobia and sinophobia, and racial discrimination are provided. Next, the deleterious effects of race-based discrimination on the emotional and physical well-being of people of color and Indigenous groups (POCI) and AAPIs are described. Finally, the article identifies the clinical implications of counseling AAPI clients, encourages a decolonization of current trauma-focused interventions, and presents specific strategies to heal race-based trauma in AAPI client populations.

Keywords: race-based trauma, discrimination, microinterventions, xenophobia, sinophobia

The outbreak of novel coronavirus (COVID-19) has led to unparalleled events across the United States and worldwide. Hospitals, nursing homes, and medical settings were quickly overwhelmed, and the vulnerability of these systems became apparent. A lack of federal consistency and political infrastructure resulted in differences across levels, quality, and types of state support. On January 31, 2020, the World Health Organization (WHO) declared COVID-19 a public health emergency of international concern. This sentiment was echoed by U.S. President Donald Trump on March 13, 2020, who warranted the pandemic an emergency for all states, tribes, territories, and the District of Columbia (Federal Emergency Management Agency [FEMA], 2020). A "shelter-in-place" order was instituted for many states and people were encouraged to stay home to prevent the spread of COVID-19. Indeed, the presence of COVID-19 has led to unprecedented times. However, the sociopolitical disparities illuminated by COVID-19 are not solely limited to institutional and political problems.

Asian Americans and Pacific Islanders (AAPIs) represent the fastest growing ethnic or racial group in the United States. In 2015, approximately 20.9 million people identified as AAPIs (Lopez et al., 2017). As a group, AAPIs encompass 40 distinct subgroups, each of which demonstrates heterogeneity across language, educational background, religion, immigration/migration history, beliefs about mental health, and attitudes toward help-seeking behaviors. For the purpose of this article, AAPIs are people who have origins rooted in East, South, and Southeast Asian countries. The present article offers a timely conceptualization of how public and societal fears related to COVID-19 may contribute to unique mental health disparities and race-based trauma in AAPIs residing in the United States. The relationships between media, increasing rates of xenophobia and sinophobia, and racial discrimination are provided. Next, the deleterious effects of race-based discrimination on the emotional and physical well-being of people of color and Indigenous groups (POCI) and AAPIs

Stacey Diane Arañez Litam, PhD, NCC, CCMHC, LPCC, is an assistant professor of counselor education at Cleveland State University. Correspondence may be addressed to Stacey Litam, Cleveland State University, 2121 Euclid Avenue, Julka Hall 275, Cleveland, OH 44115, s.litam@csuohio.edu.

are described. Finally, the article identifies the clinical implications for counseling AAPI clients, encourages a decolonization of current trauma-focused interventions, and presents specific strategies to heal race-based trauma in AAPI client populations.

Xenophobia and Sinophobia in Media

The emergence of new infectious diseases historically has led to discrimination against groups of people of non-European descent (White, 2020). Indeed, the history of international infectious disease has predominantly been framed from a distinctly European perspective, which has focused on how disease negatively impacted post-colonial sites and affected trade (White, 2020). Experiences of fear and anxiety related to infectious disease often occur when people become threatened by an illness perceived as originating from outside one's community (Taylor, 2019). Thus, the resurgence of attitudes characterized by *xenophobia,* or a fear of foreigners (Sundstrom & Kim, 2014), and *sinophobia,* which can be understood as the "intersection of fear and hatred of China" (Billé, 2015, p. 10), perpetuates a legacy of discrimination against non-White groups because of fear of illness. AAPIs have experienced a long tradition of blame and discrimination in the United States. Scapegoating AAPIs in light of COVID-19 echoes the racist "Yellow Peril" stereotype, which vilified Asian groups as a threat to job and economic security in Western nations (Kawai, 2005). The Chinese Exclusion Act of 1882, which effectively banned the immigration of Chinese persons to the United States for 10 years, further evidences historical anti-Chinese sentiments and an extensive history of discrimination against AAPIs in America (Lee, 2002).

The problematic, biased, and misleading media coverage of COVID-19 has led to increased rates of racial discrimination and sinophobic attitudes toward Chinese nationals and people of Asian origin (Wen et al., 2020). Health-related fears and phobia have been linked to misinformation fueled by sensationalist headlines (Taylor & Asmundson, 2004). Media, especially social media and the internet, are indispensable resources for information, communication, and entertainment. Following the outbreak of COVID-19, reports of discrimination and violence against Asian Americans have increased substantially across the United States (Congressional Asian American Pacific American Caucus [CAPAC], 2020).

COVID-19–related fears have resulted in the persecution of AAPIs through violent attacks (CAPAC, 2020), discrimination against their businesses, and sinophobic portrayals in media and from elected leaders (National Association for the Advancement of Colored People [NAACP], 2020). The dissemination of racially targeted content in media includes hate speech toward Chinese people, harassment, discriminatory stereotypes, and conspiracy theories (CAPAC, 2020; Schild et al., 2020; United Nations Human Rights, Office of the High Commissioner, 2020). A data analysis of two popular web platforms found a significant rise in racial slurs, invoking earlier attitudes of sinophobic propaganda. To better understand the emergence of sinophobic attitudes within online communities, Schild and colleagues (2020) collected and analyzed 222,212,841 tweets and 16,808,191 posts from Twitter and 4chan imageboards, respectively, from November 1, 2019, to March 22, 2020. The results revealed a significant increase in the presence of racial slurs that targeted Asians and Asian Americans, including "Kung-Flu," "Ching Chong," and "asshoe," a term used to denigrate the accent of Chinese people speaking English (Schild et al., 2020). "Chink" was the most popular sinophobic slur and increased substantially after Donald Trump referred to COVID-19 as "the Chinese virus" (Schild et al., 2020).

Marginalized Groups Uniquely Affected

Social inequities and policies related to COVID-19 may disproportionately affect people of color and other marginalized groups, including individuals who are homeless, people with non-dominant racial and ethnic identities, undocumented individuals, people in lower socioeconomic groups, and individuals with limited access to health care. Individuals who lack shelter, reside in congregate living settings, or

lack regular access to basic hygiene supplies may be at higher risk for exposure and transmission of COVID-19 (Devakumar et al., 2020; Tsai & Wilson, 2020). Given the increased prevalence of homelessness for lesbian, gay, bisexual, and transgender (LGBT) adolescents compared to their heterosexual counterparts (Cochran et al., 2002), persons with non-dominant sexual and gender identities additionally may be at greater risk. POCI may be disproportionately vulnerable to COVID-19 exposure because of greater rates of existing medical and mental health conditions. Higher rates of hypertension in African American and Black individuals (Go et al., 2014) and diabetes in South Asian populations (Unnikrishnan et al., 2018) have been identified as pre-existing health conditions that negatively affect the prognosis of COVID-19 treatment (Centers for Disease Control and Prevention, 2020). Undocumented persons may also face unique challenges because of fears associated with seeking medical assistance. Consequently, by the time undocumented persons arrive to medical settings, the disease has reached an advanced stage and physical health is significantly compromised (Devakumar et al., 2020).

Effects of Racial Discrimination on Wellness

Racial microaggressions are the everyday slights, insults, invalidations, and offensive behaviors experienced by POCI through interpersonal verbal and nonverbal communication, media, educational curriculum, mascots, monuments, and other forms (Sue et al., 2007). Indeed, the experiences of racism, discrimination, and microaggressions faced by POCI negatively affect their mental and physical health (Alvarez et al., 2016; American Psychological Association, 2016) and increase their risk factors for developing mental and physical health problems (Carter, 2007; Carter et al., 2005; Clark et al., 1999; Harrell, 2000; Pieterse et al., 2012). Although many Indigenous, Latinx, and Asian populations face racial discrimination and suffer from race-based stress, African American and Black individuals are disproportionately affected (Chou et al., 2012). Experiencing racial discrimination has been linked to increased rates of depression in African Americans (Chou et al., 2012; Jones et al., 2007), Pacific Islanders (Allen et al., 2017), Indigenous women (Benoit et al., 2016), and Latinx populations (Araújo & Borrell, 2006; Chou et al., 2012; Pieterse et al., 2012). Indeed, ongoing experiences of racial discrimination have been described as resulting in a chronic state of "racial battle fatigue" that taxes the mental and emotional resources of people of color (Smith et al., 2011, p. 64).

In one study of 12 common mental health disorders, including major depressive disorder, dysthymic disorder, panic disorder, separation anxiety disorder, social anxiety, generalized anxiety, post-traumatic stress, alcohol abuse, drug use, attention deficient hyperactivity disorder, oppositional defiant disorder, and conduct disorder, using a national sample (N = 5,191), perceived discrimination was positively associated with each mental health diagnosis in African American and Afro-Caribbean adults (Rodriguez-Seijas et al., 2015). Perceived racial discrimination also has deleterious effects on Asian Americans' wellness. Studies have consistently linked race-related stress and perceived discrimination in AAPIs to increased rates of psychological distress, suicidal ideation, anxiety, and depression (Gee et al., 2007; Hwang & Goto, 2008; Wei, Alvarez, et al., 2010). Additional studies have evidenced how the presence of race-based stress significantly and negatively correlates to feelings of self-esteem (Liang & Fassinger, 2008), social connectedness (Wei et al., 2012), and overall well-being (Iwamoto & Liu, 2010) in Asian American populations. The daily experiences of racial microaggressions, combined with the current political climate (Potok, 2017), represent a source of significant stress for POCI and may lead to racial trauma.

Racial trauma refers to the events or danger related to real or perceived experiences of racial discrimination (Carter, 2007). These experiences include threats of harm and injury, humiliating and shameful events, and witnessing harm to other POCI because of real or perceived racism (Carter, 2007). The effects of racial trauma parallel symptoms of other trauma-based disorders, including acute

stress disorder and post-traumatic stress disorder. POCI may experience hypervigilance, avoidance, flashbacks, and nightmares related to the events of racial discrimination (Comas-Díaz et al., 2019) and somatic expressions, including headaches, heart palpitations (Comas-Díaz et al., 2019), dizziness, confusion, and difficulty concentrating (Hinton & Jalal, 2019). Healing race-based trauma requires counselors to consider the intersectional identities that uniquely influence experiences of oppression and discrimination for marginalized groups. Because POCI experience race-based stress throughout their lives (Gee & Verissimo, 2016) and the nature of discrimination lies within sociocultural contexts (Comas-Díaz et al., 2019), healing these racial wounds can be difficult.

Although facing the daily onslaught of microaggressions and racial discrimination clearly contributes to the presence of race-based stress and trauma across POCI, specific strategies to address each of these racial groups is beyond the purview of this article. The increased rates of sinophobic attitudes, behaviors, and racial slurs fueled by COVID-19 fears, internet activity, and media misinformation are specific stressors that may uniquely affect AAPI groups. The following sections outline the clinical implications for counseling AAPIs who face racial discrimination resulting from COVID-19 fears and the current sociopolitical climate.

Clinical Implications for Counseling Asian Americans and Pacific Islanders

In the United States, an ideology of White supremacy exists, which justifies policies and practices that maintain the subordination of people of color through social arrangements using power and White privilege (Huber & Soloranzo, 2015). Addressing disparities in racial wellness thus requires counselors to challenge these existing inequalities embedded in the current social zeitgeist. The combined fear of infectious disease, misrepresentation in media, and current sociopolitical climate have illuminated the importance of identifying culturally sensitive strategies to heal race-based trauma in AAPIs. Beginning from initial assessment and intake, counselors must consider how intersectional identities such as ethnicity, country of origin, affectional identity, gender identity, age, socioeconomic status, and other statuses influence the social positioning, experiences, and worldview of their AAPI clients. Counselors must additionally be prepared to navigate language barriers, undocumented status, and challenges related to health care access with cultural humility.

As counselors prepare to screen for race-based trauma, it becomes of paramount importance to consider how Southeast Asian and Chinese populations are more likely to report somatic complaints that differ from Eurocentric trauma symptoms, including difficulty sleeping, dizziness, difficulty concentrating, and physical complaints such as headaches, stomach problems, and chronic pain (Dreher et al., 2017; Grover & Ghosh, 2014; Hinton & Good, 2009; Hinton et al., 2018). As with all clients, counselors are called to reflect on how their own internalized biases and attitudes may compromise treatment effectiveness and to avoid imposing their values onto clients (American Counseling Association, 2014). The experiences of racial oppression and discrimination toward AAPIs are often overlooked because of the *model minority* stereotype that portrays Asian Americans as achieving high educational and societal success (Ocampo & Soodjinda, 2016). In reality, AAPIs face explicit experiences of racism and physical and emotional harassment related to accents and physical appearance (Choi & Lim, 2014; Qin et al., 2008). Counselors are thus encouraged to pursue their own counseling and engage in dialogue with supervisors, friends, and colleagues to identify and challenge the presence of implicit biases or preconceived notions held about AAPI groups. Counselors must consider ways to deliver treatment within the cultural settings in which clients feel most safe and comfortable (Helms et al., 2012) to effectively heal race-based trauma in AAPIs.

Decolonizing Trauma-Based Interventions

Constructs related to trauma, traumatic stress, and trauma-based interventions are largely embedded in European perspectives and historically have failed to consider the influence of intersectional identities in trauma treatment and recovery (L. S. Brown, 2008; Hernández-Wolfe, 2013; Mattar, 2011). The importance of contextualizing trauma-based interventions when working with people of color has been identified in the literature (Helms et al., 2012), and the extant literature on trauma-based interventions has identified a lack of cultural relevance for most POCI (Bryant-Davis & Ocampo, 2006; Hinton & Good, 2016; Hinton & Lewis-Fernández, 2011). Many existing theories and trauma-based interventions may therefore lack cultural relevance for AAPI groups. Counselors must therefore decolonize trauma-based interventions and consider whether trauma treatments are culturally sensitive and appropriate for Asians and Asian Americans who present with COVID-19–related trauma symptoms.

Healing Race-Based Trauma in AAPIs

When racial discrimination occurs, people of color, including AAPIs, may experience rumination about the situation and negative self-evaluation because of lack of action (Shelton et al., 2006; Sue et al., 2007). POCI who respond passively, ignore, or do not stand up for themselves may experience greater feelings of helplessness or hopelessness, or be more likely to endorse the fatalistic belief that racism is normative and must be accepted (Williams & Williams-Morris, 2000). For many AAPI individuals, facing sinophobic attitudes and behaviors may result in problematic outcomes. Because Asian cultures tend to discourage conflict and demonstrate a preference for maintaining interpersonal harmony (Ting-Toomey et al., 2000; Yum, 1988), AAPIs may be more likely to employ the use of indirect and subtle approaches (Lee et al., 2012). Compared to other racial groups, AAPIs may be more likely to use maladaptive coping strategies linked to poorer mental health outcomes, including avoidance (Edwards & Romero, 2008), internalization of events in ways that lead to self-blame and self-criticism, social isolation (Wei, Heppner, et al., 2010), and substance use (Pokhrel & Herzog, 2014).

Promoting Mindfulness and Self-Compassion

Increasing self-compassion through mindfulness and compassion meditation represents a culturally sensitive strategy to heal race-based trauma in AAPIs. Originating from Buddhist psychology, compassion meditation helps people release feelings of anger and decrease suffering by cultivating compassion and unconditional regard toward the self and others (Germer & Neff, 2015). Increasing self-compassion may decrease feelings of guilt and shame following instances of racial discrimination by fostering feelings of love and kindness toward oneself. As an emerging clinical intervention, compassion meditation has yielded positive results in decreasing experiences of shame and self-criticism (Gilbert & Procter, 2006; Kuyken et al., 2010), reducing symptoms of depression (Graser et al., 2016; Kearney, 2015), and promoting overall psychological wellness (Hofmann et al., 2011; Shonin et al., 2015). Notably, compassion-based mindfulness interventions show promise as a culturally sensitive strategy to heal race-based trauma (Au et al., 2017; Germer & Neff, 2015; Kearney, 2015). Mindfulness interventions such as compassion meditation may additionally address societal limitations related to health care access and financial barriers. Compassion meditation can be practiced anywhere and does not require expensive books, seminars, or the use of tools.

Counselors can support AAPI clients who present with race-based trauma to cultivate self-compassion by encouraging them to focus on their immediate needs, without judgment, in the present. According to Germer and Neff (2015), the main question when cultivating self-compassion is "What do I need now?" (p. 50). This inquiry is intended to help people connect with their emotional wants, needs, and desires, in the moment, without judgment. Turning awareness toward oneself may illuminate the need for community support or peer support, or point to a physical need, such as fatigue or hunger. Counselors

may promote self-compassion through the meditative Hawaiian prayer, *Ho'oponopono.* Clients may practice the *Ho'oponopono* meditation by directing four statements toward themselves: "I love you," "I'm sorry," "Thank you," and "Forgive me." Counselors may help clients begin to heal race-based trauma by empowering them to reflect on their phenomenological experiences as each statement was made. Counselors are encouraged to engage in their own experiences of mindfulness and self-compassion to deepen their understanding of how to modify the practices for clients (Germer & Neff, 2015).

Microinterventions

   Counselors may empower AAPI clients facing racial discrimination by providing psychoeducation about microinterventions and creating opportunities for behavioral rehearsal using role plays. *Microinterventions* are everyday words, deeds, or actions that communicate validation of experiential reality, value as a person, affirmation of racial or group identity, support and encouragement, and reassurance that the receiver is not alone (Sue et al., 2019). Microinterventions seek to empower POCI, White allies, and bystanders to confront and educate perpetrators of microaggressions and have four major strategic goals: making the "invisible" visible, disarming the microaggression, educating the perpetrator, and seeking external reinforcement or support (Sue et al., 2019). Before engaging in microinterventions, it is important to consider the possible positive and negative consequences that may occur. Counselors should discourage AAPI clients from addressing microaggressions when doing so may threaten their physical safety. Engaging in microinterventions in scenarios where a strong power differential exists, such as in workplace or education settings, also requires special consideration (Sue et al., 2019). A full description of each microintervention strategy, goal, objective, rationale, and tactic are beyond the purview of this article, although a few examples for practical application for AAPI clients in counseling are provided below.

   Making the "Invisible" Visible. Making the "invisible" visible represents an important component of healing race-based trauma. The first step to liberation necessitates naming the innuendo because it provides language for POCI to describe their experiences and seek mutual validation (Freire, 1970). Counselors may empower AAPI clients to make the "invisible" visible by bringing the microaggression to the perpetrator's awareness, indicating to the perpetrator that they have spoken or behaved in an offensive way, or forcing the perpetrator to consider the impact and meaning of what has occurred (Sue et al., 2019). These tactics serve to undermine the metacognition, make the metacognition explicit, and broaden the ascribed trait (Sue et al., 2019) and may be helpful for AAPIs who experience race-based discrimination. For example, an Asian American who is accused of having "Kung-Flu" in public may make the metacognition explicit by stating, "You assume I am contagious because of the way I look." In the same scenario, ascribed traits can be broadened and clarification can be obtained by using statements such as "Anyone can become infected with COVID-19; it is not solely limited to Asians," and "Are you worried I will get you sick?" Each of these responses are intended to directly identify and address the microaggression while bringing awareness of the metacognition to the perpetrator.

   Disarming the Microaggression. Disarming the microaggression may be employed to stop or deflect the microaggression, force the perpetrator to consider their actions, and communicate disagreement (Sue et al., 2019). Helpful tactics AAPIs can use to disarm microaggressions include expressing disagreement, using an exclamation, and stating values and setting limits (Sue et al. 2019). For example, a young Asian American who sees denigrating comments about AAPI individuals on a social media page may respond with the exclamation, "Ouch!" According to Aguilar (2006), this simple exclamation communicates that something offensive has occurred and forces the person to consider the impact and meaning of their behavior. In the same situation, AAPIs may state values and set limits by responding to an offensive

comment with, "I have always been respectful of your values and recognize how people are free to hold different attitudes, but I hope you see that what you have written is offensive."

Educate the Offender. Although it is inappropriate to ask POCI to educate and confront perpetrators, as it exclusively puts the onus of change onto the marginalized person, educating the offender may represent an important strategy to affect societal change. One powerful objective is to facilitate an enlightening conversation that indicates how what has occurred was offensive (Sue et al., 2019). This tactic helps perpetrators differentiate between their intent and the resulting impact (Sue et al., 2019). Because many people become defensive and shift from action to intention when a microaggression is pointed out (Sue, 2015), differentiating between good intent and harmful impact represents a powerful educational strategy (Sue et al., 2019). For example, a Chinese woman may hear COVID-19 incorrectly termed "the Chinese virus" in a conversation among colleagues. In this scenario, she may choose to engage in an enlightening dialogue to educate the offender about how the term "Chinese virus" perpetuates offensive sinophobic attitudes. A helpful conversation starter might be, "I know you may not realize this, but referring to COVID-19 as 'the Chinese virus' denigrates Asian individuals and is offensive." In the same situation, it may additionally be helpful to point out how the term "Chinese virus" violates the WHO (2015) best practices policy for naming new human infectious diseases.

Seek External Reinforcement or Support. The final microintervention is aimed at the promotion of regular self-care, ensuring optimal levels of functioning, and communicating to perpetrators that bigoted behavior is unacceptable (Sue et al., 2019). Self-care and promoting wellness can be employed by pursuing counseling, reporting sinophobic behaviors to appropriate authorities, and seeking the support of one's spiritual or religious communities (Sue et al., 2019). An increasing number of AAPIs are reaching out to crisis support hotlines. As of March 2020, approximately 13% of AAPIs had contacted crisis text lines compared to 5% of other U.S. callers, respectively (Filbin, 2020). Similar to other POCI, the presence of social support and collective gathering represents an effective coping strategy for Asian Americans (Wei, Alvarez, et al., 2010; Wei et al., 2012; Yoo & Lee, 2005). Indeed, seeking support represents an important strategy AAPIs employ to preserve mental health.

Cultural Proverbs and Analogies

Incorporating proverbs and analogies embedded in AAPI traditions are culturally sensitive strategies to empower clients and strengthen their ethnic identity. Cultural metaphors and stories may additionally strengthen the therapeutic alliance, as AAPI clients may feel their counselor understands and appreciates their cultural background (Hinton & Jalal, 2019). Strong identification with one's ethnic group promotes wellness and serves as a protective factor in AAPI groups (Iwamoto & Liu, 2010) and Filipino Americans (Mossakowski, 2003). Counselors can empower clients to promote ethnic pride and increase cultural commitment by using proverbs and stories from client culture in counseling. Guiding AAPI clients to embrace their rich and important tradition of knowledge may promote self-esteem and decrease negative affect (Hinton & Jalal, 2019).

Two popular examples of Filipino proverbs may be helpful to promote the importance of social support and cultivate compassion when perpetrators are reluctant to recognize how their behaviors are offensive. A Filipino proverb posits, "A broom is sturdy because it is tightly bound" (in Tagalog, "*Matibay ang walis, palibhasa'y magkabigkis*"). This message aligns with a collectivistic mentality that people are stronger when standing together. Another Filipino proverb suggests, "It is hard to wake someone up who is pretending to be asleep" (in Tagalog, "*Mahirap gisingin ang nagtutulog-tulugan*"). This saying cultivates empathy and compassion for perpetrators of microaggressions and sinophobic

behavior by reminding clients how it is difficult to educate others when they are not ready or willing to expand their worldviews. Similarly, a Chinese proverb states, "If you are planning for a year, sow rice; if you are planning for a decade, plant trees; if you are planning for a lifetime, educate people." This saying may motivate clients to engage in dialogue with the people in their lives who have committed hurtful microaggressions. Because AAPI clients tend to terminate counseling at earlier rates compared to other racial groups (Sue & Sue, 2016), counselors can use appropriate cultural analogies to demystify the counseling process. For example, counselors may liken the therapeutic process to cooking a traditional noodle dish (Hinton & Jalal, 2019). Analogous to preparing *japchae* in Korean culture, *pancit palabok* in Filipino kitchens, or the Chinese dish *zhajiangmian,* healing from race-based trauma is a process that necessitates patience, creativity, commitment, and flexibility.

Discussion

The U.S. Surgeon General has recognized how racial and ethnic health disparities are strongly linked to the presence of systemic and ongoing cultural racism (U.S. Department of Health and Human Services, 2000). Counselors who hold dominant social identities (e.g., White, male, heterosexual) are uniquely positioned to use their power and privilege to advocate on behalf of AAPI clients, other POCI, and other marginalized groups by challenging systemic forms of oppression. Indeed, endorsing positive attitudes about diversity (Broido, 2000) and consciously committing to disrupting the cycle of injustice (Waters, 2010) are foundational characteristics of White allies, who seek to end disparity and work to promote the rights of oppressed groups (K. T. Brown & Ostrove, 2013). According to Sue and colleagues (2019), allies actively commit to engaging in actions that dismantle individual and institutional beliefs, practices, and policies that have created barriers for people of color.

AAPIs are facing greater rates of racial discrimination, harassment, violence, sinophobic attitudes, and racial slurs because of fears related to COVID-19 and the current sociopolitical climate. Counselors may help AAPI clients heal race-based trauma through the use of culturally adapted strategies such as promoting mindfulness and self-compassion, employing the use of microinterventions, and incorporating culturally appropriate proverbs and analogies in counseling treatment. Counselors are encouraged to adopt strategies to help AAPIs heal from race-based trauma because experiences of racial discrimination, microaggressions, and sinophobic behaviors are not limited to the current pandemic and instead represent longstanding forms of oppression embedded in American history and culture. AAPIs faced marginalization and racial discrimination before the presence of COVID-19 and will likely continue to experience race-related stress long after the discovery of a vaccination. Just as COVID-19 has illuminated disparities within medical, institutional, and political systems, it has also uncovered the enduring ethnocentric attitudes of many Americans. The proliferation of ongoing discrimination of all racial, ethnic, and marginalized groups is representative of a more insidious form of societal sickness.

Limitations and Future Areas of Research

Although the present article outlines the culturally alert strategies for healing race-based trauma among AAPIs, other marginalized groups face unique challenges related to the unprecedented effects of COVID-19 on social, institutional, and political levels. The deleterious effects of homelessness, social isolation, witnessing of real or perceived racial discrimination or violence, and issues related to LGBTQ individuals because of COVID-19–related issues and policies remain of paramount importance but were not explicitly discussed in this article. Future areas of research may examine the effects of racial discrimination during public health crises and other global events (Wen et al., 2020). Additionally, the ways in which AAPI groups respond to instances of racial discrimination and sinophobia because of COVID-19–related stress remain largely unknown. The manifestation of

intergenerational trauma on AAPI families related to COVID-19 also represents an important area of future study. Finally, the national and global effects of COVID-19 on the mental health of diverse groups represents an essential topic of future study.

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

References

Aguilar, L. C. (2006). *Ouch! That stereotype hurts: Communicating respectfully in a diverse world*. The WALK THE TALK Company.

Allen, G. K., Conklin, H., & Kane, D. K. (2017). Racial discrimination and psychological health among Polynesians in the U.S. *Cultural Diversity and Ethnic Minority Psychology*, 23(3), 416–424. https://doi.org/10.1037/cdp0000133

Alvarez, A. N., Liang, C. T. H., & Neville, H. A. (Eds). (2016). *The cost of racism for people of color: Contextualizing experiences of discrimination*. American Psychological Association.

American Counseling Association. (2014). *ACA code of ethics*. https://www.counseling.org/docs/default-source/default-document-library/2014-code-of-ethics-finaladdressc97d33f16116603abcacff0000bee5e7.pdf?sfvrsn=5d6b532c_0

American Psychological Association. (2016). *Stress in America: The impact of discrimination*.

Araújo, B. Y., & Borrell, L. N. (2006). Understanding the link between discrimination, mental health outcomes, and life chances among Latinos. *Hispanic Journal of Behavioral Sciences*, 28(2), 245–266. https://doi.org/10.1177/0739986305285825

Au, T. M., Sauer-Zavala, S., King, M. W., Petrocchi, N., Barlow, D. H., & Litz, B. T. (2017). Compassion-based therapy for trauma-related shame and posttraumatic stress: Initial evaluation using a multiple baseline design. *Behavior Therapy*, 48(2), 207–221. https://www.doi.org/10.1016/j.beth.2016.11.012

Benoit, A. C., Cotnam, J., Raboud, J., Greene, S., Beaver, K., Zoccole, A, O'Brian-Teengs, D., Balfour, L., Wu, W., & Loutfy, M. (2016). Experiences of chronic stress and mental health concerns among urban Indigenous women. *Archives of Women's Mental Health*, 19, 809–823. https://doi.org/10.1007/s00737-016-0622-8

Billé, F. (2015). *Sinophobia: Anxiety, violence, and the making of Mongolian identity*. University of Hawai'i Press.

Broido, E. M. (2000). The development of social justice allies during college: A phenomenological investigation. *Journal of College Student Development*, 41(1), 3–18.

Brown, L. S. (2008). *Cultural competence in trauma therapy: Beyond the flashback*. American Psychological Association.

Brown, K. T., & Ostrove, J. M. (2013). What does it mean to be an ally? The perception of allies from the perspective of people of color. *Journal of Applied Social Psychology*, 43(11), 2211–2222. https://doi.org/10.1111/jasp.12172

Bryant-Davis, T., & Ocampo, C. (2006). A therapeutic approach to the treatment of racist-incident-based trauma. *Journal of Emotional Abuse*, 6(4), 1–22. https://doi.org/10.1300/J135v06n04_01

Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist*, 35(1), 13–105. https://doi.org/10.1177/0011000006292033

Carter, R. T., Forsyth, J. M., Mazzula, S. L., & Williams, B. (2005). Racial discrimination and race-based traumatic stress: An exploratory investigation. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling, Volume 2: Training and practice* (pp. 447–476). Wiley.

Centers for Disease Control and Prevention. (2020). *Coronavirus disease 2019: People who are at higher risk*. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html

Choi, Y., & Lim, J. H. (2014). Korean newcomer youth's experiences of racial marginalization and internalization of the model minority myth. *Studies on Asia*, *4*(1), 44–78.

Chou, T., Asnaani, A., & Hofmann, S. G. (2012). Perception of racial discrimination and psychopathology across three U.S. ethnic minority groups. *Cultural Diversity and Ethnic Minority Psychology*, *18*(1), 74–81. http://doi.org/10.1037/a0025432

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist*, *54*(10), 805–816. https://doi.org/10.1037/0003-066X.54.10.805

Cochran, B. N., Stewart, A. J., Ginzler, J. A., & Cauce, A. M. (2002). Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health*, *92*(5), 773–777. https://doi.org/10.2105/ajph.92.5.77

Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist*, *74*(1), 1–5. http://doi.org/10.1037/amp0000442

Congressional Asian American Pacific American Caucus. (2020). *As coronavirus fears incite violence, CAPAC members urge colleagues to not stoke xenophobia.* https://capac-chu.house.gov/press-release/coronavirus-fears-incite-violence-capac-members-urge-colleagues-not-stoke-xenophobia

Devakumar, D., Shannon, G., Bhopal, S. S., & Abubaker, I. (2020). Racism and discrimination in COVID-19 responses. *The Lancet*, *395*(10231), 1194. https://doi.org/10.1016/S0140-6736(20)30792-3

Dreher, A., Hahn, E., Diefenbacher, A., Nguyen, M. H., Böge, K., Burian, H., Dettling, M., Burian, R., & Ta, T. M. T. (2017). Cultural differences in symptom representation for depression and somatization measured by the PHQ between Vietnamese and German psychiatric outpatients. *Journal of Psychosomatic Research*, *102*, 71–77. https://doi.org/10.1016/j.jpsychores.2017.09.010

Edwards, L. M., & Romero, A. J. (2008). Coping with discrimination among Mexican descent adolescents. *Hispanic Journal of Behavioral Sciences*, *30*(1), 24–39. https://doi.org/10.1177/0739986307311431

Federal Emergency Management Agency. (2020). *COVID-19 emergency declaration.* https://www.fema.gov/news-release/2020/03/13/covid-19-emergency-declaration

Filbin, B. (2020, March 20). *Bob's notes on COVID-19: Mental health data on the pandemic.* Crisis Text Line. https://www.crisistextline.org/data/bobs-notes-on-covid-19-mental-health-data-on-the-pandemic

Freire, P. (1970). *Pedagogy of the oppressed*. Continuum.

Gee, G. C., Spencer, M., Chen, J., Yip, T., & Takeuchi, D. T. (2007). The association between self-reported racial discrimination and 12-month DSM-IV mental disorders among Asian Americans nationwide. *Social Science & Medicine*, *64*(10), 1984–1996. https://doi.org/10.1016/j.socscimed.2007.02.013

Gee, G. C., & Verissimo, A. D. O. (2016). Racism and behavioral outcomes over the life course. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), *The cost of racism for people of color: Contextualizing experiences of discrimination* (pp. 133–162). American Psychological Association.

Germer, C. K., & Neff, K. D. (2015). Cultivating self-compassion in trauma survivors. In V. M. Follette, J. Briere, D. Rozelle, J. W. Hopper, & D. I. Rome (Eds.), *Mindfulness-oriented interventions for trauma: Integrating contemplative practices* (pp. 43–58). Guilford.

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy*, *13*(6), 353–379. https://doi.org/10.1002/cpp.507

Go, A. S., Mozaffarian, D., Roger, V. L., Benjamin, E. J., Berry, J. D., Blaha, M. J., Dai, S., Ford, E. S., Fox, C. S., Franco, S., Fullerton, H. J., Gillespie, C., Hailpern, S. M., Heit, J. A., Howard, V. J., Huffman, M. D., Judd, S. E., Kissela, B. M., Kittner, S. J. . . . Turner, M. B. (2014). Executive summary: Heart disease and stroke statistics—2014 update: A report from the American Heart Association. *Circulation*, *129*(3), 399–410. https://doi.org/10.1161/01.cir.0000442015.53336.12

Graser, J., Höfling, V., Weßlau, C., Mendes, A., & Stangier, U. (2016). Effects of a 12-week mindfulness, compassion, and loving kindness program on chronic depression: A pilot within-subjects wait-list controlled trial. *Journal of Cognitive Psychotherapy*, *30*(1), 35–49. https://doi.org/10.1891/0889-8391.30.1.35

Grover, S., & Ghosh, A. (2014). Somatic symptom and related disorders in Asians and Asian Americans. *Asian Journal of Psychiatry*, *7*, 77–79. https://doi.org/10.1016/j.ajp.2013.11.014

Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of color. *American Journal of Orthopsychiatry*, *70*(1), 42–57. https://doi.org/10.1037/h0087722

Helms, J. E., Nicolas, G., & Green, C. E. (2012). Racism and ethnoviolence as trauma: Enhancing professional and research training. *Traumatology*, *18*(1), 65–74. https://doi.org/10.1177/1534765610396728

Hernández-Wolfe, P. (2013). *A borderlands view on Latinos, Latin Americans, and decolonization: Rethinking mental health*. Jason Aronson.

Hinton, D. E., & Good, B. J. (Eds.). (2009). *Culture and panic disorder.* Stanford University Press.

Hinton, D. E., & Good, B. J. (Eds.). (2016). *Culture and PTSD: Trauma in global and historical perspective*. University of Pennsylvania Press.

Hinton, D. E., & Jalal, B. (2019). Dimensions of culturally sensitive CBT: Application to Southeast Asian populations. *American Journal of Orthopsychiatry*, *89*(4), 493–507. https://doi.org/10.1037/ort0000392

Hinton, D. E., & Lewis-Fernández, R. (2011). The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5. *Depression & Anxiety*, *28*(9), 783–801. https://doi.org/10.1002/da.20753

Hinton, D. E., Pollack, A. A., Weiss, B., & Trung, L. T. (2018). Culturally sensitive assessment of anxious-depressive distress in Vietnam: Avoiding category truncation. *Transcultural Psychiatry, 55*(3), 384–404. https://doi.org/10.1177/1363461518764500

Hofmann, S. G., Grossman, P., & Hinton, D. E. (2011). Loving-kindness and compassion meditation: Potential for psychological interventions. *Clinical Psychology Review*, *31*(7), 1126–1132. https://doi.org/10.1016/j.cpr.2011.07.003

Huber, L. P., & Soloranzo, D. G. (2015). Racial microaggressions as a tool for critical race research. *Race, Ethnicity and Education*, *18*(3), 297–320. https://doi.org/10.1080/13613324.2014.994173

Hwang, W.-C., & Goto, S. (2008). The impact of perceived racial discrimination on the mental health of Asian American and Latino college students. *Cultural Diversity and Ethnic Minority Psychology*, *14*(4), 326–335. https://doi.org/10.1037/1099-9809.14.4.326

Iwamoto, D. K., & Liu, W. M. (2010). The impact of racial identity, ethnic identity, Asian values, and race-related stress on Asian Americans and Asian international college students' psychological well-being. *Journal of Counseling Psychology*, *57*(1), 79–91. https://doi.org/10.1037/a0017393

Jones, H. L., Cross, W. E., Jr., & DeFour, D. C. (2007). Race-related stress, racial identity attitudes, and mental health among Black women. *Journal of Black Psychology*, 33(2), 208–231. https://doi.org/10.1177/0095798407299517

Kawai, Y. (2005). Stereotyping Asian Americans: The dialectic of the model minority and the Yellow Peril. *Howard Journal of Communications*, *16*(2), 109–130. http://doi.org/10.1080/10646170590948974

Kearney, D. J. (2015). Mindfulness-based stress reduction and loving-kindness meditation for traumatized veterans. In V. M. Follette, J. Briere, D. Rozelle, J. W. Hopper, & D. I. Rome (Eds.), *Mindfulness-oriented interventions for trauma: Integrating contemplative practices* (pp. 273–283). Guilford.

Kuyken, W., Watkins, E., Holden, E., White, K., Taylor, R. S., Byford, S., Evans, A., Radford, S., Teasdale, J. D., & Dalgleish, T. (2010). How does mindfulness-based cognitive therapy work? *Behaviour Research and Therapy*, *48*(11), 1105–1112. https://doi.org/10.1016/j.brat.2010.08.003

Lee, E. (2002). The Chinese exclusion example: Race, immigration, and American gatekeeping, 1882-1924. *Journal of American Ethnic History*, *21*(3), 36–62.

Lee, E. A., Soto, J. A., Swim, J. K., & Bernstein, M. J. (2012). Bitter reproach or sweet revenge: Cultural differences in response to racism. *Personality and Social Psychology Bulletin*, *38*(7), 920–932. http://doi.org/10.1177/0146167212440292

Liang, C. T. H., & Fassinger, R. E. (2008). The role of collective self-esteem for Asian Americans experiencing racism-related stress: A test of moderator and mediator hypotheses. *Cultural Diversity and Ethnic Minority Psychology*, *14*(1), 19–28. https://doi.org/10.1037/1099-9809.14.1.19

Lopez, G., Ruiz, N. G., & Patten, E. (2017). *Key facts about Asian Americans, a diverse and growing population.* https://www.pewresearch.org/fact-tank/2017/09/08/key-facts-about-asian-americans

Mattar, S. (2011). Educating and training the next generations of traumatologists: Development of cultural competencies. *Psychological Trauma: Theory, Research, Practice, and Policy*, *3*(3), 258–265. https://doi.org/10.1037/a0024477

Mossakowski, K. N. (2003). Coping with perceived discrimination: Does ethnic identity protect mental health? *Journal of Health and Social Behavior*, 44(3), 318–331. https://doi.org/10.2307/1519782

National Association for the Advancement of Colored People. (2020, March 17). *Civil rights and racial justice organizations denounce discrimination against Asian Americans and urge unity in responding to coronavirus pandemic.* https://www.naacp.org/latest/civil-rights-racial-justice-organizations-denounce-discrimination-asian-americans-urge-unity-responding-coronavirus-pandemic

Ocampo, A. C., & Soodjinda, D. (2016). Invisible Asian Americans: The intersection of sexuality, race, and education among gay Asian Americans. *Race, Ethnicity, and Education*, 19(3), 480–499. https://doi.org/10.1080/13613324.2015.1095169

Pieterse, A. L., Todd, N. R., Neville, H. A., & Carter, R. T. (2012). Perceived racism and mental health among Black American adults: A meta-analytic review. *Journal of Counseling Psychology*, 59(1), 1–9. https://doi.org/10.1037/a0026208

Pieterse, A., & Powell, S. (2016). A theoretical overview of the impact of racism on people of color. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), *The cost of racism for people of color: Contextualizing experiences of discrimination* (pp. 11–30). American Psychological Association.

Pokhrel, P., & Herzog, T. A. (2014). Historical trauma and substance use among Native Hawaiian college students. *American Journal of Health Behavior*, 38(3), 420–429. https://doi.org/10.5993/AJHB.38.3.11

Potok, M. (2017). The Trump effect. *Intelligence Report.* https://www.splcenter.org/fighting-hate/intelligence-report/2017/trump-effect

Qin, D. B., Way, N., & Rana, M. (2008). The "model minority" and their discontent: Examining peer discrimination and harassment of Chinese American immigrant youth. *New Directions for Child and Adolescent Development*, 2008(121), 27–42. https://doi.org/10.1002/cd.221

Rodriguez-Seijas, C., Stohl, M., Hasin, D. S., & Eaton, N. R. (2015). Transdiagnostic factors and mediation of the relationship between perceived racial discrimination and mental disorders. *JAMA Psychiatry*, 72(7), 706–713. https://doi.org/10.1001/jamapsychiatry.2015.0148

Schild, L., Ling, C., Blackburn, J., Stringhini, G., Zhang, Y., & Zannettou, S. (2020). "Go eat a bat, Chang!" An early look on the emergence of sinophobic behavior on web communities in the face of COVID-19. *Computers and Society*, 1–16. https://arxiv.org/pdf/2004.04046.pdf

Shelton, J. N., Richeson, J. A., Salvatore, J., & Hill, D. M. (2006). Silence is not golden: The intrapersonal consequences of not confronting prejudice. In S. Levin & C. van Laar (Eds.), *Stigma and group inequality: Social psychological perspectives* (pp. 65–81). Lawrence Erlbaum.

Shonin, E., Van Gordon, W., Compare, A., Zangeneh, M., & Griffiths, M. D. (2015). Buddhist-derived loving-kindness and compassion meditation for the treatment of psychopathology: A systematic review. *Mindfulness*, 6(5), 1161–1180. https://www.doi.org/10.1007/s12671-014-0368-1

Smith, W. A., Hung, M., & Franklin, J. D. (2011). Racial battle fatigue and the miseducation of Black men: Microaggressions, societal problems, and environmental stress. *The Journal of Negro Education*, 80(1), 63–82. https://doi.org/10.2307/41341106

Sue, D. W. (2015). *Race talk and the conspiracy of silence: Understanding and facilitating difficult dialogues on race.* Wiley.

Sue, D. W., Alsaidi, S., Awad, M. N., Glaeser, E., Calle, C. Z., & Mendez, N. (2019). Disarming racial microaggressions: Microintervention strategies for targets, White allies, and bystanders. *American Psychologist*, 74(1), 128–142. https://doi.org/10.1037/amp0000296

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, 62(4), 271–286. https://doi.org/10.1037/0003-066X.62.4.271

Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory and practice* (7th ed.). Wiley.

Sundstrom, R. R., & Kim, D. H. (2014). Xenophobia and racism. *Critical Philosophy of Race*, 2(1), 20–45. https://doi.org/10.5325/critphilrace.2.1.0020

Taylor, S. (2019). *The psychology of pandemics: Preparing for the next global outbreak of infectious disease.* Cambridge Scholars Publishing.

Taylor, S., & Asmundson, G. J. G. (2004). *Treating health anxiety: A cognitive-behavioral approach.* Guilford.

Ting-Toomey, S., Yee-Jung, K. K., Shapiro, R. B., Garcia, W., Wright, T. J., & Oetzel, J. G. (2000). Ethnic/cultural identity salience and conflict styles in four US ethnic groups. *International Journal of Intercultural Relations*, 24(1), 47–81. https://doi.org/10.1016/S0147-1767(99)00023-1

Tsai, J., & Wilson, M. (2020). COVID-19: A potential public health problem for homeless populations. *The Lancet*, *5*(4), e186–e187. https://doi.org/10.1016/S2468-2667(20)30053-0

United Nations Human Rights, Office of the High Commissioner. (2020, March 23). *States should take action against COVID-19-related expressions of xenophobia, says UN expert.* https://www.ohchr.org/EN/News Events/Pages/DisplayNews.aspx?NewsID=25739&LangID=E

Unnikrishnan, R., Gupta, P. K., & Mohan, V. (2018). Diabetes in South Asians: Phenotype, clinical presentation, and natural history. *Current Diabetes Reports*, *18*(30). https://doi.org/10.1007/s11892-018-1002-8

U.S. Department of Health and Human Services. (2000). *Mental health: Culture, race and ethnicity: A supplement to* Mental health: A report of the Surgeon General.

Waters, A. (2010). Book review: Injustice. *Local Economy*, *25*(5–6), 523–525. https://doi.org/10.1080/02690942.2010.525995

Wei, M., Alvarez, A. N., Ku, T.-Y., Russell, D. W., & Bonett, D. G. (2010). Development and validation of a Coping with Discrimination Scale: Factor structure, reliability, and validity. *Journal of Counseling Psychology*, *57*(3), 328–344. https://doi.org/10.1037/a0019969

Wei, M., Heppner, P. P., Ku, T.-Y., & Liao, K. Y.-H. (2010). Racial discrimination stress, coping, and depressive symptoms among Asian Americans: A moderation analysis. *Asian American Journal of Psychology*, *1*(2), 136–150. https://doi.org/10.1037/a0020157

Wei, M., Wang, K. T., Heppner, P. P., & Du, Y. (2012). Ethnic and mainstream social connectedness, perceived racial discrimination, and posttraumatic stress symptoms. *Journal of Counseling Psychology*, *59*(3), 486–493. https://doi.org/10.1037/a0028000

Wen, J., Aston, J., Liu, X., & Ying, T. (2020). Effects of misleading media coverage on public health crisis: A case of the 2019 novel coronavirus outbreak in China. *Anatolia: An International Journal of Tourism and Hospitality Research.* https://doi.org/10.1080/13032917.2020.1730621

White, A. I. R. (2020). The art of medicine: Historical linkages: Epidemic threat, economic risk, and xenophobia. *The Lancet*, *395*, 1250–1251. https://doi.org/10.1016/S0140-6736(20)30737-6

Williams, D. R., & Williams-Morris, R. (2000). Racism and mental health: The African American experience. *Ethnicity and Health*, *5*(3–4), 243–268. https://doi.org/10.1080/713667453

World Health Organization. (2015, May 8). *WHO issues best practices for naming new human infectious diseases*. https://www.who.int/mediacentre/news/notes/2015/naming-new-diseases/en

Yoo, H. C., & Lee, R. M. (2005). Ethnic identity and approach-type coping as moderators of the racial discrimination/well-being relation in Asian Americans. *Journal of Counseling Psychology*, *52*(4), 497–506. https://doi.org/10.1037/0022-0167.52.4.497

Yum, J. O. (1988). The impact of Confucianism on interpersonal relationships and communication patterns in East Asia. *Communication Monographs*, *55*(4), 374–388. https://doi.org/10.1080/03637758809376178

nbcc

Attachment, Ego Resilience, Emerging Adulthood, Social Resources, and Well-Being Among Traditional-Aged College Students

Joel A. Lane

To improve conceptualizations of college student mental health, the present study (*N* = 538) compared predictors of well-being that comprise both well-established counseling theories (e.g., attachment) and newer models specific to the life experience of the millennial generation and Generation Z. Predictors included internal resources (i.e., attachment security, ego resilience), emerging adulthood identification, and social resources (i.e., social support, social media usage). Each variable set predicted significant variance. The emerging adulthood and social media variables accounted for approximately 7% of variance in both psychological well-being and life satisfaction. Identifying emerging adulthood as a time of negativity and instability was the second strongest predictor of psychological well-being, while identifying emerging adulthood as a time of experimentation and possibilities was the second biggest predictor of life satisfaction. Implications for conceptualizing and treating today's students are discussed.

Keywords: college counseling, emerging adulthood, social media, attachment, social support

In recent years, higher education personnel have noticed declines in college student emotional health and corresponding increases in stress, depression, and anxiety (Watkins et al., 2012). The rates of students exhibiting frequent anxiety and depression symptoms have nearly doubled over a 30-year period and are now two to three times higher than those of the general population (American College Health Association [ACHA], 2015). Administrators have also described corresponding changes in college counseling services, especially regarding the increased need for crisis intervention and triage services (Watkins et al., 2012).

These trends roughly correspond to the millennial generation and Generation Z entering college. The societal forces that characterize these generational cohorts, including the proliferation of social media (Ellison et al., 2007; McCay-Peet & Quan-Haase, 2017) and increases in parental involvement and corresponding decreases in perceptions of college student maturity and autonomy (Watkins et al., 2012), seem to have substantially altered the psychosocial trajectories for today's traditional-aged college populations (Arnett, 2004, 2016). The counseling profession has wrestled with how best to respond to these trends, and in many cases has relied on conceptual frameworks and theories of psychosocial development created long before the emergence of the millennial generation. It seems timely to attempt to develop a framework for mental health and well-being during the college years that incorporates theories specific to present generations of traditional-aged college students with more well-established theories of development. Such is the purpose of the present study, in which the contributions to college student well-being of attachment security (Bowlby, 1969/1997), ego resilience (Block & Block, 1980), and social support are integrated with and compared to the theory of emerging adulthood (Arnett, 2004), a conceptualization of psychosocial development occurring from the late teens through the 20s for contemporary generations.

Joel A. Lane, PhD, NCC, LPC, is an associate professor and department chair at Portland State University. Correspondence may be addressed to Joel Lane, 250G Fourth Avenue Building, 1900 SW 4th Ave., Portland, OR 97201, lanejoel@pdx.edu.

Attachment and Ego Resilience

It is generally accepted that the constructs of attachment security and ego resilience play important roles in college student mental health and well-being (e.g., Lane, 2015; Taylor et al., 2014). According to Bowlby (1969/1997), the quality of our earliest interactions with caregivers provides us with relational templates, or types of *attachment*, that influence self-worth and interpersonal functioning throughout the life span. *Ego resilience* is a personality trait reflecting our ability to adapt and thrive amid stress and transition (Block & Block, 1980; Taylor et al., 2014). In the present study, attachment and ego resilience are conceptualized as *internal resources* because they are instilled early in life, relatively stable over time, and influential to mental health during the college years (Lane, 2016; Lane et al., 2017; Taylor et al., 2014).

Attachment and ego resilience also similarly impact functioning in times of challenge. With secure attachment, individuals are more likely to believe themselves capable of handling adversity and that others can be called upon in times of need (Brennan et al., 1998), presumably because of the consistent responsiveness of their caregivers earlier in life. Conversely, insecure attachment can lead individuals to doubt their own capabilities (i.e., attachment anxiety) or the intentions of others to provide them with support (i.e., attachment avoidance) in times of need. These internalized beliefs can lead to problematic outcomes during distressing situations (Wei et al., 2007), including maladaptive interpersonal dependence or isolation and a heightened focus on the distress (Brennan et al., 1998). Similarly, individuals high in ego resilience are generally able to respond to stressful situations with flexibility and an assortment of healthy coping behaviors (Taylor et al., 2014). Conversely, individuals low in ego resilience may lack the diversity of healthy coping strategies necessary to effectively persevere through a range of life challenges, and they may be prone to giving up when frustrated (Block & Block, 1980). Thus, individuals with attachment insecurity and low ego resilience are at an increased risk of accumulating stress during stressful situations rather than persevering through them (Brennan et al., 1998), which is a likely explanation for the associations of each construct with depression and anxiety symptoms (Taylor et al., 2014).

This latter point is especially important in the context of the present study. The college experience contains numerous life and role transitions, including leaving home, establishing independence, reconstructing social support networks, and developing professional goals (Lane, 2015). Each of these transitions pose opportunities for students high in internal resources to thrive and risks for those who are low in internal resources to accumulate stress and negative mental health symptoms (Lane, 2015). Accordingly, internal resources are conceptualized as the first set of constructs in the present model. That is, they seem to provide a foundation for college student mental health and well-being and perhaps do so by contributing to other potentially relevant aspects of well-being, such as identification with emerging adulthood (Schnyders & Lane, 2018) and social support (Galambos et al., 2006).

Emerging Adulthood

Although attachment and ego resilience have long been considered contributors to college student mental health and well-being, many of the aforementioned factors involved in declining mental health trajectories comprise social forces unique to present-day young adults. *Emerging adulthood* (Arnett, 2004) is a theory that describes the effects of such factors on psychosocial functioning between the ages of 18 and 29. Specifically, it suggests that this age range now represents a period of life distinct from both adolescence and adulthood. The theory describes several dimensions that are representative of the present-day emerging adult experience, including a prolonged period of identity exploration (i.e., using the emerging adulthood years to consider and audition preferences regarding career, worldviews, romantic relationships, and interpersonal characteristics), significant demographic and relational instability (e.g., increased likelihood of multiple residence changes with respect to previous generations,

causing disruptions in social groups), subjectively feeling in between adolescence and adulthood, and idealistic thinking about future possibilities (Arnett, 2004). These dimensions suggest that emerging adulthood is a complex phenomenon with significant individual variation: One's degree of identification with each dimension can shape their relative satisfaction with the overall emerging adulthood experience (Baggio et al., 2015). Moreover, some evidence suggests that parental attachment quality predicts one's identification with the various themes of emerging adulthood (Schnyders & Lane, 2018).

Emerging adulthood theory has several implications in the context of college student well-being. First, life transition is a salient theme of emerging adulthood, given that the late teens and 20s are a time of leaving the parental household, creating new attachment and support networks, entering and persisting through college (for many emerging adults), and entering the world of work (Arnett, 2004). These transitions can leave emerging adults vulnerable to distress (Lane et al., 2017) and are central features of the college student experience. Second, emerging adulthood suggests that present traditional-aged college students are at an earlier stage of psychosocial development than prior generations, even though expectations placed on them have remained stable (Arnett, 2004). Thus, emerging adult college students are still expected to navigate the many transitions of the college experience regardless of whether or not they have developed the necessary maturity and life skills. Finally, the emerging adulthood years constitute a high degree of risk-taking behaviors, impulsivity, and psychiatric risk (Arnett, 2004; Baggio et al., 2015). That is, not only is emerging adulthood a time of vulnerability to stress, but also a time of elevated risk for maladaptive stress responses. Thus, in the context of the present study, it is possible that the emerging adult experience uniquely contributes to mental health and well-being with respect to the contribution of internal resources.

Social Resources

Like interpersonal resources and emerging adulthood, social support is a construct with implications for mental health. The degree to which an individual feels supported by their close relationships mitigates distress during stressful situations (Sarason et al., 1991). Individuals who are satisfied with their social support also report less depression, anxiety, and loneliness, and enhanced well-being compared to those low in social support (Galambos et al., 2006).

The aforementioned societal changes impacting emerging adulthood also have implications for college student social support. Today's emerging adult social support networks have grown in complexity as psychosocial developmental trajectories have continued to evolve (Arnett, 2004) and social media has become an increasingly ingrained aspect of everyday life. These changes necessitate reconsideration of the construct of social support in the 21st century. That is, what are the implications for social support when interpersonal contact is increasingly conducted electronically? Is it possible for one to derive the benefits of social support from social media interactions? To address these questions, Manago et al. (2012) asked a sample of college students to respond to various support-related questions while browsing Facebook. Participants were able to use Facebook to meet certain intimacy needs, especially that of emotional disclosure, and the size of one's Facebook friends list was positively associated with perceived social support and life satisfaction. Others have suggested that social media sites provide social capital and facilitate sustained connection with potentially beneficial relationships (Ellison et al., 2007). In light of these ideas, the present study conceptualizes social resources to include both social support and social media usage. Assessing the degree to which each construct impacts college student mental health and well-being is important given the ubiquity of social media on college campuses and the current disagreement among scholars regarding its benefits (Manago et al., 2012) and drawbacks (Twenge, 2013). Given that social support seems to facilitate the contributions of internal resources to mental health (Taylor et al., 2014) and emerging adulthood contributes to

increasingly complex social networks (Arnett, 2004), social resources are conceptualized as a third level of constructs in the present model, after internal resources and emerging adulthood identification.

Present Study

The present study was designed to address several literature gaps concerning college student mental health and well-being. First, it combines several disparate threads of related research by testing a model including internal resources (i.e., attachment security and ego resilience), identification with the dimensions of emerging adulthood, and social resources (i.e., social support and social media usage). Although some research has examined the additive impact of more than one of these sets of constructs together (e.g., attachment and social support), no existing research has examined all three collectively. Second, the present study examined the mental health implications of emerging adulthood and social media usage: two constructs that are the result of 21st century societal forces. A primary hypothesis of the study was that each predictor variable set would explain unique and additive variance for two characteristics of college student mental health (i.e., psychological well-being [PWB] and life satisfaction). A secondary hypothesis was that emerging adulthood identification and social media usage would predict unique variance in each outcome variable even after accounting for the effects of all other predictor variables in the model.

Method

Participants and Procedure

Participants in this IRB-approved study were traditional-aged undergraduate students from a large, public university in a metropolitan area of the Pacific Northwest. Participants were recruited via a recruitment email sent to a random sample of students meeting the inclusion criteria (i.e., 18 to 25 years old and enrolled as a full-time undergraduate student). An a priori power analysis was conducted to determine appropriate sample size (Faul et al., 2007). Given the large number of variables in the model and the fact that Hypothesis 2 was based on semipartial correlations, a small-to-medium effect size was selected ($f^2 = .08$). Results suggested an ideal sample size of approximately 400 participants. Assuming an approximate 10% response rate (Manfreda et al., 2008), recruitment emails were sent to 4,000 undergraduates.

The recruitment email contained a link to an online survey containing all demographic and study variable items. Surveys were received from 616 undergraduates (15.4% response rate). Data were treated according to the recommendations for multivariate analysis by Meyers et al. (2013). That is, 56 cases (9.1%) were removed because they contained missing data on at least 50% of the items. An additional 17 cases (2.8%) were removed for indicating that they were no longer paying attention at the midpoint of the survey. The remaining missing values were replaced with their respective item mean because no item was missing more than seven cases (1.3%) and no variable contained more than two missing items for any remaining participant. Data were screened for multivariate outliers using Mahalanobis distance, resulting in the removal of five (0.9%) participants. Thus, the study sample consisted of 538 participants.

The study sample had a mean age of 21.72 years ($SD = 2.05$) and was predominantly female ($n = 378$, 70.3%), while other participants identified as male ($n = 142$, 26.4%) or other ($n = 16$, 3.0%), and two participants declined to answer. The sample was racially diverse, as 341 (63.4%) participants identified as White, 64 (11.9%) as Latinx, 63 (11.7%) as Asian or Pacific Islander, 14 (2.6%) as Black or African American, 11 (2.0%) as Arab American or Middle Eastern, eight (1.5%) as Native American, 27 (5.0%) as multiracial, and seven (1.3%) as other, while three participants declined to answer.

Instruments

Attachment security. As the first internal resources variable, attachment security was measured using the 12-item Experiences in Close Relationship Scale-Short Form (ECR-S; Wei et al., 2007). The items are evenly divided into two subscales: Attachment Anxiety (e.g., "I need a lot of reassurance that I am loved by my partner") and Attachment Avoidance (e.g., "I am nervous when partners get too close to me"). Items are rated on a 7-point Likert scale. Scores were summed, with higher scores indicating higher attachment insecurity for each dimension. Internal consistencies in the present sample (α = .78 for attachment anxiety, α = .80 for attachment avoidance) mirrored those reported by the ECR-S authors (α = .77 and α = .78, respectively).

Ego resilience. Ego resilience served as the other internal resources variable. It was measured using an 11-item version of Block and Block's (1980) Ego-Resiliency Scale (Taylor et al., 2014). Items (e.g., "I can bounce back and recover after a stressful or bad experience") are rated on a Likert scale ranging from one (*most undescriptive of me*) to nine (*most descriptive of me*). Higher total scores indicate higher ego resilience. The 11-item version has demonstrated internal consistencies ranging from .63 to .81 across multiple time points with a sample of emerging adults (Taylor et al., 2014). Internal consistency in the present sample was .73.

Emerging adulthood. The second level of predictor variables comprised dimensions of emerging adulthood. Identification with emerging adulthood dimensions was assessed using the 8-item Inventory of Dimensions of Emerging Adulthood (IDEA-8; Baggio et al., 2015). The items are evenly divided into four subscales (i.e., Experimentation/Possibilities, Negativity/Instability, Identity Exploration, and Feeling In Between [adolescence and adulthood]) that each represent dimensions of emerging adult theory (Arnett, 2004). Participants rate the degree to which various statements represent the present time in their lives (e.g., "this is a time of deciding on your own beliefs and values") on a 4-point scale (1 = *strongly disagree*, 4 = *strongly agree*). Scores for each subscale are summed to indicate how participants feel each dimension characterizes their emerging adulthood experience. The IDEA-8 subscales demonstrate internal consistencies ranging from .66 to .76 (Baggio et al., 2015), mirroring the range found in the present sample (α = .69 to α = .77).

Social support. Social support served as the first social resources variable. It was measured using the 6-item Subjective Social Support subscale of the Duke Social Support Index (Blazer et al., 1990). Items (e.g., "Can you talk about your deepest problems with at least some of your family and friends?") are rated on a 5-point scale (1 = *none of the time*, 5 = *all of the time*), with higher scores indicating higher perceived social support. Internal consistency in the present sample was .85, mirroring estimates found in prior studies (α = .82; Hawley et al., 2014).

Facebook usage. The other social resources variable was social media usage, measured using the 8-item Facebook Intensity Scale (FIS; Ellison et al., 2007). Although numerous social media platforms are popular among college students, developers of social media usage instruments have focused on Facebook. Given its recognizability and ubiquity, it remains the best proxy for assessing overall social media usage (Ortiz-Ospina, 2019). The first FIS item asks participants to approximate their number of Facebook "friends," while the second item asks them to approximate time spent on Facebook each day. The remaining items ask participants to rate their agreement with various items assessing the importance of Facebook in their lives (e.g., "Facebook has become a part of my daily routine"). Items are first standardized and then summed to create an index of Facebook usage. The FIS authors reported strong convergent validity and internal consistency (α = .83), mirroring that found in the present sample (α = .87).

College student mental health. Operationalizing mental health is challenging given its many existing conceptualizations. Some authors have argued that mental health and mental illness are separate constructs entirely (e.g., Lent, 2004). Lent (2004) suggested that a complete understanding of mental health incorporates both PWB and subjective well-being (i.e., happiness) and added that subjective well-being is best conceptualized as a higher-order outcome of PWB. Others have argued that PWB and depression are opposite ends of the same construct (Bech et al., 2003), suggesting that PWB instruments also measure depressive affect and vice versa. Collectively, and in conjunction with the focus on depressive symptoms in the aforementioned college student mental health research, it seems useful to conceptualize mental health using indices of PWB and life satisfaction (Lent, 2004).

Psychological well-being. PWB was measured using the 5-item World Health Organization-Five Well-Being Index (WHO-5; Bech et al., 2003). Each item is a positively worded self-statement measuring the absence of various symptoms of depression (e.g., "I have felt calm and relaxed"). Because of its ability to measure both well-being and depression, it was selected as an ideal candidate for the present study. The presence of each statement over a 2-week period is rated on a 6-point scale (0 = *not present*, 5 = *constantly present*). Scores are multiplied by four to create a 0–100 scale, with higher scores indicating higher PWB, and scores below 28 indicating clinical depression (Bech et al., 2003). The authors reported strong evidence for reliability (α = .82) and validity. In the present sample, internal consistency was .81.

Life satisfaction. Life satisfaction was measured using the Satisfaction with Life Scale (SWLS; Diener et al., 1985). Participants rate agreement with five items (e.g., "In most ways my life is close to my ideal") on a 7-point scale (1 = *strongly disagree*, 7 = *strongly agree*). Internal consistency in both the validation study and present sample was .87.

Results

Table 1 presents the descriptive statistics and intercorrelations for all study variables. With the exception of the emerging adult feeling in between variable, all variables were significantly correlated with each of the outcome variables. Significant correlations ranged from small to large for both PWB (r = .12, p < .05 for Facebook usage and r = .44, p < .001 for ego resilience) and life satisfaction (r = .12, p < .01 for identity exploration and r = .50, p < .001 for social support). Also, the outcome variables were significantly associated with three emerging adulthood variables in different directions. That is, they were positively correlated with experimentation/possibilities and identity exploration, and they were negatively and moderately correlated with negativity/instability; however, neither outcome variable was significantly associated with the feeling in between variable.

To reduce the possibility of confounds in the regression results, several potential covariates were tested for their relatedness to the outcome variables. Based on prior research, age, gender, and race were tested (Galambos et al., 2006; Schnyders & Lane, 2018). Gender and race were dummy coded so that a) 0 = *non-woman* (i.e., man or other) and 1 = *woman*, and b) 0 = *non-White* and 1 = *White*. Significant differences were present in the Satisfaction with Life Scale scores on the basis of gender: $t(537)$ = -2.841, p < .01. The mean life satisfaction score for women in the sample was 1.91 points higher than for non-women. Thus, all subsequent analyses controlled for the effects of gender. No other significant associations involving the potential covariates were present.

Table 1

Pearson Intercorrelations Among Study Variables

Variables			Intercorrelations									
	M	*SD*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
1. AAn.	23.42	7.28	–									
2. AAv.	17.03	6.76	.07	–								
3. ER	69.10	11.94	-.33**	-.08	–							
4. EP	7.08	1.16	-.17**	-.04	.24**	–						
5. NI	6.90	1.24	.20**	.06	-.25**	-.06	–					
6. IE	6.80	1.34	-.05	.04	.12*	.38**	.07	–				
7. IB	6.83	1.38	.06	.06	-.01	.22**	.12*	.41*	–			
8. SS	21.98	4.27	-.25**	-.27**	.32**	.21**	-.19**	.07	.05	–		
9. FB	21.75	8.72	.13*	-.11*	-.05	.08	-.02	.08	.16**	.14*	–	
10. PWB	55.35	18.72	-.27**	-.14*	.44**	.32**	-.34**	.16**	.03	.40**	.12*	–
11. LS	21.72	7.21	-.25**	-.25**	.39**	.36**	-.30**	.12*	-.02	.50**	.14*	.61**

Note. N = 538. AAn. = attachment anxiety; AAv. = attachment avoidance; ER = ego resilience; EP = experimentation/possibilities; NI = negativity/instability; IE = identity exploration; IB = feeling in between; SS = social support; FB = Facebook usage; PWB = psychological well-being; LS = life satisfaction.
*p < .05. **p < .001

Hypothesis 1 predicted that internal resources, emerging adulthood identification, and social resources would each predict unique and additive variance in each outcome variable. Thus, two hierarchical regression analyses were conducted (one with PWB as the outcome variable and one with life satisfaction as the outcome). Each set of predictors was entered as an individual level in the hierarchical regression. Table 2 presents the results of these analyses. As can be seen in Table 2, Hypothesis 1 was fully supported. Each predictor variable set predicted significant additive variance in each outcome variable after accounting for the preceding predictor variable sets in the model. It is also useful to note that the social resources variables predicted over twice as much additive variance in life satisfaction (ΔR^2 = .08, $p < .001$) compared to that of PWB (ΔR^2 = .03, $p < .001$). The model accounted for 36% of the variance in PWB and 41% of the variance in life satisfaction.

Table 2

Summary of Hierarchical Regression Analyses Predicting PWB and Life Satisfaction

Step and Variable	ΔR^2	ΔF	β	t	r_{sp}
Outcome variable: PWB					
Step 1 – Internal resources	.22	38.619***			
Attachment anxiety			-.14	-3.438**	-.07*
Attachment avoidance			-.09	-2.308*	-.03
Ego resilience			.40	9.685***	.23***
Step 2 – Emerging adulthood	.09	8.259***			
Experimentation/possibilities			.19	4.677***	.14***
Negativity/instability			-.23	-6.177***	-.20***
Identity exploration			.06	1.403	.05
Feeling in between			.00	0.03	-.02
Step 3 – Social resources	.03	1.681***			
Social support			.19	4.679***	.16***
Facebook usage			.09	2.361*	.08*
Outcome variable: Life satisfaction					
Step 1 – Internal resources	.22	32.966***			
Attachment anxiety			-.12	-2.960**	-.03
Attachment avoidance			-.20	-5.185***	-.11**
Ego resilience			.36	8.711***	.17***
Step 2 – Emerging adulthood	.09	8.131***			
Experimentation/possibilities			.26	6.571***	.20***
Negativity/instability			-.19	-5.139***	-.15***
Identity exploration			.01	0.304	.02
Feeling in between			-.05	-1.273	-.07*
Step 3 – Social resources	.08	4.872***			
Social support			.31	8.138***	.27***
Facebook usage			.08	2.176*	.07*

Note. N = 538. Results control for the effects of gender. r_{sp} = semipartial correlation. r_{sp} is reported for the last step in each model.
* $p < .05$, ** $p < .01$, *** $p < .001$.

Hypothesis 2 predicted that the emerging adulthood variables and Facebook usage would each predict significant individual variance in each outcome variable after accounting for the effects of all other predictor variables. To test this hypothesis, semipartial correlations (r_{sp}) were examined for all variables at the last step of the hierarchical regression (i.e., the step in which all variables are entered into the model). Semipartial correlations examine the unique variance explained by a single predictor after accounting for the collective variance explained by all other predictors (Meyers et al., 2013). As

can be seen in Table 2, significant semipartial correlations predicting PWB included the negativity/instability (r_{sp} = -.20, p < .001), experimentation/possibilities (r_{sp} = .14, p < .001), and Facebook usage (r_{sp} = .08, p < .05) variables. Of all the predictors of PWB in the model, negativity/instability made the second largest individual contribution. Of the predictors of life satisfaction, significant semipartial correlations included experimentation/possibilities (r_{sp} = .20, p < .001), negativity/instability (r_{sp} = -.15, p < .001), feeling in between (r_{sp} = -.07, p < .05), and Facebook usage (r_{sp} = .07, p < .05). The experimentation/possibilities variable made the second largest individual contribution to life satisfaction. However, because identity exploration was not significant for either outcome variable, and feeling in between was not significant for life satisfaction, Hypothesis 2 was only partially supported. Collectively, the emerging adulthood and Facebook variables accounted for 7.4% of unique variance in PWB and 7.1% of unique variance in life satisfaction.

Discussion

The present findings yield several useful contributions. First, they bridge disparate threads of research by comparing the contributions of well-established mental health predictors with those of constructs unique to present-day college students, each of which contributed uniquely to college student mental health. Although many of the effects of the individual variables were small, the emerging adulthood and Facebook variables collectively explained roughly 7% of unique variance in the mental health variables over and above that explained by the more well-established constructs. As such, the findings are consistent with the assertion that constructs like attachment, ego resilience, and social support, while useful to conceptualizing college student mental health, may nevertheless be aided by also considering factors unique to 21st-century students.

The positive associations between Facebook usage and college student mental health are noteworthy, given the current disagreement regarding the impact of social media use. Contrary to concerns regarding social media overuse (e.g., Twenge, 2013), the present study found that Facebook usage positively predicted PWB and life satisfaction, albeit with a small effect. This was true even after controlling for other predictor variables, suggesting that Facebook provided a small but unique contribution to college student mental health. This finding supports the conclusions of Manago et al. (2012) that Facebook can fulfill certain social support needs for students. There may also be negative implications for societal reliance on social media use (e.g., Twenge, 2013), including its promotion of unhealthy comparison behaviors and cyberbullying. Nevertheless, the present findings and those of Manago et al. demonstrate the positive contributions of social media to college student mental health.

The significance of some of the emerging adulthood variables also warrants discussion. The degree to which participants identified with emerging adulthood being a period of experimentation and possibilities was positively associated with PWB and life satisfaction, while the degree to which they identified with emerging adulthood being a period of negativity and instability was negatively associated with PWB and life satisfaction. Moreover, identifying emerging adulthood as a time of feeling in between adolescence and adulthood was negatively associated with life satisfaction. Even after accounting for all other control and predictor variables, emerging adult instability was the second strongest predictor of PWB (after ego resilience), while emerging adult experimentation/possibilities was the second strongest predictor of life satisfaction (after social support). These findings add important context to prior empirical conclusions that emerging adulthood is associated with negative mental health (Baggio et al., 2015). That is, while each of the dimensions of emerging adulthood represents important developmental processes toward reaching adulthood (Arnett, 2004), only some of these dimensions (especially viewing emerging adulthood as a period of experimentation or instability) seem relevant

to college student mental health. Additionally, feeling in between adolescence and adulthood was negatively associated with life satisfaction but unassociated with PWB. This finding underscores the complex contributions of emerging adulthood to college student mental health. Previous research has indicated that life satisfaction decreases during adolescence (Goldbeck et al., 2007). Accordingly, it is plausible that subjectively identifying the emerging adult years as feeling in between adolescence and adulthood results in life satisfaction trajectories that more closely mirror those of adolescence compared to emerging adults who feel less in between adolescence and adulthood. Although such conclusions require further validation, it nevertheless can help college counselors understand which factors of the emerging adult experience are relevant foci of clinical attention.

Implications for Counselors

The present results yield several useful insights that can aid mental health counselors who work with college-aged populations. Most prominently, counselors are encouraged to conceptualize their clients using a blend of foundational and contemporary models. Life for 21st-century college-aged individuals is unprecedentedly complex (Arnett, 2004; Kruisselbrink Flatt, 2013). It is important for college counselors to acknowledge this complexity, as doing so may represent an important form of cultural competence working with millennial generation and Generation Z individuals (Lane, 2015). Counselors are encouraged to utilize emerging adulthood theory when conceptualizing their clients, as this framework contains important departures from other identity development models. For example, counselors are likely to be more familiar with Erikson's (1959/1994) framework than emerging adulthood theory. The former model suggests that identity development occurs during the teenage years, while the latter model asserts that identity development is a process that now extends well into the 20s (Arnett, 2004). Emerging adulthood theory also suggests that, as a result of this prolonged identity development process, traditional-aged college students are likely to temporarily exhibit heightened self-focus and idealistic thinking. Acknowledging these factors could facilitate a more empathic understanding of the behaviors that contribute to some counselors and scholars endorsing negative stereotypes against millennials and Generation Z individuals (Lane, 2015). Incorporating emerging adulthood theory could help college counselors be more mindful of the evolving nature of the transition to adulthood and its contributions to mental health.

The findings involving the social resources variables also have novel implications for counseling college students. Although social support has long been established as an important target for improving mental health, counselors are encouraged to acknowledge both the unprecedented complexity of emerging adult social support networks (Arnett, 2004) and also the ability of emerging adults to receive social support from face-to-face and electronic interactions (Manago et al., 2012). Accordingly, it is important to continue exploring the potential therapeutic applications of social media and other forms of technology. For example, an exciting direction in this regard is the growing use of informal support groups via social media (Manago et al., 2012), which exist for many counseling-relevant issues. Such groups provide a sense of community and help members remember that they are not alone in their struggles. Moreover, present mental health trajectories among college students have necessitated a shift in focus for many college counseling centers toward crisis intervention and outreach (Watkins et al., 2012). For many college counseling centers, social media remains an underutilized tool, despite the recent development of social media and text-based initiatives for each of these objectives (Evans et al., 2013). Such programs might be especially useful in today's higher education climate in which symptom severity seems to be increasing while budgetary resources for college counseling centers are often stagnant or decreasing (American College Health Association, 2015; Watkins et al., 2012).

Limitations

Several limitations in the present study warrant consideration. First, the results relied on a convenience sample, and it is impossible to know whether there are group differences between the 15.4% of invited college students who participated compared to those who did not. Second, the findings are correlational in nature, and the directionality of the relationships cannot be assured. Third, although the sample was racially diverse, it was predominantly female. Fourth, it should be noted that the social media variable in this study consisted solely of Facebook usage; the findings may have been different had other prominent social media platforms been represented.

Implications for Future Research

Future research efforts should continue to explore the mental health implications of the study's variables. First, it would be useful to confirm the findings with a more gender-representative sample. The model should also be explored with a longitudinal sample to determine mental health trajectories through various transitions common during the college experience. It would also be useful to explore potential mediating effects among the variables in the model, which could provide further empirical support for the theoretical sequencing of the variable sets. Other research efforts could further explore the therapeutic applications of social media. Such efforts could aid understanding of the evolving needs of college-aged populations.

Conclusion

The college years constitute considerable mental health risks that seem particularly pronounced for current generations of traditional-aged college students. The present findings suggest that traditional models of college student mental health can be aided by also incorporating generation-specific factors, including emerging adulthood identification and social media usage. Such generation-specific factors seem to predict unique variance in college student mental health characteristics, namely PWB and life satisfaction. The findings underscore the importance that counselors consider contemporary models, including emerging adulthood theory, when conceptualizing and treating traditional-aged college student clients.

References

American College Health Association. (2015). *Spring 2015 reference group executive summary*. https://www.achaorg/
documents/ncha/NCHA-II_WEB_SPRING_2015_REFERENCE_GROUP_EXECUTIVE_SUMMARY.pdf

Arnett, J. J. (2004). *Emerging adulthood: The winding road from the late teens through the twenties.* Oxford University Press.

Arnett, J. J. (2016). College students as emerging adults: The developmental implications of the college context. *Emerging Adulthood*, 4(3), 219–222. https://doi.org/10.1177/2167696815587422

Baggio, S., Iglesias, K., Studer, J., & Gmel, G. (2015). An 8-item short form of the Inventory of Dimensions of Emerging Adulthood (IDEA) among young Swiss men. *Evaluation & the Health Professions*, 38(2), 246–254. https://doi.org/10.1177/0163278714540681

Bech, P., Olsen, L. R., Kjoller, M., & Rasmussen, N. K. (2003). Measuring well-being rather than the absence of distress symptoms: A comparison of the SF-36 Mental Health subscale and the WHO-Five Well-Being Scale. *International Journal of Methods in Psychiatric Research*, *12*(2), 85–91. https://doi.org/10.1002/mpr.145

Blazer, D., Hybels, C., & Hughes, D. C. (1990). *Duke Social Support Index.* Educational Testing Service.

Block, J. H., & Block, J. (1980). The role of ego-control and ego-resiliency in the organization of behavior. In W. A. Collins (Ed.), *Minnesota symposia on child psychology* (Vol. 13, pp. 39–101). Erlbaum.

Bowlby, J. (1997). *Attachment and loss: Vol. 1. Attachment* (Original work published 1969). Basic Books.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46–76). Guilford Press.

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction With Life Scale. *Journal of Personality Assessment*, *49*(1), 71–75.

Ellison, N. B., Steinfield, C., & Lampe, C. (2007). The benefits of Facebook "friends": Social capital and college students' use of online social network sites. *Journal of Computer-Mediated Communication*, *12*(4), 1143–1168. https://doi.org/10.1111/j.1083-6101.2007.00367.x

Erikson, E. H. (1994). *Identity and the life cycle* (Original work published 1959). W. W. Norton.

Evans, W. P., Davidson, L., & Sicafuse, L. (2013). Someone to listen: Increasing youth help-seeking behavior through a text-based crisis line for youth. *Journal of Community Psychology*, *41*(4), 471–487. https://doi.org/10.1002/jcop.21551

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*(2), 175–191. https://doi.org/10.3758/BF03193146

Galambos, N. L., Barker, E. T., & Krahn, H. J. (2006). Depression, self-esteem, and anger in emerging adulthood: Seven-year trajectories. *Developmental Psychology*, *42*(2), 350–365. https://doi.org/10.1037/0012-1649.42.2.350

Goldbeck, L., Schmitz, T. G., Besier, T., Herschbach, P., & Henrich, G. (2007). Life satisfaction decreases during adolescence. *Quality of Life Research*, *16*(6), 969–979. https://doi.org/10.1007/s11136-007-9205-5

Hawley, L. D., Leibert, T. W., & Lane, J. A. (2014). The relationship between socioeconomic status and counseling outcomes. *The Professional Counselor*, *4*(4), 390–403. https://doi.org/10.15241/ldh.4.4.390

Kruisselbrink Flatt, A. (2013). A suffering generation: Six factors contributing to the mental health crisis in North American higher education. *College Quarterly*, *16*(1).

Lane, J. A. (2015). Counseling emerging adults in transition: Practical applications of attachment and social support research. *The Professional Counselor*, *5*(1), 15–27. https://doi.org/10.15241/jal.5.1.15

Lane, J. A. (2016). Attachment, well-being, and college senior concerns about the transition out of college. *Journal of College Counseling*, *19*(3), 231–245. https://doi.org/10.1002/jocc.12046

Lane, J. A., Leibert, T. W., & Goka-Dubose, E. (2017). The impact of life transition on emerging adult attachment, social support, and well-being: A multiple-group comparison. *Journal of Counseling & Development*, *95*(4), 378–388. https://doi.org/10.1002/jcad.12153

Lent, R. W. (2004). Toward a unifying theoretical and practical perspective on well-being and psychosocial adjustment. *Journal of Counseling Psychology*, *51*(4), 482–509. https://doi.org/10.1037/0022-0167.51.4.482

Manago, A. M., Taylor, T., & Greenfield, P. M. (2012). Me and my 400 friends: The anatomy of college students' Facebook networks, their communication patterns, and well-being. *Developmental Psychology*, *48*(2), 369–380. https://doi.org/10.1037/a0026338

Manfreda, K. L., Bosnjak, M., Berzelak, J., Haas, I., & Vehovar, V. (2008). Web surveys versus other survey modes: A meta-analysis comparing response rates. *International Journal of Market Research*, *50*(1), 79–104. https://doi.org/10.1177/147078530805000107

McCay-Peet, L., & Quan-Haase, A. (2017). What is social media and what can social media research help us answer? In L. Sloan & A. Quan-Haase (Eds.), *The SAGE handbook of social media research methods* (pp. 13–26). SAGE.

Meyers, L. S., Gamst, G., & Guarino, A. J. (2013). *Applied multivariate research: Design and interpretation* (2nd ed.). SAGE.

Ortiz-Ospina, E. (2019). *The rise of social media*. Oxford University. https://ourworldindata.org/rise-of-social-media

Sarason, B. R., Pierce, G. R., Shearin, E. N., Sarason, I. G., Waltz, J. A., & Poppe, L. (1991). Perceived social support and working models of self and actual others. *Journal of Personality and Social Psychology*, *60*(2), 273–287. https://doi.org/10.1037/0022-3514.60.2.273

Schnyders, C. M., & Lane, J. A. (2018). Gender, parent and peer relationships, and identification with emerging adulthood among college students. *Journal of College Counseling*, *21*(3), 239–251. https://doi.org/10.1002/jocc.12106

Taylor, Z. E., Doane, L. D., & Eisenberg, N. (2014). Transitioning from high school to college: Relations of social support, ego-resiliency, and maladjustment during emerging adulthood. *Emerging Adulthood*, *2*(2), 105–115. https://doi.org/10.1177/2167696813506885

Twenge, J. M. (2013). Does online social media lead to social connection or social disconnection? *Journal of College and Character*, *14*(1), 11–20. https://doi.org/10.1515/jcc-2013-0003

Watkins, D. C., Hunt, J. B., & Eisenberg, D. (2012). Increased demand for mental health services on college campuses: Perspectives from administrators. *Qualitative Social Work*, *11*(3), 319–337. https://doi.org/10.1177/1473325011401468

Wei, M., Russell, D. W., Mallinckrodt, B., & Vogel, D. L. (2007). The Experiences in Close Relationship Scale (ECR)-Short Form: Reliability, validity, and factor structure. *Journal of Personality Assessment*, *88*(2), 187–204. https://doi.org/10.1080/00223890701268041

Serving Students in Foster Care: Implications and Interventions for School Counselors

Hannah Brinser, Addy Wissel

Students in foster care frequently experience barriers that influence their personal, social, and academic success. These challenges may include trauma, abuse, neglect, and loss—all of which influence a student's ability to be successful in school. Combined with these experiences, students in foster care lack the same access to resources and support as their peers. To this end, school counselors have the opportunity to utilize their unique position within the school community to effectively serve and address the complex needs of students in foster care. This paper addresses the current research, presenting problems, implications, and interventions school counselors can utilize when working with this population.

Keywords: **students, foster care, school counseling, support, interventions**

In 2017, there were a total of 442,995 children and youth in the foster care system (U.S. Department of Health and Human Services, 2018). Given the number of these students in schools and communities, school counselors have the opportunity to utilize their position within the school system to identify, respond to, and advocate for the needs of students in foster care to ensure equity and access in all areas. Although all students need positive relationships and stability to be successful, students in foster care often lack the same access to support, resources, and opportunities as their peers (McKellar & Cowen, 2011; Palmieri & La Salle, 2017). These barriers and challenges contribute to gaps in achievement, relationships, and skills for these students (Palmieri & La Salle, 2017). Compared to their peers, students in foster care are more likely to be absent from school, repeat a grade, and change schools (Cutuli et al., 2013; Palmieri & La Salle, 2017; Unrau et al., 2012), which ultimately impacts their ability to establish and maintain relationships. Additionally, students in foster care are twice as likely to receive out-of-school suspensions, over three times as likely to receive special education services, and over 20% less likely to graduate from high school (National Working Group for Foster Care and Education [NWGFCE], 2018).

When it comes to higher education, students in foster care are less likely to enroll in college preparatory classes, attend college, and obtain a 4-year degree when compared to their peers (Kirk et al., 2013; Unrau et al., 2012). Research suggests that as little as 3%–10.8% of youth previously in foster care attain a 4-year degree, compared to the national college completion rate of 32.5% (NWGFCE, 2018). However, it is important for school counselors to realize that between 70%–84% of students in foster care desire going to college (Courtney et al., 2010; NWGFCE, 2018). Although students in foster care feel motivated to attend and complete college, academic achievement can easily become another barrier. On average, students in foster care receive both lower ACT scores and high school GPAs and perform lower on standardized tests compared to their peers—all of which influence one's admission to college (O'Malley et al., 2015; Unrau et al., 2012).

Unfortunately, it is also common for students in foster care to experience other challenges that influence their success in school, such as trauma. Trauma can include abuse; neglect; and the loss of family members, friends, and communities (Scherr, 2014). Without adequate support, trauma can

Hannah Brinser is a master's candidate at Gonzaga University. Addy Wissel, PhD, is an associate professor and program director at Gonzaga University. Correspondence may be addressed to Hannah Brinser, 502 E. Boone Ave., Spokane, WA 99258, hannahbrinser@gmail.com.

impact a student's executive functioning and memory, ultimately affecting their ability to learn (Avery & Freundlich, 2009). Additionally, separation from family members, disrupted relationships, and frequent transitions lead to an increased risk for difficulties in expressing and regulating emotions, tolerating ambiguity, and problem-solving (O'Malley et al., 2015; Unrau et al., 2012). These interrelated and complex factors contribute to the achievement gap experienced by students in foster care as evidenced by lower academic achievement and less engagement in school (Pecora et al., 2006; Unrau et al., 2012).

Importance of Serving This Population

When considering interventions to support students in foster care, it is important to explore what they believe will be helpful for their growth and success. It is likely that the majority of students in foster care already feel a lack of control over what occurs in their lives (Scherr, 2014). Therefore, this is an opportunity to encourage student involvement while increasing student self-efficacy. Clemens et al. (2017) found that students in foster care emphasize the importance of having opportunities to connect with others in similar situations, learning practical skills, and implementing different strategies to better their lives. To provide a sense of normalcy and belonging, school counselors can advocate for interventions that promote connectedness and engagement with other students (Unrau et al., 2012).

Removing barriers, improving access to services, maintaining enrollment, improving attendance, and facilitating academic progress is critical in promoting success for students in foster care (Gilligan, 2007). Therefore, school counselors should be aware of the barriers related to access that exist for students in foster care and should be intentional in taking steps to remove any inequities. Working proactively and using a strengths-based approach that acknowledges the skills, strengths, and resiliency of students are ways in which school counselors can effectively meet the needs of students in foster care (Gilligan, 2007; Scherr, 2014). To illustrate, a strengths-based approach can be utilized with students who have anxious attachment patterns by acknowledging their ability to care for others, rather than focusing on the negative aspects of their attachment behaviors (e.g., being too "needy"). Although it can be easy to focus on the behaviors and disruptions that occur, school counselors have the opportunity to instead focus on these students' accomplishments, strengths, and dreams. Ultimately, it is evident that students in foster care face many challenges that influence their ability to be successful. In an effort to address this need, the following section outlines interventions for school counselors to use when working with students in foster care.

Interventions

School Climate
Positive school relationships are an essential part of school climate and can serve as a protective factor for students experiencing adversity (Furlong et al., 2011; O'Malley et al., 2015). Therefore, focusing on school climate may be an effective approach in supporting students in foster care, as positive school relationships can also help close achievement gaps between these students and their peers (Clemens et al., 2017). For example, positive school climate decreases rates of disruptive behaviors, truancy, fights, and suspensions at school (Hopson & Lee, 2011). In addition, Voight et al. (2013) found that students' positive school climate perceptions also contributed to academic achievement as indicated by state standardized test scores. School counselors can enhance school climate by allowing student voices, utilizing empowerment strategies, implementing evidence-based programs, providing adult mentoring (O'Malley et al., 2015), and working to create a positive peer culture (Bergin & Bergin, 2009).

School Culture

It is particularly important to pay attention to school culture, as these shared norms, beliefs, and behaviors affect perceptions of school climate (MacNeil et al., 2009). To create a positive school culture, Ziomek-Daigle et al. (2016) recommended that school counselors implement interventions using a multi-tiered system of supports. For example, providing classroom lessons on topics such as kindness, empathy, and acceptance are Tier 1 interventions that work to cultivate a positive school culture (Bergin & Bergin, 2009; Ziomek-Daigle et al., 2016). Additionally, school culture can be influenced by creating shared values and expectations for students throughout the school community (MacNeil et al., 2009). For example, school counselors can utilize empowerment strategies when teaching students in foster care to advocate for themselves and find autonomy in meeting their needs. The school counselor might say, "Last week, you worked so hard at learning to use 'I statements' when expressing your needs and feelings to others! In class, I even saw that you raised your hand to ask for a break when you started to get overwhelmed in math. How might you use similar skills to advocate for yourself when you get frustrated in social studies?" In this way, the school counselor is improving school culture by creating a shared expectation among students, teachers, and staff.

Educational Experiences

Moreover, school counselors can enhance school climate by facilitating enriching educational experiences that contribute to academic success (Gilligan, 2007). To ensure that students in the foster care system receive the same educational experiences as their peers, school counselors can screen, monitor, plan, communicate, and collaborate with other stakeholders (e.g., teachers, administration, staff, and foster families) to ensure equity and access for students in foster care (Palmieri & La Salle, 2017). Educating stakeholders about working with students in foster care can encourage inclusive assignments, promote an understanding of potential responses and reactions from students, and decrease negative behavioral perceptions (McKellar & Cowen, 2011). Additionally, including students in decisions about their education, where they attend school, and the support they receive can increase their self-efficacy, goal development, and self-advocacy skills (Palmieri & La Salle, 2017). This intentionality can also help them feel welcome, respected, and important—all of which increase their school connection.

Collaborating With Stakeholders

Planning

School counselors should plan to accommodate and work with students who may enter school in the middle of the year, as 34% of students in foster care experience five or more school changes by the time they reach the age of 18 (NWGFCE, 2018). When these students arrive at school, it is important that school counselors welcome them, explain classroom and school procedures, show them around the school, and facilitate connections with other students (Palmieri & La Salle, 2017). From the beginning, school counselors can prioritize involving the foster family by calling to welcome them, answering any questions they have, providing them with helpful information (e.g., teacher contact information), and following up with them after a few weeks. For example, packets can be sent home with students so foster families have access to any relevant documents or previous newsletters containing helpful information (McKellar & Cowen, 2011). Additionally, it may be beneficial for school counselors to invite the foster family to meet with them in person to create a stronger foster family and school partnership. Furthermore, incomplete student records can have a significant effect on academic services for students in foster care. Therefore, school counselors should work diligently with other school districts to retrieve and maintain these records (McKellar & Cowen, 2011).

Training

   Along with planning, school counselors can provide all stakeholders with evidence-based information to effectively serve and address the needs of students in foster care (Kerr & Cossar, 2014). With this purpose in mind, school counselors can provide training to stakeholders on topics such as reflective listening, creating secure attachments, recognizing and responding to feelings and behaviors, and setting limits and boundaries (Kerr & Cossar, 2014). Informed stakeholders can more effectively support and respond to the unique needs of students in foster care, and in turn, students may be more successful in managing their emotions and behaviors (Palmieri & La Salle, 2017). This awareness can also strengthen relationships that promote school success (Kerr & Cossar, 2014). Additionally, school counselors can be proactive in collaborating with stakeholders to create structured and supportive classroom environments where students in foster care feel safe while learning. For example, working with teachers to modify assignments that have the potential to be triggering (e.g., family-based assignments) is essential in promoting student–teacher relationships and academic achievement (C. Mitchell, 2010; Palmieri & La Salle, 2017).

Inclusion

   Students in foster care often experience triggers at school, whether it is from an assignment (e.g., family-based assignments), a topic discussed in class, or a community event that seems to be exclusively for biological parents (West et al., 2014). When these experiences occur, students in foster care do not always have the ability to self-regulate and utilize healthy coping skills (West et al., 2014). For this reason, it is essential to not only advocate for inclusive assignments and events but to also help students effectively manage their triggers so they can be academically and relationally successful. Additionally, it may be helpful to provide stakeholders with information about why certain activities lack inclusivity for students in foster care and offer possible alternatives or modifications for these experiences. To illustrate, events such as "Muffins with Moms" and "Donuts with Dads" can be altered for inclusivity by expanding the population to include anyone in the student's support system (e.g., "Floats with Friends" or "Popcorn with Important People").

   Additionally, an assignment about creating a family tree could be modified for inclusivity by focusing on the diversity of family structures. C. Mitchell (2010) offers the alternative of creating "The Rooted Family Tree," in which the roots represent one's birth family, the student as the trunk, and the foster or adoptive family filling in the branches. Similarly, "The Family Houses Diagram" utilizes houses instead of trees to allow for multiple places of living and the option to form a connection between birth, foster, or other family types (C. Mitchell, 2010). Another common assignment given in schools is to bring a baby picture to share with the class. This lacks inclusivity for students in foster care, as they might not have these pictures or there may be difficult memories attached to them. Additionally, this puts the student in the painful position of having to explain why they do not have these pictures (C. Mitchell, 2010). As a result, C. Mitchell (2010) recommends framing the assignment as a choice: Bring a picture of yourself as a baby or at a younger age, on a vacation or holiday, or engaging in any activity that you enjoy.

Relationships

   Knowing how to cultivate secure attachments with students in foster care is especially relevant for stakeholders, as positive student–adult relationships can influence other relationships in the student's life by altering their internal working model (Bergin & Bergin, 2009; Sabol & Pianta, 2012). Although it can be difficult to create and maintain secure relationships with students who experience insecure attachment (Bergin & Bergin, 2009), stakeholders have the opportunity to fill in attachment gaps that may exist for students in foster care. Secure attachment is related to higher grades and standardized

test scores, increased emotion regulation, and higher self-efficacy (Bergin & Bergin, 2009; Golding et al., 2013). Moreover, students with insecure attachment tend to show less curiosity (Granot & Mayseless, 2001), have poorer quality friendships, and exhibit behavior problems (Bergin & Bergin, 2009; Golding et al., 2013).

Importantly, attachment to teachers, rather than just biological parents, is linked to school success (O'Connor & McCartney, 2007; Sabol & Pianta, 2012). When students have healthy relationships with their teachers and perceive them as supportive, they show greater interest and engagement in school, which leads to improvements in academic achievement (Bergin & Bergin, 2009; Golding et al., 2013). Additionally, students who experience insecure attachment crave positive, warm, and trusting relationships but often lack the skills to create them. For this reason, stakeholders can help nurture secure relationships by being genuine, maintaining high expectations, and providing as much choice and autonomy as possible (Bergin & Bergin, 2009). Furthermore, noticing when these students are not at school, or when they return after an absence, can help them know they are valued and cared for.

To advocate, school counselors can help stakeholders understand why students with insecure attachment are behaving and reacting in certain ways, while also helping staff to respond in ways that disconfirm students' insecure working models (Bergin & Bergin, 2009). In this way, staff can show that students' particular beliefs about relationships with others may not always be true. To illustrate, not asking for help in the classroom, ignoring the teacher, or denying the need for assistance could be a manifestation of an insecure avoidant attachment style (Golding et al., 2013). This student does not want to become close or show vulnerability, as they fear that the teacher will reject or separate from them (e.g., their internal working model). For these students, it can be easier to not ask for help or engage in classroom projects at all than risk the hurt of rejection (Golding et al., 2013). A teacher who misunderstands this might believe they are unable to adequately support the student. As a result, they may stop trying to help, which confirms the student's internal working model of fear and rejection. Instead, the teacher can disconfirm this student's internal working model by providing reassurance of their consistency and availability (Golding et al., 2013). For example, the teacher conveying that they want to help, while also asking how they can help, offers healthy choice and autonomy. Encouraging small changes in how stakeholders respond to students in foster care provides a space for positive and secure relationships to develop.

Skill Development and Addressing Unique Experiences
Behavior Management, Emotion Regulation, and Social Skills
Difficulties in behavior management, emotion regulation, and social skills are common among students in the foster care system, as they lack control over many events that occur in their lives (Octoman et al., 2014; Scherr, 2014). These students' unique and complex experiences can impact their ability to appropriately manage their emotions, behaviors, and interactions with others. Unfortunately, these extreme emotions and behaviors often result in several different placements, the loss of relationships, and the loss of school and community connections (Octoman et al., 2014).

Given this information, school counselors can contribute to student success by collaborating with stakeholders to communicate appropriate behavior, identify boundaries, and explicitly state expectations. Providing behavioral support, management, and individual attention can help students engage in positive behaviors that facilitate their success at school and in the classroom (Palmieri & La Salle, 2017). Additionally, working with students to identify and manage emotions decreases externalizing behaviors, reduces stress levels, and improves relationships. Likewise, providing education about control, acceptance, coping skills, and distress tolerance are applicable emotion regulation interventions to utilize

with students in foster care (Benzies & Mychasiuk, 2009). Groups and interventions on topics such as social skills, problem-solving, making and keeping friends, and appropriate behaviors can help students develop healthy interpersonal relationships (Scherr, 2014; Zins & Elias, 2007).

Grief and Loss

Additionally, it is crucial that school counselors intentionally address the unique and complex experiences of students in foster care. For example, these students often experience non-death losses that go unacknowledged, including the loss of parents, siblings, friends, and communities (M. B. Mitchell, 2018). These losses may involve a lack of clarity and create confusion about a loved one's physical or psychological presence, commonly referred to as *ambiguous loss* (Boss, 1999; Lee & Whiting, 2007). To illustrate, being separated from one's family and placed into foster care can generate grief and loss reactions, including confusion, isolation, distress, uncertainty, helplessness, denial, extreme behaviors, and guilt (Lee & Whiting, 2007; M. B. Mitchell & Kuczynski, 2010). Disenfranchised grief occurs when others disregard and do not acknowledge a loss (Doka, 1989; M. B. Mitchell, 2018). Unfortunately, it is common for the child welfare system and society to ignore experiences of grief and loss in foster care (M. B. Mitchell, 2018; M. B. Mitchell & Kuczynski, 2010).

In an effort to address this, school counselors can begin by identifying, acknowledging, and validating losses that are not caused by death but produce many similar grief responses (M. B. Mitchell, 2016, 2018). Additionally, school counselors can educate stakeholders about ambiguous loss and disenfranchised grief, as it is important for the entire school community to have an understanding about manifestations of grief and loss when working with these students (e.g., internalizing and externalizing). In general, school counselors can advocate for students in foster care by validating their experiences, equipping them with education and resources, helping others understand why their experiences embody grief and loss, and acknowledging the inherent confusion involved in their unique situations (Lee & Whiting, 2007).

Accessing School and Community Resources

School Engagement

Students involved in their school community through extracurricular activities, leadership, and positions of responsibility often experience more motivation and engagement in learning (Gilligan, 2007). Additionally, such engagement is beneficial in creating a sense of normalcy, belonging, and community with other students. Unfortunately, these opportunities can seem limited to students in the foster care system because of cost, timing, and transportation barriers (Palmieri & La Salle, 2017). Therefore, it is critical that school counselors collaborate, advocate, and act to remove these barriers, as engagement in the school community can result in academic, social, and behavioral improvements (Scherr, 2014). School counselors can facilitate this involvement and engagement in the school community by collaborating with other stakeholders to provide opportunities. For example, encouraging and assisting students in foster care to navigate and obtain leadership positions (e.g., student government) will not only improve their engagement in school, but also increase their self-efficacy and sense of belonging within the school community. Additionally, school counselors can collaborate with other professionals (e.g., social workers, school psychologists, and school nurses) to identify and address different areas of support, resources, and opportunities for these students.

Group Counseling

With a national student–school counselor ratio of 455:1 (American School Counselor Association, 2019), group counseling is a promising approach to help school counselors meet the complex needs of students who are in foster care. Additionally, this is an effective way to encourage involvement and connectedness with students who have similar backgrounds, while providing these students with the

skills that they need to be successful (Palmieri & La Salle, 2017). Involvement in group counseling can help create a sense of normalcy, belonging, and community with other students (Alvord & Grados, 2005) and can also result in academic, social, and behavioral improvements (Scherr, 2014).

Hambrick et al. (2016) found that children in foster care experienced improvements in behavior, academics, quality of life, attachment, placement stability, and emotion regulation following their participation in group-based interventions. Although participating in a small group with other students in the foster care system may provide the opportunity to feel understood and less alone, students may also benefit from engaging in group activities with typical peers. For example, students in foster care might participate in a "lunch bunch" group where they eat in community with the school counselor and other like-age peers. In these groups, students can play, learn from watching the interactions of peers, and develop the skills necessary for initiating and maintaining positive peer relationships.

Utilizing a reality therapy approach for group counseling seems particularly beneficial, as it addresses choice, control, and healthy ways of getting one's needs met—all common issues students in foster care may struggle with (Benzies & Mychasiuk, 2009; Cameron, 2013; Kress et al., 2019). These components are essential in empowering students to choose how they respond to and face the challenges in their lives (Benzies & Mychasiuk, 2009). In this approach, school counselors can assume the roles of teacher, advocate, and encourager by educating about responsibility, choices, and the importance of meaningful relationships (Kress et al., 2019). Utilizing the WDEP system (i.e., wants, doing, evaluation, and planning) to explore questions, including "What do you want?", "What are you doing?", and "Is it working?", helps students assess if their current behaviors are getting them what they desire, and if they are not, how they can change in healthy ways (Wubbolding, 2011).

Because behavior is intentional, it is beneficial to look at each student's behavior as an attempt to satisfy their needs (Glasser, 1984, 2000). Additionally, focusing on the here and now is helpful in guiding and educating students about effective and appropriate ways to get their needs met by others (Glasser, 1992, 2000). As many students in foster care have not always had their needs met in the past, they must learn to have their needs met in healthy and effective ways (Octoman et al., 2014). For example, a student who is grabbing and touching other students might be trying to get their need of love and belonging met. In this situation, it would be a helpful learning experience to guide this student to meet this need in a different way, such as asking the peer permission for a hug or setting aside time to spend with them later (Octoman et al., 2014).

When using this approach, school counselors can reframe behavior to emphasize student strengths, identify and celebrate students' acceptance of choice and responsibility, create anticipation for change, and communicate hope about success (Kress et al., 2019). School counselors can also prioritize rapport building; creating safety through rules, goals, and expectations; and helping students realize that they are not alone in their experiences (Alvord & Grados, 2005; Gladding, 2016; Kress et al., 2019). Other small groups that address issues such as social skills, making and keeping friends, and college and career exploration may also be helpful for students in foster care.

Mentorship Programs

Students in the foster care system experience many transitions and losses, which can result in disruptions to the adult and peer relationships that support educational success. In this way, mentorship programs work to reduce risk and provide protective support to students in foster care (Scherr, 2014). These students value having a mentor who provides support and encouragement on topics related to academics, college, and life (Clemens et al., 2017; Dworsky & Pérez , 2010) and

benefit from having a consistent, trustworthy, and non-familial adult in their lives (Benzies & Mychasiuk, 2009). Mentorship programs contribute to fewer behavior referrals, less school mobility, and improved graduation rates (Salazar et al., 2016). Additionally, the accountability of mentorship can motivate students to improve their attendance, achievement, and engagement in school. Given this information, facilitating connectedness and mentorship for these students is crucial in providing them with the support, consistency, and encouragement they need to accomplish their goals.

The Check and Connect Model is evidence-based and targets students who show warning signs of disengaging from school such as poor attendance, behavioral issues, and low grades (Tilbury et al., 2014), all of which are particularly relevant for students in foster care. Potential mentors can be natural (e.g., someone already present and supportive in the student's life) or someone from the community interested in volunteering (Salazar et al., 2016). Utilizing natural mentors, if available, is beneficial in acknowledging the natural supports that already exist in students' lives. For example, if a student already has a trusting relationship with a staff member, it is important to utilize this connection to maintain stability. However, if a student is unable to identify any natural mentors, working with volunteers in the community is also an excellent option. Both are impactful in different ways, and the quality of the connection is what is really crucial (Salazar et al., 2016).

It is essential that mentors are consistent, empathetic, authentic, and committed to supporting students in foster care. Mentors not only serve as a relational connection for these students but also help youth expand their social support networks, set goals, explore postsecondary options, and increase involvement in the school community (Salazar et al., 2016). School counselors can work with mentors to monitor student performance variables, such as absences, behavioral referrals, and grades, while helping students solve problems, identify skills, and reach their goals (University of Minnesota, 2019). Mentorship programs should be flexible and tailored to the needs of each student and their mentor, as some pairs might benefit from more or less time to connect (Salazar et al., 2016). Ultimately, these programs can be helpful in providing students in foster care with the connection and support they need to be successful, while also contributing to the development of other secure relationships in their lives (Palmieri & La Salle, 2017).

Community Partnerships

For students in foster care, it is essential that support extends beyond the school community. To do this, school counselors can establish relationships and collaborate with the student, foster family, school, and foster care system (Palmieri & La Salle, 2017). These home–school partnerships are critical in meeting the needs of students in foster care. Additionally, foster families feel more supported when they are involved and their input is valued (Palmieri & La Salle, 2017). Utilizing and forming plans around academic and behavioral expectations, attendance, flexibility with requirements, and communication with stakeholders can be helpful in promoting success (McKellar & Cowen, 2011). Furthermore, tangible and emotional support can act as protective factors and meet the needs of students through the provision of goods and services (Piel et al., 2017). For example, school counselors can create or utilize community-based food and nutrition programs to ensure that basic needs are being met.

Mental Health Services

Equally important, students in foster care often experience difficulties that affect their mental health. Evidence-based treatments such as trauma-focused cognitive behavior therapy (TF-CBT), behavior therapy, cognitive behavior therapy (CBT), and parent–child interaction therapy can be adapted for the school setting (Landsverk et al., 2009). These models of counseling are helpful in addressing symptoms, while also promoting healthy behavior and functioning. Combined with this,

school counselors can also provide outpatient information to foster families and case workers about local resources and services available to students in foster care. In these cases, it is helpful to collaborate with the designated outpatient counselor to provide the most effective support and generalize learned skills across settings (Landsverk et al., 2009).

Conclusion

Students in foster care experience a number of barriers and challenges that influence their success in school, both academically and socially, as well as in adulthood. In addition, students in foster care lack the same access to resources and support as their peers, which contributes to gaps in academic achievement, relational success, and overall well-being. By enhancing school climate, planning, providing training to stakeholders, and promoting positive educational experiences, students in foster care can receive the foundational support they need to begin learning. Additionally, by utilizing group counseling, implementing mentorship programs, targeting specific behavior, addressing experiences of grief and loss, and accessing community resources, students in foster care can gain the skills they need to be successful in all areas. Despite the many challenges students in foster care face, school counselors have the opportunity to utilize their unique position in their schools and communities to advocate for these students, reach them through evidence-based interventions, remove barriers to learning, and ultimately equip them with the tools and skills they need to experience greater success.

References

Alvord, M. K., & Grados, J. J. (2005). Enhancing resilience in children: A proactive approach. *Professional Psychology: Research and Practice*, *36*(3), 238–245. https://doi.org/10.1037/0735-7028.36.3.238

American School Counselor Association. (2019). *State-by-state student-to-counselor ratio report: 10-year trends.* https://www.schoolcounselor.org/asca/media/asca/Publications/ratioreport.pdf

Avery, R. J., & Freundlich, M. (2009). You're all grown up now: Termination of foster care support at age 18. *Journal of Adolescence*, *32*(2), 247–257. https://doi.org/10.1016/j.adolescence.2008.03.009

Benzies, K., & Mychasiuk, R. (2009). Fostering family resiliency: A review of the key protective factors. *Child & Family Social Work*, *14*(1), 103–114. https://doi.org/10.1111/j.1365-2206.2008.00586.x

Bergin, C., & Bergin, D. (2009). Attachment in the classroom. *Educational Psychology Review*, *21*(2), 141–170. https://doi.org/10.1007/s10648-009-9104-0

Boss, P. (1999). *Ambiguous loss: Learning to live with unresolved grief.* Harvard University Press.

Cameron, A. (2013). Choice theory and reality therapy applied to group work and group therapy. *International Journal of Choice Theory and Reality Therapy*, *32*(2), 25–35.

Clemens, E. V., Helm, H. M., Myers, K., Thomas, C., & Tis, M. (2017). The voices of youth formerly in foster care: Perspectives on educational attainment gaps. *Children and Youth Services Review*, *79*, 65–77. https://doi.org/10.1016/j.childyouth.2017.06.003

Courtney, M. E., Dworsky, A., Lee, J. S., & Raap, M. (2010). *Midwest evaluation of the adult functioning of former foster youth: Outcomes at ages 23 and 24.* Chapin Hall at the University of Chicago. https://rhyclearinghouse.acf.hhs.gov/sites/default/files/docs/18690-Midwest_Evaluation-Outcomes_at_Ages_23_and_24.pdf

Cutuli, J. J., Desjardins, C. D., Herbers, J. E., Long, J. D., Heistad, D., Chan, C.-K., Hinz, E., & Masten, A. S. (2013). Academic achievement trajectories of homeless and highly mobile students: Resilience in the context of chronic and acute risk. *Child Development*, *84*(3), 841–857. https://doi.org/10.1111/cdev.12013

Doka, K. J. (Ed.). (1989). *Disenfranchised grief: Recognizing hidden sorrow*. Lexington Books.

Dworsky, A., & Pérez, A. (2010). Helping former foster youth graduate from college through campus support programs. *Children and Youth Services Review*, *32*(2), 255–263. https://doi.org/10.1016/j.childyouth.2009.09.004

Furlong, M., Sharkey, J., Quirk, M., & Dowdy, E. (2011). Exploring the protective and promotive effects of school connectedness on the relation between psychological health risk and problem behaviors/experiences. *Journal of Educational and Developmental Psychology*, *1*(1), 18–34. https://doi.org/10.5539/jedp.v1n1p18

Gilligan, R. (2007). Adversity, resilience and the educational progress of young people in public care. *Emotional and Behavioural Difficulties*, *12*(2), 135–145. https://doi.org/10.1080/13632750701315631

Gladding, S. T. (2016). *Groups: A counseling specialty* (7th ed.). Pearson.

Glasser, W. (1984). *Take effective control of your life.* Harper & Row.

Glasser, W. (1992). *The quality school: Managing students without coercion* (2nd ed.). Harper Perennial.

Glasser, W. (2000). *Counseling with choice theory: The new reality therapy*. HarperCollins.

Golding, K. S., Fain, J., Frost, A., Mills, C., Worrall, H., Roberts, N., Durrant, E., & Templeton, S. (2013). *Observing children with attachment difficulties in school: A tool for identifying and supporting emotional and social difficulties in children aged 5–11.* Jessica Kingsley.

Granot, D., & Mayseless, O. (2001). Attachment security and adjustment to school in middle childhood. *International Journal of Behavioral Development*, *25*(6), 530–541. https://doi.org/10.1080/01650250042000366

Hambrick, E. P., Oppenheim-Weller, S., N'zi, A. M., & Taussig, H. N. (2016). Mental health interventions for children in foster care: A systematic review. *Children and Youth Services Review*, *70*, 65–77. https://doi.org/10.1016/j.childyouth.2016.09.002

Hopson, L. M., & Lee, E. (2011). Mitigating the effect of family poverty on academic and behavioral outcomes: The role of school climate in middle and high school. *Children and Youth Services Review*, *33*(11), 2221–2229. https://doi.org/10.1016/j.childyouth.2011.07.006

Kerr, L., & Cossar, J. (2014). Attachment interventions with foster and adoptive parents: A systematic review. *Child Abuse Review*, *23*(6), 426–439. https://doi.org/10.1002/car.2313

Kirk, C. M., Lewis, R. K., Nilsen, C., & Colvin, D. Q. (2013). Foster care and college: The educational aspirations and expectations of youth in the foster care system. *Youth & Society*, *45*(3), 307–323. https://doi.org/10.1177/0044118X11417734

Kress, V. E., Paylo, M. J., & Stargell, N. A. (2019). *Counseling children and adolescents.* Pearson.

Landsverk, J. A., Burns, B. J., Stambaugh, L. F., & Reutz, J. A. R. (2009). Psychosocial interventions for children and adolescents in foster care: Review of research literature. *Child Welfare: Journal of Policy, Practice, and Program*, *88*(1), 49–69.

Lee, R. E., & Whiting, J. B. (2007). Foster children's expressions of ambiguous loss. *The American Journal of Family Therapy*, *35*(5), 417–428. https://doi.org/10.1080/01926180601057499

MacNeil, A. J., Prater, D. L., & Busch, S. (2009). The effects of school culture and climate on student achievement. *International Journal of Leadership in Education*, *12*(1), 73–84. https://doi.org/10.1080/13603120701576241

McKellar, N., & Cowen, K. C. (2011). Supporting students in foster care. *Principal Leadership*, *12*(1), 12–16.

Mitchell, C. (2010). Back to school: A guide to making schools and school assignments more adoption-friendly. *Adoption Advocate*, *27*, 1–9. https://www.adoptioncouncil.org/images/stories/NCFA_ADOPTION_ADVOCATE_NO27.pdf

Mitchell, M. B. (2016). The family dance: Ambiguous loss, meaning making, and the psychological family in foster care. *Journal of Family Theory & Review*, *8*(3), 360–372. https://doi.org/10.1111/jftr.12151

Mitchell, M. B. (2018). "No one acknowledged my loss and hurt": Non-death loss, grief, and trauma in foster care. *Child and Adolescent Social Work Journal*, *35*, 1–9. https://doi.org/10.1007/s10560-017-0502-8

Mitchell, M. B., & Kuczynski, L. (2010). Does anyone know what is going on? Examining children's lived experience of the transition into foster care. *Children and Youth Services Review*, *32*(3), 437–444. https://doi.org/10.1016/j.childyouth.2009.10.023

National Working Group for Foster Care and Education. (2018). *Fostering success in education: National fact sheet on the educational outcomes of children in foster care.* http://www.fostercareandeducation.org/Desktop Modules/Bring2mind/DMX/Download.aspx?portalid=0&EntryId=2100&Command=Core_Download

O'Connor, E., & McCartney, K. (2007). Examining teacher–child relationships and achievement as part of an ecological model of development. *American Educational Research Journal*, *44*(2), 340–369. https://doi.org/10.3102/0002831207302172

Octoman, O., McLean, S., & Sleep, J. (2014). Children in foster care: What behaviours do carers find challenging? *Clinical Psychologist*, *18*(1), 10–20. https://doi.org/10.1111/cp.12022

O'Malley, M., Voight, A., Renshaw, T. L., & Eklund, K. (2015). School climate, family structure, and academic achievement: A study of moderation effects. *School Psychology Quarterly*, *30*(1), 142–157. https://doi.org/10.1037/spq0000076

Palmieri, L. E., & La Salle, T. P. (2017). Supporting students in foster care. *Psychology in the Schools*, *54*(2), 117–126. https://doi.org/10.1002/pits.21990

Pecora, P. J., Williams, J., Kessler, R. C., Hiripi, E., O'Brien, K., Emerson, J., Herrick, M. A., & Torres, D. (2006). Assessing the educational achievements of adults who were formerly placed in family foster care. *Child & Family Social Work*, *11*(3), 220–231. https://doi.org/10.1111/j.1365-2206.2006.00429.x

Piel, M. H., Geiger, J. M., Julien-Chinn, F. J., & Lietz, C. A. (2017). An ecological systems approach to understanding social support in foster family resilience. *Child & Family Social Work*, *22*(2), 1034–1043. https://doi.org/10.1111/cfs.12323

Sabol, T. J., & Pianta, R. C. (2012). Recent trends in research on teacher–child relationships. *Attachment & Human Development*, *14*(3), 213–231. https://doi.org/10.1080/14616734.2012.672262

Salazar, A. M., Roe, S. S., Ullrich, J. S., & Haggerty, K. P. (2016). Professional and youth perspectives on higher education-focused interventions for youth transitioning from foster care. *Children and Youth Services Review*, *64*, 23–34. https://doi.org/10.1016/j.childyouth.2016.02.027

Scherr, T. G. (2014). Best practices in working with children living in foster care. In P. L. Harrison & A. Thomas (Eds.), *Best practices in school psychology: Foundations* (pp. 169–179). NASP Publications.

Tilbury, C., Creed, P., Buys, N., Osmond, J., & Crawford, M. (2014). Making a connection: School engagement of young people in care. *Child & Family Social Work*, *19*(4), 455–466. https://doi.org/10.1111/cfs.12045

University of Minnesota. (2019, December 26). *Check and connect student engagement intervention.* Institute on Community Integration. http://checkandconnect.umn.edu/

Unrau, Y. A., Font, S. A., & Rawls, G. (2012). Readiness for college engagement among students who have aged out of foster care. *Children and Youth Services Review*, *34*(1), 76–83. https://doi.org/10.1016/j.childyouth.2011.09.002

U.S. Department of Health and Human Services. (2018). *The AFCARS report: Preliminary FY 2017 estimates as of August 10, 2018 – No. 25*. Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport25.pdf

Voight, A., Austin, G., & Hanson, T. (2013). *A climate for academic success: How school climate distinguishes schools that are beating the achievement odds (Report Summary)*. WestEd.

West, S. D., Day, A. G., Somers, C. L., & Baroni, B. A. (2014). Student perspectives on how trauma experiences manifest in the classroom: Engaging court-involved youth in the development of a trauma-informed teaching curriculum. *Children and Youth Services Review*, *38*, 58–65. https://doi.org/10.1016/j.childyouth.2014.01.013

Wubbolding, R. E. (2011). *Reality therapy: Theories of psychotherapy series.* American Psychological Association.

Zins, J. E., & Elias, M. J. (2007). Social and emotional learning: Promoting the development of all students. *Journal of Educational and Psychological Consultation*, *17*(2-3), 233–255. https://doi.org/10.1080/10474410701413152

Ziomek-Daigle, J., Goodman-Scott, E., Cavin, J., & Donohue, P. (2016). Integrating a multi-tiered system of supports with comprehensive school counseling programs. *The Professional Counselor*, *6*(3), 220–232. https://doi.org/10.15241/jzd.6.3.220

nbcc

Clinical Work With Clients Who Self-Injure: A Descriptive Study

Amanda Giordano, Lindsay A. Lundeen, Chelsea M. Scoffone,
Erin P. Kilpatrick, Frank B. Gorritz

Nonsuicidal self-injury (NSSI) is a common clinical concern. We surveyed a national sample of 94 licensed clinicians to better understand their work with clients who self-injure. Our data revealed that over the past year, 95.7% (*n* = 90) of the sample reported working with at least one client who self-injured. Thirty-six clinicians (38%) reported that most or all of their clients who self-injured were adolescents, 61 (64.9%) reported that most or all clients who self-injured were female, and 43 (45.7%) reported that most or all clients who self-injured engaged in cutting as the primary NSSI method. About 35% (*n* = 33) of the clinicians in our sample indicated they have never asked clients who self-injured about their online activity related to NSSI. The majority of our participants (*n* = 78; 83%) supported the notion that NSSI could be an addictive behavior for some clients and less than half (*n* = 42; 44.7%) received NSSI training in their graduate coursework.

Keywords: **nonsuicidal self-injury, NSSI, licensed clinicians, training, behavioral addiction**

Nonsuicidal self-injury (NSSI) is a complex phenomenon. Favazza (1998) defined NSSI as "the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent" (p. 260). The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013) noted that NSSI is intentional and self-inflicted body damage that is not socially sanctioned (e.g., piercings or tattoos) and lacks suicidal intent. The fact that NSSI is intentional and direct distinguishes it from unplanned or indirect forms of self-harm such as disordered eating or substance abuse (Favazza, 1998; Walsh, 2012). Furthermore, although a relationship exists, NSSI is distinct from suicide attempts in that it is a means of seeking relief and coping, thereby sustaining rather than ending one's life (Walsh, 2012; Wester & Trepal, 2017). NSSI has been conceptualized as a behavioral addiction (Buser & Buser, 2013) given that some clients demonstrate a loss of control over NSSI, continued engagement despite negative consequences, craving to engage in NSSI, and compulsivity, which are hallmarks of addiction. Also, researchers have found evidence for NSSI contagion, in which the behavior is imitated by others in a specific community (Walsh, 2012; Walsh & Rosen, 1985). Given these complexities, it is imperative that clinicians are adequately trained to assess and treat NSSI.

In light of previously published prevalence rates, it is likely that most clinicians will work with clients who self-injure at some point in their careers. Indeed, 21%–80% of inpatient clients and 22%–40% of outpatient clients have reported engagement in self-injurious behavior (Wester & Trepal, 2017). Moreover, in a national sample of 74 clinical practitioners, 60 (81%) reported working with clients who self-injured (Trepal & Wester, 2007), and among 443 school counselors, 357 (81%) reported working with at least one student engaged in self-injury (Roberts-Dobie & Donatelle, 2007). Much has changed, however, in the social landscape related to self-injury, including the popularity of sharing NSSI images online; television shows, movies, and songs depicting NSSI; and celebrities disclosing NSSI behavior. Thus, we sought to investigate licensed clinicians' experiences working with clients who self-injure to provide updated information and better inform the profession of counseling.

Amanda Giordano, PhD, LPC, is an assistant professor at the University of Georgia. Lindsay A. Lundeen, MS, NCC, is a doctoral student at the University of Georgia. Chelsea M. Scoffone, MEd, is a doctoral student at the University of Georgia. Erin P. Kilpatrick, MS, NCC, LPC, is a doctoral student at the University of Georgia. Frank B. Gorritz, MS, NCC, is a doctoral student at the University of Georgia. Correspondence may be addressed to Amanda Giordano, 422G Aderhold Hall, 110 Carlton Street, Athens, GA 30602, amanda.giordano@uga.edu.

Terminology and Prevalence of NSSI

NSSI is not a new abnormal behavior. Indeed, it was documented in the gospel account of Mark written between A.D. 55 and 65, in which the author described a man cutting himself with stones (Mark 5:5; *NIV Life Application Study Bible*, 1984). Self-injurious behavior has been labeled *self-mutilation*, *self-harm*, *deliberate self-harm*, *parasuicide*, *cutting*, and *non-suicidal self-directed violence* (Wester & Trepal, 2017). In this paper, we use the term *nonsuicidal self-injury* (NSSI) as it is currently listed as the proposed diagnosis in the *DSM-5* (Section III, Conditions for Further Study; APA, 2013).

Current prevalence rates indicate that NSSI affects a substantial portion of the population, particularly female adolescents (Nock, 2009; Wester & Trepal, 2017). For example, in a study of 665 adolescents, researchers determined that 8% engaged in NSSI at some point in their lives, which included 9% of the females in the sample and 6.7% of the males (Barrocas et al., 2012). Furthermore, Doyle and colleagues (2017) surveyed adolescents in Ireland and found that 12% had engaged in NSSI, the majority (72.8%) of which were female. Moreover, the examination of data from emergency room visits among youth in the United States (10–24 years of age) indicated a rise in non-fatal self-inflicted injury among females (with and without suicidal intent) from 2001 to 2015 (Mercado et al., 2017). Specifically, self-inflicted injuries with a sharp object rose from 261 incidents in 2001 to 1,021 incidents in 2015 (Mercado et al., 2017). Along with adolescent populations, NSSI is a growing concern among young adults. Wester et al. (2018) examined NSSI among three cohorts of freshman college students and found that lifetime NSSI increased from 16% in the 2008 cohort to 45% in the 2015 cohort. Additionally, current NSSI increased from 2.6% in the 2008 cohort to 19.4% in the 2015 cohort (Wester et al., 2018).

Motives for NSSI

The function of NSSI can be challenging to comprehend among those who do not engage in the behavior. Criterion B in the proposed criteria for NSSI Disorder in the *DSM-5* (APA, 2013) highlighted three potential functions: (a) to relieve negative feelings and cognitions, (b) to address relational difficulties, and (c) to stimulate positive feelings. Indeed, emotion regulation is a primary motivation for NSSI (Nock, 2009). Among 108 adolescents in inpatient treatment who engaged in self-injurious thoughts or behaviors, Nock and Prinstein (2004) found 52.9% engaged in NSSI to relieve negative emotions, 34.1% engaged to feel something, and 30.6% engaged as a form of self-punishment. Doyle et al. (2017) found 79% of adolescents who engaged in NSSI did so to find relief from negative emotions or cognitions, 38% engaged to punish themselves, and 35% sought to communicate the extent of their distress. In light of the many means of emotion regulation that exist, Nock (2009) identified three reasons why some individuals choose NSSI: (a) as a result of social learning from the media, friends, and family; (b) as a form of punishment via self-directed abuse; and (c) as a means of social signaling, or communicating with others (particularly when other forms of communication were ineffective). Engaging in NSSI may be a more accessible, affordable, and easy-to-hide method of emotion regulation compared to other strategies such as substance abuse (Nock, 2009).

NSSI Social Contagion

One important consideration related to NSSI is *social contagion*, or the engagement in a behavior by at least two people in a group within 24 hours (Jarvi et al., 2013; Walsh, 2012; Walsh & Rosen, 1985; Wester & Trepal, 2017). Individuals can become exposed to NSSI through peers, family members, media, and song lyrics, which contribute to social learning (Jarvi et al., 2013; Nock, 2009) and potentially sensationalize the behavior (Walsh, 2012). In a review of the literature, researchers found 16 studies supporting the association between social contagion and NSSI (Jarvi et al., 2013). In a seminal work, Walsh and Rosen (1985) studied the behavior of 25 adolescents in treatment for

various mental health diagnoses for one year. The researchers analyzed the frequency and timing of particular behaviors, including NSSI, and found significant clustering of self-injurious incidents, supporting contagion for NSSI among the group. Furthermore, researchers have found that a small portion of those who engage in NSSI do so to influence others (e.g., get the attention of a particular person, manipulate others, or elicit care; Doyle et al., 2017; Nock, 2008).

In light of the ubiquitous nature of the internet, NSSI social contagion may occur among online groups, as well as those that exist offline. Walsh (2012) noted that factors contributing to social contagion offline can also occur online within the context of social networking sites, message boards, chat rooms, and YouTube. Researchers have confirmed the prevalence of NSSI images and videos online. Lewis and colleagues (2011) investigated NSSI videos on YouTube and found that the top 100 NSSI videos were viewed over 2 million times. Miguel et al. (2017) found 770 NSSI-related images on three social media platforms in a 6-month period using one search term (#cutting). The researchers classified 59.5% of the images as graphic in nature (Miguel et al., 2017). Although there are potential benefits of online communication about NSSI, such as encouraging help-seeking and support, online NSSI-related images and videos pose risks as well. Lewis et al. (2012) noted that online mediums may provide reinforcement for NSSI, provide tips and strategies (such as first aid considerations), and trigger urges among users to engage in NSSI.

NSSI as a Behavioral Addiction

Given its seemingly compulsive nature, some authors have proposed the conceptualization of NSSI as a behavioral addiction (Buser & Buser, 2013; Davis & Lewis, 2019). Indeed, Buser and Buser (2013) posited that for some individuals, NSSI reflects the commonly used criteria for addiction, including compulsivity, loss of control, continuation despite negative consequences, relief from negative emotions, and tolerance. Specifically, tolerance to NSSI can develop as a result of frequent activation of the endogenous opioid system, to which the individual becomes less sensitive (Buser & Buser, 2013; Walsh, 2012). Tolerance among those who self-injure may manifest as increased frequency of NSSI, increased severity of skin tissue damage, or the use of additional NSSI methods (Wester & Trepal, 2017). In the content analysis of 500 posts on NSSI online message boards, Davis and Lewis (2019) determined six themes that underscored the addictive nature of NSSI: urge/obsession, relapse, can't/don't want to stop, coping mechanism, hiding shame, and getting worse/not enough. These themes indicate that some individuals who engage in NSSI experience cravings, a loss of control, urges, and relapse—all common features of addictive behaviors (American Society of Addiction Medicine, 2019). Given the growing acceptance of behavioral addictions, as evidenced by recent changes and additions to both the *DSM-5* (APA, 2013) and the *International Classification of Diseases* (*ICD-11*; World Health Organization, 2018), it is important to assess whether clinicians working with clients who self-injure conceptualize the behavior as addictive.

Purpose of the Study

Although some researchers have investigated the experience of clinicians addressing clients who self-injure (Roberts-Dobie & Donatelle, 2007; Trepal & Wester, 2007), the growing prevalence of NSSI (Mercado et al., 2017; Wester et al., 2018) warrants updated information. Therefore, we designed the current study to explore licensed clinicians' experiences with clients who engage in self-injurious behaviors. Specifically, we sought to examine the frequency of addressing NSSI in clinical work, characteristics of clients who self-injure, NSSI assessment practices, the role of the internet in NSSI, clinicians' beliefs pertaining to NSSI, and clinical training and competence.

Method

Sample

Our sample consisted of 94 licensed clinicians in the United States. Participants ranged in age from 26 to 70 years old with a mean age of 45 (*SD* = 11.06). Eighty (85.1%) participants identified as White, six (6.4%) as Black/African American, three (3.2%) as biracial/multiracial, three (3.2%) as other, and two (2.1%) as Latino(a)/Hispanic. With regard to gender, 79 (84%) participants identified as female, 13 (13.8%) as male, one (1.1%) as transgender, and one (1.1%) as other. Of the 94 participants, 82 (87.2%) identified as heterosexual, five (5.3%) as bisexual, three (3.2%) as queer, two (2.1%) as lesbian, and one (1.1%) each as gay and other.

In relation to professional background, the clinicians represented varying degree levels and educational fields of study. Most of the participants' highest degree was a master's (*n* = 86; 91.5%), while seven (7.4%) earned a doctoral degree, and one (1.1%) participant earned a specialist degree. Fifty-six (59.6%) of the participants reported that their highest degree was from a CACREP-accredited program, while 26 (27.7%) of the participants came from a non–CACREP-accredited program, and 12 (12.8%) did not answer the question. Some diversity existed among participants' programs of study and licensure: 51 (54.3%) participants studied professional counseling or counselor education, 27 (28.7%) studied counseling psychology, seven (7.4%) studied clinical psychology, six (6.4%) studied other areas not listed, and three (3.2%) studied rehabilitation counseling. In terms of licensure, 47 (50%) participants were licensed professional counselors (LPCs), 19 (20.2%) were licensed mental health counselors (LMHCs), 15 (16%) were licensed professional clinical counselors (LPCCs), 11 (11.7%) held licensures not listed in our questionnaire, 11 (11.7%) were licensed clinical professional counselors (LCPCs), seven (7.4%) were licensed clinical mental health counselors (LCMHCs), four (4.3%) were licensed professional counselors of mental health (LPCMHs), three (3.2%) were licensed marriage and family therapists (LMFTs), and one (1.1%) was a licensed chemical dependency counselor (LCDC).

The participants had varying years of clinical experience. Eighteen (19.1%) participants had been counseling clients for 1–5 years, 43 (45.7%) for 6–10 years, 17 (18.1%) for 11–15 years, six (6.4%) for 16–20 years, three (3.2%) for 21–25 years, five (5.3%) for 26–30 years, and two (2.1%) for more than 30 years. All participants stated they were currently seeing clients. We asked participants to describe their typical client base by selecting all applicable responses: 84 (89.4%) of the participants counseled adults, 37 (39.4%) counseled adolescents, 37 (39.4%) counseled college students, 27 (28.7%) counseled couples, 19 (20.2%) counseled children, and 12 (12.8%) counseled families.

Instrument

Similar to the approach employed by Trepal and Wester (2007), our questionnaire consisted of two sections: participants' demographics and clinical experiences with NSSI. In the demographics section, we assessed participants' age, race, ethnicity, gender, sexual orientation, education, clinical license, and typical client base. Next, to better understand clinical work with clients who self-injure, we compiled a series of descriptive, Likert-type assessment items. Specifically, the questionnaire items explored how often clinicians addressed issues of NSSI in counseling, characteristics of clients who self-injured, methods of assessing NSSI, clients' internet and social networking activity pertaining to self-injury, the extent to which clinicians conceptualized NSSI as an addiction and whether NSSI should be a formal diagnosis included in the *DSM* proper (rather than as an appendix), extent of clinical training pertaining to NSSI, and perceived clinical competence when working with issues of NSSI among clients. In sum, the questionnaire contained 22 items related to clinical work with NSSI.

Design

We acquired our national sample of licensed clinical participants using the clinician database on the *Psychology Today* website. Specifically, we conducted a search of clinicians with experience addressing a general clinical issue (i.e., anxiety) within each of the 50 states. We identified the names of the first 13 licensed clinicians from each state and searched the internet for their email addresses. If an email address could not be found, we replaced this clinician with the next licensed clinician listed on the *Psychology Today* website for that particular state. We continued this process until we had names and email addresses for 13 licensed clinicians from each state, yielding 650 potential participants.

We calculated a desired sample of 650 given that researchers purported an average response rate of 15.7% for online research surveys sent to professional counselors in the "other" category (members of state-level associations), which most closely reflected our sample (Poynton et al., 2019). After receiving approval from the Institutional Review Board, we emailed the questionnaire link utilizing the Qualtrics software program to the 650 potential participants. Fifty-two emails were undeliverable, resulting in 598 emails sent. We sent participants three reminder emails over the course of three weeks. We received 102 questionnaires (17.1% response rate) from our national sample of licensed clinicians. After removing eight unfinished questionnaires, our final sample consisted of 94 participants (adjusted response rate = 15.7%).

Results

To answer our research questions regarding licensed clinicians' experiences with client NSSI, we assessed descriptive data resulting from responses to our questionnaire. The data fell into six broad categories: (a) frequency of NSSI in clinical work, (b) descriptions of clients who self-injure, (c) assessment of NSSI, (d) role of the internet, (e) clinicians' beliefs about NSSI as an addiction and formal diagnosis, and (f) NSSI-related training and perceived competence.

Frequency of NSSI in Clinical Work

We first sought to examine how frequently licensed clinicians worked with clients who self-injured. Specifically, we asked our sample how often in the totality of their clinical work they addressed client NSSI. Results indicated that only two (2.1%) clinicians had never worked with a client reporting NSSI, 37 (39.4%) addressed NSSI rarely (about 10% of the time), 33 (35.1%) addressed NSSI occasionally (about 30% of the time), 13 (13.8%) addressed NSSI a moderate amount (about 50% of the time), five (5.3%) addressed NSSI frequently (about 70% of the time), and four (4.3%) addressed NSSI almost always (about 90% of the time). Thus, among a national sample of 94 licensed clinicians, 92 (97.9%) reported working with NSSI at some point in their careers, with 55 (58.5%) reporting that they addressed NSSI 30% of the time or more.

We also assessed frequency of NSSI among clients in the past year. Only one (1.1%) clinician reported not having self-injuring clients in the previous 12 months. Fifty-one (54.3%) clinicians worked with 1–5 clients who self-injured, 24 (25.5%) worked with 6–10 clients who self-injured, six (6.4%) worked with 11–15 clients who self-injured, and nine (9.6%) worked with more than 15 clients who self-injured. Three (3.2%) participants did not respond to this item.

Descriptions of Clients Who Self-Injure

We then examined clinicians' descriptions of clients who reported NSSI. Specifically, we inquired about age, gender, race, and method of self-harm by asking clinicians what portion of their clients who self-injured fell into various categories (Table 1). Sixty-one (64.9%) clinicians reported that

most or all of their clients who self-injured were female, five (5.3%) reported that most or all of their clients who self-injured were transgender, and one (1.1%) reported that most or all clients who self-injured were male. With regard to race, 63 (67.0%) clinicians reported that most or all of their clients who self-injured were White and nine (9.6%) clinicians reported that most or all of their clients who self-injured were members of a marginalized racial group. With regard to age, 36 (38.3%) clinicians reported that most or all of their clients who self-injured were adolescents, 31 (33.0%) reported that most or all of their clients who self-injured were adults, and one (1.1%) reported that most or all of their clients who self-injured were children. In terms of method of self-injury, 43 (45.7%) clinicians reported that most or all of their clients who self-injured engaged in cutting and seven (7.4%) clinicians reported that most or all of their clients who self-injured engaged in self-injurious behavior other than cutting (e.g., burning, hitting, scratching, punching). Therefore, the experience of NSSI is diverse. Although a substantial portion of clinicians reported that the majority of clients presenting with NSSI were White female adolescents who engaged in cutting, numerous clinicians indicated some clients (up to 50%) were male or transgender, children or adults, clients of color, and engaged in methods other than cutting.

Table 1

Number of Clinicians Endorsing Each Response

Item: Among your clients who self-injure, what portion are:	None (0%)	Some (<50%)	About half (50%)	Most (>50%)	All (100%)
Female	1 (1.1%)	17 (18.1%)	12 (12.8%)	43 (45.7%)	18 (19.1%)
Male	21 (22.3%)	57 (60.6%)	11 (11.7%)	1 (1.1%)	0
Transgender	39 (41.5%)	37 (39.4%)	9 (9.6%)	3 (3.2%)	2 (2.1%)
White	2 (2.1%)	20 (21.3%)	6 (6.4%)	45 (47.9%)	18 (19.1%)
Person of Color	25 (26.6%)	51 (54.3%)	7 (7.4%)	6 (6.4%)	3 (3.2%)
Children	64 (68.1%)	24 (25.5%)	0	0	1 (1.1%)
Adolescents	19 (20.2%)	22 (23.4%)	15 (16.0%)	31 (33.0%)	5 (5.3%)
Adults	7 (7.4%)	39 (41.5%)	13 (13.8%)	22 (23.4%)	9 (9.6%)
Engaged primarily in cutting	2 (2.1%)	32 (34.0%)	14 (14.9%)	35 (37.2%)	8 (8.5%)
Engaged primarily in self-injurious behavior other than cutting	19 (20.2%)	52 (55.3%)	14 (14.9%)	6 (6.4%)	1 (1.1%)

Note. Numerical values refer to number of clinicians endorsing that response, followed by percent of clinicians out of the total (*N* = 94); percentages do not equate to 100 because of missing items: female (missing 3), male (missing 4), transgender (missing 4), White (missing 3), person of color (missing 2), children (missing 5), adolescents (missing 2), adults (missing 4), primarily cutting (missing 3), primarily other behavior (missing 2).

Assessment of NSSI

We also examined data related to the clinical assessment of NSSI. The most commonly endorsed form of assessing NSSI among clinicians was informal assessment through dialogue (n = 83, 88.3%), followed by the use of formal NSSI assessment instruments (n = 21, 22.3%). One (1.1%) clinician reported never assessing NSSI in their clinical work. We also inquired as to whether or not clinicians' intake forms contained items related to NSSI. Forty-six (48.9%) reported yes, the NSSI item was separate from suicide items; 22 (23.4%) reported yes, the NSSI item was in conjunction with suicide attempts; 16 (17.0%) clinicians reported no, their intake form did not have an item related to NSSI; and 10 (10.6%) did not know or did not answer this question.

Role of the Internet in Client Self-Injurious Behavior

We investigated participants' responses to items related to clients' internet use related to NSSI. Specifically, we asked clinicians what portion of their clients engaging in NSSI utilized the internet or social networking sites (SNS) to share pictures of self-injury. Forty-two (44.7%) clinicians reported they did not know because they never discussed the issue with their clients who self-injured. Twenty-six (27.7%) clinicians reported that some (up to 50%) of their clients who self-injured shared NSSI pictures online, 20 (21.3%) reported none of their clients who self-injured shared NSSI pictures online, and three (3.2%) reported that half to all of their clients who self-injured shared NSSI pictures online. In response to the item assessing the frequency in which clinicians asked clients who self-injured about their internet and SNS use related to self-injury, 33 (35.1%) clinicians reported they never asked about this topic, 27 (28.7%) asked sometimes (less than 50% of the time), seven (7.4%) asked about half the time, 17 (18.1%) asked most of the time (more than 50%), and eight (8.5%) always asked. Therefore, it appears that clinicians do not consistently inquire about clients' internet and SNS use as it relates to NSSI, but those who do find that some of their clients share pictures of self-injury online.

Clinicians' Beliefs About NSSI

In light of the current status of NSSI Disorder as a condition for further study in the *DSM-5* (APA, 2013) and debate about the addictive nature of NSSI, we asked clinicians to share their beliefs on these two topics. With regard to diagnostic status, 32 (34%) clinicians believed NSSI Disorder should be a formal diagnosis in the next edition of the *DSM*, 24 (25.5%) did not have a preference, and 13 (13.8%) did not believe it should be a diagnosis. Twenty-five (26.6%) participants did not respond to this item. Pertaining to the conceptualization of NSSI as an addiction, 78 (83.0%) clinicians believed that for some individuals, NSSI can be an addiction; eight (8.5%) did not believe NSSI could be an addiction; six (6.4%) stated they did not know; and two (2.1%) did not answer this item. Thus, it appears that one third of the sample supported a formal diagnosis of NSSI Disorder in the *DSM* proper and a large majority of the sample agreed that NSSI could be an addictive behavior.

NSSI-Related Training and Competence

Finally, participants reported settings in which they received training to address NSSI in clinical work (participants could select all modalities that applied). The most common training modality was continuing education (e.g., conference presentations, workshops, seminars), which was endorsed by 55 (58.5%) clinicians. On-the-job training was the second most common modality, endorsed by 47 (50.0%) clinicians, followed by graduate school coursework, endorsed by 42 (44.7%) clinicians; self-study, endorsed by 38 (40.4%) clinicians; and graduate school internships, endorsed by 28 (29.8%) clinicians. Three (3.2%) clinicians reported that they had never received NSSI training. Clinicians further reported the extent to which they felt competent addressing NSSI in counseling. Four (4.3%) clinicians felt extremely incompetent, eight (8.5%) felt somewhat incompetent, 10 (10.6%) felt neither

competent nor incompetent, 54 (57.4%) felt somewhat competent, and 17 (18.1%) felt extremely competent. One (1.1%) clinician did not respond to this item. Overall, clinicians primarily received NSSI training via continuing education workshops and on-the-job experiences. About half of our sample felt somewhat competent to address NSSI, indicating opportunities to improve NSSI training and competence among clinicians.

Discussion

Given the rising prevalence of NSSI (Mercado et al., 2017; Wester et al., 2018) and new considerations such as social contagion (Walsh, 2012; Walsh & Rosen, 1985) and sharing NSSI images online (Lewis et al., 2011; Miguel et al., 2017), continued research is needed related to clinical work with self-injury. We disseminated a questionnaire among a national sample of licensed clinicians to examine the prevalence of NSSI, descriptions of clients who engage in NSSI, means of assessing NSSI, role of the internet in NSSI behaviors, clinicians' beliefs about NSSI, and NSSI training and perceived competence. Our results indicated that most clinicians surveyed (*n* = 92, 97.9%) have worked with at least one client who engaged in NSSI. This prevalence rate suggests a potential increase in the presenting concern since Trepal and Wester's (2007) study, in which 81% of practicing counselors reported working with a client who self-injured during their careers. Furthermore, our results revealed that 95.7% (*n* = 90) of clinicians treated at least one client participating in NSSI within the past year. Although researchers have determined that 8% of adolescents (Barrocas et al., 2012) and 45% of college freshman (Wester et al., 2018) in naturalistic samples engaged in NSSI at some point in their lifetimes, it appears the frequency might be higher among clients seeking counseling services.

Previous researchers have established that NSSI is more prevalent among females than males (Barrocas et al., 2012; Doyle et al., 2017; Mercado et al., 2017). Our results confirmed these findings as 61 (64.9%) of the clinicians in our sample indicated that most or all of their clients who self-injured were female, as compared to only one (1.1%) who said most or all were male. It is important to note, however, the prevalence of clinicians who reported working with male clients who self-injured. Specifically, 57 (60.6%) noted that some of their clients who self-injured were male and 11 (11.7%) reported that about half of their clients who self-injured were male. Thus, these results indicate that although NSSI is more prevalent among females, it also occurs among male populations. Additionally, although NSSI typically begins in adolescence (Nock & Prinstein, 2004; Wester & Trepal, 2017), 31 (33%) of the clinicians in our sample reported that most or all of their clients who engaged in NSSI were adults. It is imperative, therefore, that clinicians who work with both adolescents and adults are prepared to effectively screen for and treat NSSI.

Regarding the assessment of self-injurious behaviors, our results revealed that only 21 (22.3%) clinicians utilized formal NSSI assessments. Although informal assessment measures often are effective, clinicians could benefit from reviewing psychometrically sound NSSI assessment instruments such as the Deliberate Self-Harm Inventory (Gratz, 2001), the Alexian Brothers Urge to Self-Injure Scale (ABUSI; Washburn et al., 2010), or the Non-Suicidal Self-Injury-Assessment Tool (Whitlock et al., 2014; see Wester & Trepal, 2017, for an extensive description of multiple NSSI assessments).White Kress (2003) summarized that clinicians should assess the function, severity, and dynamics of NSSI, including age of onset, emotions while engaging in NSSI, antecedents to NSSI, desire and efforts to stop or control NSSI, use of substances while self-injuring, medical complications, and changes over time.

We also sought to understand the role of the internet and SNS in NSSI behaviors. Specifically, we inquired of licensed clinicians the extent to which their clients utilized the internet or SNS to share NSSI

images and the frequency in which they asked clients who self-injured about their internet behavior. According to the results of our survey, almost half of clinicians surveyed ($n = 42$; 44.7%) did not know about the role of the internet or SNS among clients who self-injured because they did not ask. Twenty-nine (30.9%) clinicians reported that at least some of their clients used the internet to share pictures. Furthermore, 33 (35.1%) of the clinicians in our study disclosed they had never asked about SNS or the internet when assessing and treating clients engaging in NSSI, and 27 (28.7%) reported asking less than 50% of the time. These numbers indicate a need for clinicians to have access to current research related to the prevalence of viewing and sharing NSSI images online (Lewis et al., 2011; Miguel et al., 2017). For example, Lewis and Seko (2016) thematically examined 27 empirical studies investigating the perceived effects of online behavior among those who self-injure. The authors reported both perceived benefits of online NSSI activity (i.e., mitigation of social isolation, recovery encouragement, emotional self-disclosure, and curbing NSSI urges) as well as perceived risks (i.e., NSSI reinforcement, triggering NSSI urges, and stigmatization of NSSI; Lewis & Seko, 2016). In addition, previous researchers have found that a portion of individuals engaging in NSSI do so to influence others (Doyle et al., 2017; Nock, 2008), and thus may be particularly attracted to sharing NSSI images online. Given the complex role of the internet in self-injury, it seems imperative that clinicians broach the subject with clients who self-injure.

Our results also demonstrated a strong belief among clinicians ($n = 78$; 83%) that NSSI can be an addictive behavior for some clients, which supports the stance of previous researchers who conceptualize NSSI as a behavioral addiction (Buser & Buser, 2013). The conceptualization of NSSI as an addictive behavior, with particular emphasis on the stimulation of the endogenous opioid system, has important implications for treatment. Evidence-based addictions treatment strategies such as 12-step support group attendance (Connors et al., 2001) and motivational interviewing (Miller & Rollnick, 2013) can be helpful approaches for working with client NSSI.

Finally, we examined clinicians' training experience and perceived competence related to NSSI. Less than half of our participants ($n = 42$; 44.7%) received NSSI training in their graduate-level coursework. The number of clinicians seeking NSSI training via continuing education ($n = 55$; 58.5%) and self-study ($n = 38$; 40.4%) is indicative of the desire for more knowledge related to self-injury. In addition, roughly 23% ($n = 22$) of our sample felt less than "somewhat competent" when addressing NSSI in their clinical work. This perceived incompetency reflects the reported lack of training related to NSSI treatment. Ultimately, this data highlights the opportunity to substantially improve NSSI training to increase clinical competence.

Implications for Counselors

The results of the current study have implications for clinical work with NSSI, specifically in the realms of assessment and treatment. Although many clinicians in our study reported effective assessment measures related to NSSI, an important step for improving assessment might be to include a separate NSSI item on intake forms distinct from suicidal behavior. Sixteen clinicians (17%) in our study said their intake form did not inquire about NSSI, and 22 (23.4%) said the item was written in conjunction with suicidal ideation and attempts. The combination of NSSI and suicidal thoughts or ideations on an intake form can make client conceptualization and treatment goals challenging. NSSI and suicide attempts have markedly different motives (Favazza, 1998; Walsh, 2012; Wester & Trepal, 2017); therefore, listing the behaviors as two separate intake items may best serve both clinicians and clients. Specifically, clinicians could provide a definition of NSSI (Favazza, 1998) on the form to help clients understand the terminology. For clients who indicate that they are engaging in NSSI, clinicians can then utilize formal assessment instruments or the proposed NSSI Disorder diagnostic criteria in the *DSM-5* (APA, 2013) to gain a thorough understanding of the behavior. Additionally, clinicians may

best serve clients by assessing NSSI with all individuals, regardless of gender, age, racial, or ethnic identification, by asking a broad question such as "Have you ever deliberately hurt yourself?" rather than "Have you ever cut yourself?" to be inclusive of multiple forms of NSSI.

With regard to treatment strategies for NSSI, several useful approaches exist. Dialectical behavior therapy (Linehan, 1993) is a counseling method combining cognitive-behavioral and mindfulness techniques for work with clients diagnosed with borderline personality disorder (BPD). NSSI can be associated with BPD given that self-mutilation is listed as a diagnostic criterion for the disorder (APA, 2013). Researchers have found empirical support for the efficacy of dialectical behavior therapy with regard to NSSI (Choate, 2012; Muehlenkamp, 2006); thus, this treatment approach may be useful for clients with BPD and NSSI. Self-injury also can exist apart from a BPD diagnosis (Muehlenkamp, 2005). In these instances, treatment for self-injurious behavior (T-SIB; Andover et al., 2015) may be a useful approach. T-SIB is a 9-week intervention designed for young adults who self-injure. The intervention includes providing psychoeducation, increasing motivation to change, conducting functional analysis, developing replacement behaviors, increasing distress tolerance, and cognitive restructuring (Andover et al., 2015, 2017). Some empirical support exists for the efficacy of T-SIB among young adults, and the treatment manual provides detailed information for clinicians using the approach (Andover et al., 2015, 2017).

Regardless of the therapeutic intervention, it would behoove clinicians to inquire about clients' online activities related to NSSI to inform treatment plans and goals. Clients' online activities could include watching NSSI videos; viewing NSSI images; posting and sharing NSSI images on SNS; communicating with others who self-injure via chatrooms and NSSI websites; or seeking information related to how to conceal, clean, or perform NSSI. As part of their recovery plan, it may be helpful for clients and counselors to develop strategies for healthy online behaviors to minimize triggers, urges, or the normalization of NSSI. Even for clients who describe using the internet to find support for their NSSI, clinicians have the opportunity to describe potential risks with NSSI online activity as well (Lewis & Seko, 2016).

Limitations and Future Research

This study is not without limitations. First, our final participant sample consisted of only 94 licensed clinicians, which reflected a 15.7% response rate. Although this is fairly typical for online surveys (Poynton et al., 2019), there were many potential respondents who did not participate, and we were unable to determine if non-respondents differed significantly from respondents. Additionally, in order to obtain a nationally representative sample, we utilized the clinician database found on *Psychology Today*. Thus, our participants were limited to only those clinicians who registered for that particular website. Furthermore, although our questionnaire was robust, we did not inquire about the nature of internet use among clients with NSSI. Future researchers may choose to assess whether clients primarily use the internet for education related to NSSI, to find support, to share images, or to read others' accounts of NSSI behaviors. Finally, we utilized only licensed clinicians for this study. Future researchers may choose to replicate this study with specific types of counselors such as school counselors, inpatient counselors, and outpatient counselors to assess experiences with individuals who self-injure. In these various settings, researchers may inquire as to how clinicians code for NSSI, given that it is not included in the *DSM-5* proper.

Conclusion

Nonsuicidal self-injury is a prevalent concern among clients seeking clinical services. We sought to understand clinicians' experiences working with NSSI by surveying a national sample of licensed practitioners (*N* = 94). As demonstrated by our results, NSSI affects individuals across age ranges and gender identifications, although it is most prevalent among White female adolescents. Our findings indicate that the majority of clinicians (97.9%) worked with at least one client who engaged in NSSI in the past year. Furthermore, the majority of our sample (83.0%) supported the stance that NSSI can be an addictive behavior. Finally, our study indicates a need for more training related to NSSI in graduate programs and an emphasis on differentiating between NSSI and suicide attempts on intake forms and in clinical work.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

American Society of Addiction Medicine (2019). *Definition of addiction*. https://www.asam.org/resources/definition-of-addiction

Andover, M. S., Schatten, H. T., Morris, B. W., Holman, C. S., & Miller, I. W. (2017). An intervention for nonsuicidal self-injury in young adults: A pilot randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *85*(6), 620–631. http://doi.org/10.1037/ccp0000206

Andover, M. S., Schatten, H. T., Morris, B. W., & Miller, I. W. (2015). Development of an intervention for nonsuicidal self-injury in young adults: An open pilot trial. *Cognitive and Behavioral Practice*, *22*(4), 491–503. https://doi.org/10.1016/j.cbpra.2014.05.003

Barrocas, A. L., Hankin, B. L., Young, J. F., & Abela, J. R. Z. (2012). Rates of nonsuicidal self-injury in youth: Age, sex, and behavioral methods in a community sample. *Pediatrics*, *130*(1), 39–45. https://doi.org/10.1542/peds.2011-2094

Buser, T. J., & Buser, J. K. (2013). Conceptualizing nonsuicidal self-injury as a process addiction: Review of research and implications for counselor training and practice. *Journal of Addiction & Offender Counseling*, *34*(1), 16–29. https://doi.org/10.1002/j.2161-1874.2013.00011.x

Choate, L. H. (2012). Counseling adolescents who engage in nonsuicidal self-injury: A dialectical behavior therapy approach. *Journal of Mental Health Counseling*, *34*(1), 56–71. https://doi.org/10.17744/mehc.34.1.506780307v16m402

Connors, G. J., Tonigan, J. S., & Miller, W. R. (2001). A longitudinal model of intake symptomatology, AA participation and outcome: Retrospective study of the Project MATCH outpatient and aftercare samples. *Journal of Studies on Alcohol*, *62*(6), 817–825. https://doi.org/10.15288/jsa.2001.62.817

Davis, S., & Lewis, C. A. (2019). Addicted to self-harm? The case of online postings on self-harm message boards. *International Journal of Mental Health and Addiction*, *17*, 1020–1035. https://doi.org/10.1007/s11469-018-9975-8

Doyle, L., Sheridan, A., & Treacy, M. P. (2017). Motivations for adolescent self-harm and the implications for mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, *24*(2-3), 134–142. https://doi.org/10.1111/jpm.12360

Favazza, A. R. (1998). The coming of age of self-mutilation. *The Journal of Nervous and Mental Disease*, *186*(5), 259–268. https://doi.org/10.1097/00005053-199805000-00001

Gratz, K. L. (2001). Measurement of deliberate self-harm: Preliminary data on the Deliberate Self-Harm Inventory. *Journal of Psychopathology and Behavioral Assessment*, *23*, 253–263. https://doi.org/10.1023/A:1012779403943

Jarvi, S., Jackson, B., Swenson, L., & Crawford, H. (2013). The impact of social contagion on non-suicidal self-injury: A review of the literature. *Archives of Suicide Research*, *17*(1), 1–19. https://doi.org/10.1080/13811118.2013.748404

Lewis, S. P., Heath, N. L., Michal, N. J., & Duggan, J. M. (2012). Non-suicidal self-injury youth and the internet: What mental health professionals need to know. *Child and Adolescent Psychiatry and Mental Health*, *6*, 13–21. https://doi.org/10.1186/1753-2000-6-13

Lewis, S. P., Heath, N. L., St. Denis, J. M., & Noble, R. (2011). The scope of nonsuicidal self-injury on YouTube. *Pediatrics*, *127*(3), e552–e557. https://doi.org/10.1542/peds.2010-2317

Lewis, S. P., & Seko, Y. (2016). A double-edged sword: A review of benefits and risks of online nonsuicidal self-injury activities. *Journal of Clinical Psychology*, *72*(3), 249–262. https://doi.org/10.1002/jclp.22242

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford.

Mercado, M. C., Holland, K., Leemis, R. W., Stone, D. M., & Wang, J. (2017). Trends in emergency department visits for nonfatal self-inflicted injuries among youth aged 10 to 24 years in the United States, 2001–2015. *JAMA*, *318*(19), 1931–1933. https://doi.org/10.1001/jama.2017.13317

Miguel, E. M., Chou, T., Golik, A., Cornacchio, D., Sanchez, A. L., DeSerisy, M., & Comer, J. S. (2017). Examining the scope and patterns of deliberate self-injurious cutting content on popular social media. *Depression and Anxiety*, *34*(9), 786–793. https://doi.org/10.1002/da.22668

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). Guilford.

Muehlenkamp, J. J. (2005). Self-injurious behavior as a separate clinical syndrome. *American Journal of Orthopsychiatry*, *75*(2), 324–333. https://doi.org/10.1037/0002-9432.75.2.324

Muehlenkamp, J. J. (2006). Empirically supported treatments and general therapy guidelines for non-suicidal self-injury. *Journal of Mental Health Counseling*, *28*(2), 166–185. https://doi.org/10.17744/mehc.28.2.6w61cut2lxjdg3m7

NIV Life Application Study Bible. (1984). Tyndale House Publishers.

Nock, M. K. (2008). Actions speak louder than words: An elaborated theoretical model of the social functions of self-injury and other harmful behaviors. *Applied and Preventive Psychology*, *12*(4), 159–168. https://doi.org/10.1016/j.appsy.2008.05.002

Nock, M. K. (2009). Why do people hurt themselves? New insights into the nature and functions of self-injury. *Current Directions in Psychological Science*, *18*(2), 78–83. https://doi.org/10.1111/j.1467-8721.2009.01613.x

Nock, M. K., & Prinstein, M. J. (2004). A functional approach to the assessment of self-mutilative behavior. *Journal of Consulting and Clinical Psychology*, *72*(5), 885–890. https://doi.org/10.1037/0022-006X.72.5.885

Poynton, T. A., DeFouw, E. R., & Morizio, L. J. (2019). A systematic review of online response rates in four counseling journals. *Journal of Counseling & Development*, *97*(1), 33–42. https://doi.org/10.1002/jcad.12233

Roberts-Dobie, S., & Donatelle, R. J. (2007). School counselors and student self-injury. *Journal of School Health*, *77*(5), 257–264. https://doi.org/10.1111/j.1746-1561.2007.00201.x

Trepal, H. C., & Wester, K. L. (2007). Self-injurious behaviors, diagnoses, and treatment methods: What mental health professional are reporting. *Journal of Mental Health Counseling*, *29*(4), 363–375. https://doi.org/10.17744/mehc.29.4.d277t298667q5367

Walsh, B. W. (2012). *Treating self-injury: A practical guide* (2nd ed.). Guilford.

Walsh, B. W., & Rosen, P. (1985). Self-mutilation and contagion: An empirical test. *The American Journal of Psychiatry*, *142*(1), 119–120. https://doi.org/10.1176/ajp.142.1.119

Washburn, J. J., Juzwin, K. R., Styer, D. M., & Aldridge, D. (2010). Measuring the urge to self-injure: Preliminary data from a clinical sample. *Psychiatry Research*, *178*(3), 540–544. https://doi.org/10.1016/j.psychres.2010.05.018

Wester, K., & Trepal, H. C. (2017). *Non-suicidal self-injury: Wellness perspectives on behaviors, symptoms, and diagnosis.* Routledge.

Wester, K., Trepal, H., & King, K. (2018). Nonsuicidal self-injury: Increased prevalence in engagement. *Suicide and Life-Threatening Behavior*, *48*(6), 690–698. https://doi.org/10.1111/sltb.12389

White Kress, V. E. (2003). Self-injurious behaviors: Assessment and diagnosis. *Journal of Counseling & Development*, *81*(4), 490–496. https://doi.org/10.1002/j.1556-6678.2003.tb00276.x

Whitlock, J., Exner-Cortens, D., & Purington, A. (2014). Assessment of nonsuicidal self-injury: Development and initial validation of the Non-Suicidal Self-Injury–Assessment Tool (NSSI-AT). *Psychological Assessment*, *26*(3), 935–946. https://doi.org/10.1037/a0036611

World Health Organization. (2018). *International statistical classification of diseases and related health problems* (11th Revision). https://icd.who.int/en

nbcc

Infusing Service Learning Into the Counselor Education Curriculum

Kristen Arla Langellier, Randall L. Astramovich, Elizabeth A. Doughty Horn

Counselors are frequently called upon to be advocates for their clients and, more broadly, to advocate for the counseling profession. However, many new counselors struggle with integrating advocacy work in their counseling practice. This article provides an overview of service learning and identifies ways counselor educators may foster advocacy skills among counselors-in-training through the use of planned service learning experiences in the counselor education curriculum. The authors then provide examples of service learning activities for use within the Council for Accreditation of Counseling and Related Educational Programs (CACREP) 2016 core curricular areas, including professional orientation and ethical practice, social and cultural diversity, career development, helping relationships, and group work.

Keywords: advocacy, service learning, counselor education, ACA, CACREP

University faculty members frequently include service learning experiences in the undergraduate curriculum as a means for helping prepare students to develop as community members through meaningful civic engagement experiences that are augmented with classroom education (Servaty-Seib & Tedrick Parikh, 2014; Stanton & Wagner, 2006). Unfortunately, service learning assignments tend to diminish significantly as students make the transition from undergraduate to graduate education (Jett & Delgado-Romero, 2009; Servaty-Seib & Tedrick Parikh, 2014; Stanton & Wagner, 2006). Much of the existing scholarly literature centers around the impact of service learning on students who are at a traditional undergraduate age (Jett & Delgado-Romero, 2009; Servaty-Seib & Tedrick Parikh, 2014). The lack of service learning opportunities in the graduate curriculum is surprising, given that service learning may help students develop a deeper sense of community, appreciate others' perspectives, and identify avenues for contributing to social change (Cipolle, 2010).

Within graduate counselor training programs, counselor educators could more frequently utilize service learning projects (SLPs) in order to enhance knowledge of diverse community cultures among counselors-in-training (CITs) as well as provide CITs with opportunities to assess community needs and implement advocacy efforts. The counseling profession's Multicultural and Social Justice Counseling Competencies (MSJCC), revised in 2016, states the importance of "integrating social justice advocacy into the various modalities of counseling" (Ratts et al., 2016, p. 31). In addition, the MSJCC posits that counselors and counselor educators conceptualize clients through a socioecological lens so as to understand the social structures affecting their world. Service learning curricula often include a social justice focus, which has been demonstrated to help students understand the structures in place that oppress others (Tinkler et al., 2015). With these guidelines in mind, the purpose of this article is to provide practical suggestions to help counselor educators infuse service learning into their curriculum, thus offering CITs more opportunities for personal and professional development.

Kristen Arla Langellier, PhD, NCC, is an assistant professor at the University of South Dakota. Randall L. Astramovich, PhD, LCPC, is an associate professor at Idaho State University. Elizabeth A. Doughty Horn, PhD, LCPC, is a professor at Idaho State University. Correspondence may be addressed to Kristen Langellier, Division of Counseling and Psychology in Education, University of South Dakota, 414 E. Clark St., Vermillion, SD 57069, kristen.langellier@usd.edu.

Service Learning

Service learning was first introduced in the early 1900s as a method for fostering academic and social learning and advancements for students via community involvement (Barbee et al., 2003). Bringle and Hatcher (1995) defined service learning as

> a credit-bearing, educational experience in which students a) participate in an organized service activity that meets identified community needs, and b) reflect on the service activity in such a way as to gain further understanding of course content, a broader appreciation of the discipline, and an enhanced sense of civic responsibility. (p. 112)

Since its inception, many disciplines have found service learning useful as a method of merging the academic with the practical; it has become popular with disciplines such as nursing (Backer Condon et al., 2015), teacher education (Tinkler et al., 2015), and public health (Sabo et al., 2015).

With respect to counselor education, there has been a diminutive amount of research related to the implementation and effectiveness of service learning. In 2009, Jett and Delgado-Romero described service learning as an area of developing research in counselor education, and this could still be said today. There is a paucity of literature regarding service learning in graduate education (Servaty-Seib & Tedrick Parikh, 2014) and, more specifically, within counselor education. Yet university faculty, particularly counselor educators, are tasked with the challenge of bridging academic theory and research with "real-world" experiences. Therefore, SLPs may serve as a method for students and faculty to connect with the community in which they live and beyond (Nikels et al., 2007).

After reviewing service learning literature, Dotson-Blake et al. (2010) determined successful SLPs contain five essential characteristics that contribute to the overall intention of service learning. They contended successful SLPs should be developed in concert with a community or professional partner, contain coherent and well-defined expectations, incorporate stakeholder support, consider students' developmental levels, allow ample opportunity for reflective practices, and broaden or expand because of the impact of the project (Dotson-Blake et al., 2010). Focusing on the above underpinnings of successful SLPs could potentially assist counselor educators in the planning and implementation stages of these sorts of projects, as they can take time and considerable effort to develop.

Service Learning and Social Justice

According to Cipolle (2010), social justice and service learning are interrelated. She asserted that service learning and social justice need to be considered together so as to accomplish a larger goal of connection with the community. An additional component to service learning is the development of critical consciousness. Students engaging in service learning as a means of social justice may gain compassion and understanding from their participation (Cipolle, 2010). A by-product of service learning with a social justice focus may be the development of self-awareness through students' opportunities to see for themselves how others live their lives; perhaps students will also see the impact of the dominant culture (Cipolle, 2010). Self-awareness is a key component of the 2016 MSJCC (Ratts et al., 2016) and is found throughout the Council for Accreditation of Counseling and Related Educational Programs (CACREP) 2016 Standards (CACREP, 2015). Additionally, the *ACA Code of Ethics* asserts that counselors should ascribe to self-awareness to maintain ethical practice and reflection (American Counseling Association [ACA], 2014).

Service Learning Versus Community Service

An important distinction between community service and service learning lies within the beneficiaries of each. Within community service, the beneficiaries are those receiving the service. Service learning posits a reciprocal model, with both the recipient of service and student benefitting from the project (Blankson et al., 2015). Thus, SLPs provide students with opportunities to be exposed to issues of social justice that may foster empathy and cultural self-awareness. Students can benefit from service learning as it may assist them in developing increased compassion for others (George, 2015). With the continued focus on social justice within many disciplines, SLPs may provide another avenue for counselor educators to help students more fully understand the diverse needs of their communities and advocate for the underserved.

Throughout participation in an SLP, and at the completion, students are encouraged to apply critical thinking to their efforts and reflect on progress, barriers, and benefits (Blankson et al., 2015). For successful service learning to occur, projects should be connected to specific course objectives. Such a curricular emphasis is not generally a component of community service initiatives. By combining student projects and course material, instructors are able to help students solidify course material into practical applications (McDonald & Dominguez, 2015). This experiential avenue may appeal to non-traditional learners and provide more integration of material than didactic coursework alone (Currie-Mueller & Littlefield, 2018).

Effects of Service Learning

Cipolle (2010) reported that students participating in early service learning received numerous benefits, including having higher self-confidence, feeling empowered, gaining self-awareness, developing patience and compassion, recognizing their privilege, and developing a connection and commitment to their community. All of these outcomes are consistent with the aims and goals of standards, competencies, and codes of ethics within the counseling profession (ACA, 2014; CACREP, 2015; Ratts et al., 2016).

Scott and Graham (2015) reported an increase in empathy and community engagement for school-age children when participating in service learning. They also reported that several previous works measured similar favorable effects among high school– and college-age individuals. Because of these overlapping desired effects and the need to incorporate social justice throughout the curriculum, service learning would fit well into current models of counselor education.

Service Learning Efforts in Counselor Education

The *ACA Code of Ethics* (2014) calls upon professional counselors to donate their time to services for which they receive little to no financial compensation. The incorporation of SLPs could provide an opportunity to fulfill this ethical obligation while training students and connecting with the community. A dearth of literature exists as to specific counselor education service learning efforts. Of the few results, many are focused on pre-practicum level SLPs (Barbee et al., 2003; Jett & Delgado-Romero, 2009), pedagogical tools woven into the multicultural and diversity-based courses (Burnett et al., 2004; Nikels et al., 2007), and group leadership training (Bjornestad et al., 2016; Midgett et al., 2016). Alvarado and Gonzalez (2013) studied the impact of an SLP on pre-practicum–level counseling students and found that students reported an increase in their confidence in using the core counseling skills and a deeper connection with the community outside of the university setting. Havlik et al. (2016) explored the effect SLPs had on CITs and found similar themes to Alvarado and Gonzalez, particularly that of raised levels of confidence in the ability to use the core counseling skills.

In other counselor education–related studies, researchers also reported positive impacts of service learning. One such impact was that of raised student self-efficacy (Barbee et al., 2003; Jett & Delgado-Romero, 2009; Murray et al., 2006). An added and practical benefit for students has also been a greater understanding and familiarity of the roles and settings of professional counselors and a deepened understanding of counselors' roles within professional agencies. Students were able to examine their own professional interests prior to practicum work and participate in valuable networking experiences with other professionals (Jett & Delgado-Romero, 2009).

An increased compassion for the population with whom they work has been reported (Arnold & McMurtery, 2011) as a result of service learning. Burnett et al. (2005) reported increased counselor self-awareness, which is an important component of counselor education, regardless of delivery method, program accreditation, or instructor pedagogy. They also reported a component of a successful service learning course to be peer-learning. Peer-learning involves the giving and receiving of feedback, and this provides a foundation for experiences of group supervision feedback later in counseling programs (Burnett et al., 2005). A frequent reported result of participation in service learning has been increased multicultural competence and social justice awareness on the part of the student (Burnett et al., 2004; Lee & Kelley Petersen, 2018; Lee & McAdams, 2019; Shannonhouse et al., 2018). In short, the incorporation of SLPs would benefit counselor educators in developing desired qualities in beginning counselors while giving them opportunities to network and more fully integrate material.

Integrating Service Learning Into Counselor Education
Freire (2000) espoused that education should inspire students to become active and engaged members of the classroom in order to develop a deeper critical consciousness of society. Keeping Freire's goal in mind, counselor educators could utilize service learning to bridge the divide that exists between the "ivory tower" and communities outside of academia. Counselors are called to apply their theoretical knowledge to real-world clients and to be advocates for those whose voices are silenced because of various forms of oppression (ACA, 2014; CACREP, 2015; Ratts et al., 2016). Through participation in SLPs, students are able to see firsthand the effects of oppression and assist with creating solutions; often, the projects chosen contain an element of social justice (George, 2015). Furthermore, SLPs woven into coursework may provide the opportunity for students to begin finding their voices as advocates and activists in a supportive environment, where peers are available to assist with potential problems that may arise.

By encouraging CITs to participate in SLPs earlier and often within their graduate education, students may have more opportunities to engage with diverse populations and to experience community environments and sociopolitical influences faced by different groups. The focus of clinical work during the practicum and internship phases of counselor education typically emphasizes counselor skill development and client progress rather than community-focused perspectives (Barbee et al., 2003; Jett & Delgado-Romero, 2009). Thus, by incorporating SLPs into regular coursework, students may feel freer to engage holistically in a community system rather than focus narrowly on their own counseling skill development and individual client progress. For all SLPs, there is the potential for students to experience the project components as challenging to complete. In this situation, students may be redirected to identify and analyze barriers to the success of the project and to identify strategies for eliminating those barriers.

Gehlert et al. (2014) argued that SLPs can also serve as potential gatekeeping tools. They posited that by engaging with individuals outside of the classroom experience, especially earlier than the

practicum stage, students might decide for themselves that the counseling profession is not the right choice for their career (Gehlert et al., 2014). They further contended that utilizing SLPs early in students' programs of study will allow the opportunity for faculty to identify students who might be in need of remediation plans before they are working with clients (Gehlert et al., 2014).

Counselors are urged to be advocates for the profession and for clients (ACA, 2014). Service learning may function as a natural initiation into that identity (Manis, 2012; Toporek & Worthington, 2014) and could possibly provide a bridge between an identity as a counselor and that of a counselor advocate. Another potential benefit of service learning is that students may be able to gain knowledge as to the realities of the profession beyond specific contact hour requirements to satisfy internship and licensure requirements. This could prove helpful as a gatekeeping tool as well. Students who find themselves disliking significant aspects of the profession might choose to leave the program without requiring faculty intervention.

Experiences of SLPs can be distilled into poster presentations or conference presentations. In this context, SLPs benefit both CITs and counselor educators, as professional development can occur for both. For students, conferences can be valuable networking opportunities, and for counselor educators, conference-related activities fall under required professional development (ACA, 2014; CACREP, 2015). Experiences could also serve as the foundation for manuscripts and research projects, both of which are considered professional development.

Service Learning Opportunities Within Specific Counseling Content Areas

CACREP (2015) provides counselor educators with standards for training that can be used to facilitate course development, learning objectives, and class assignments. Several core content areas within a CACREP-aligned counseling curriculum may offer instructors and students the chance to engage in SLPs. Because little information currently exists regarding best practices for service learning within counselor education, the authors created example SLPs that are based on CACREP standards and rooted in the relevant content area literature. These are designed to facilitate the development of advocacy skills in a variety of environments. It should be noted that with any SLP, it is important for counselor educators to engage in continued monitoring of projects and student placements. Given that SLPs provide a reciprocal benefit for both students and the community, it is important to ensure everyone involved is experiencing ongoing added value. Therefore, counselor educators are encouraged to create and maintain relationships with stakeholders for feedback throughout the SLP and to make adjustments as necessary.

Professional Orientation and Ethical Practice

Licensure remains an important topic within the counseling profession (Bergman, 2013; Bobby, 2013) and professional counselors are now able to obtain licensure in all states (Bergman, 2013; Urofsky, 2013). In order to become more familiar with state licensure policies and procedures, an SLP might involve student interviews with a member of the state licensure board and reflection upon that experience through a written journal entry. Questions posed to the board member could range from the practical aspects of obtaining a license in their state to the broader implications of ethical issues the board encounters. Student findings could then be utilized to develop a project involving the entire class in which students brainstorm ideas about what assistance the board might need in terms of outreach or advocacy. Examples could include barriers to licensure because of cost or English as a second language (making the testing aspect of obtaining licensure difficult). Students and faculty could use class time deciding what action to take and then implement and assess their plan.

Another example of an SLP that falls under this core content area is for students to volunteer time (e.g., 6 hours or more over a semester) assisting their state branch of ACA. An important aspect of the profession of counseling is involvement with relevant policy and legislation (Bergman, 2013). Students interested in getting involved in this area could spend time working with the lobbyist for their state's ACA branch (provided the state has retained a lobbyist) in order to assist them in advocating for the profession. Simple tasks such as assisting with office work can be of significant help to one working in a high-stress position and can prepare students for the realities of clinical work. State and federal government have a significant role in shaping the profession (Bergman, 2013), and because of this, counselor educators can utilize service learning in order to inspire students to become involved early in their careers.

Should the state ACA branch not have retained a lobbyist, students can work with branch leadership in order to determine barriers. Perhaps costs are prohibitive, in which case students could help with fundraising efforts and outreach. Encouraging master's students to take interest in policy and legislation pertaining to the profession will give them the foundation for making meaningful change and assisting with social justice efforts (Cipolle, 2010; Bergman, 2013).

Social and Cultural Diversity
Much of the existing literature regarding service learning and counselor education focuses on social and cultural diversity with regards to SLPs (Burnett et al., 2004). Philosophically, SLPs align with the aims and scope of the MSJCC (Ratts et al., 2016). Frequently, course assignments contain a cultural immersion project in order for counselors to encounter experiences in which their personal values might cause a conflict when working with clients (Burnett et al., 2004; Canfield et al., 2009). Service learning experiences could easily augment the student learning process within multicultural or diversity courses by helping students experience cultural immersion, which may foster greater compassion, empathy, and cultural sensitivity (Cipolle, 2010; Burnett et al., 2004).

One possibility for a social and cultural diversity–focused SLP would involve students working at a shelter for homeless populations or a center for refugees. Students could also find an organization that serves a minority or oppressed population and partner with them to help fill a need they are experiencing. Students would therefore gain experience working with people from groups with whom they may have limited prior experience. This can assist with students identifying their own privileges prior to working in the counseling setting. Ideally, students would contact the shelter or center at the start of the semester in order to ascertain the exact needs of the agency.

An additional SLP could focus on assisting an organization that advocates for minority or oppressed populations. This also emphasizes gaining experience with diverse populations; however, students would have more freedom in choosing the specific population and could gain more experience in understanding the systems involved in advocacy work. Ideally, the instructor would encourage students to choose organizations in which the student is challenged by their privileges (e.g., not being identified as a member of the population served). Through this project, students have the opportunity to work with a wider variety of individuals and help to bring about social change via their specific project goals. For instance, students could choose a women's health center that has experienced a decline in attendance. The students might investigate and discover a particular city bus route was discontinued, making transportation to the health center difficult for residents. Students might then partner with various organizations with van access (such as churches) and raise money for weekly transportation in and out of the area.

Career Development

Within the career development area of the CACREP core curriculum, students have the possibility of learning about their own careers and the impact careers have on the lives of clients. Examples of SLPs can include opportunities for students to immerse themselves within various aspects of career development. Several SLPs could come from partnering with a local employment agency. Students could discover barriers to employment for members of the local community and implement a project to alleviate some of those barriers. For example, students might discover a lack of late-night childcare in their community, which affects those working during the evening and night. They might implement a project in which university students provide childcare for a reasonable cost to the parents, making finding employment easier. If liability issues make this too difficult, students could focus their attention on fundraising to hire more qualified individuals to provide the childcare.

As mental health and wellness are primary foci of professional counselors (ACA, 2014; CACREP, 2015), a second potential SLP assignment related to career development could be for students to partner with a local business and provide mental health and wellness screenings, and education via seminars or workshops. Ideally, students would familiarize themselves with the company insurance (or lack thereof) and prepare referrals and resources accordingly. Workshops and seminars could be an avenue for educating employees and the community at large about wellness, prevention, and good mental health. These could be delivered via "brown bag lunches" or more formal trainings for employees.

Helping Relationships

As CITs progress though counselor education programs, it might be helpful for them to discover new ways to employ their skills in helping relationships outside of counseling sessions. Much of the aforementioned scholarship exploring service learning within counselor education discovered an increase in self-efficacy with respect to core counseling skills as a result of participating in SLPs (Alvarado & Gonzalez, 2013; Havlik et al., 2016). An SLP suitable for this core curriculum could be to partner with a suicide prevention agency and provide assistance where needed. For example, students might work on a suicide hotline or provide referrals for people in distress, utilizing their relationship-building skills and reflective listening while learning about suicide assessment or prevention efforts within the community. Of course, it is important to consider students' level of development and readiness to work with individuals who are suicidal. Counselor educators should ensure there are appropriate supports and supervision for students in these settings. A related project could be for school counseling students to partner with such an organization to create a developmentally appropriate suicide education presentation for high school–age children and deliver it to area schools.

Another SLP focused on the helping relationship might involve students seeking non-counseling placements at local counseling agencies or private practice settings. Ideally, students would have the opportunity to immerse themselves in many elements of practice without having a focus on accruing direct client contact hours. Spending time at an agency before practice might provide students with opportunities to learn many aspects of the profession and the operations of the agency, which in turn could help students decide within which settings they would like to work. This project might also help inform students about potential barriers clients might face in accessing services. They could develop a plan for removing the barriers, which might include identifying potential sources of funding for the project (e.g., grants, scholarships, community donations) and providing an outline of how to access this funding. Another potential benefit to this project is that it could provide students with the opportunity to network within the local counseling community and connect agencies with potential interns.

Group Work

   SLPs that correspond to group work can be similar to those under the helping relationships core curriculum. For example, students could partner with a local counseling agency that provides group counseling services. Students could determine if clients encounter any barriers to receiving group counseling and implement a plan for eliminating the barrier(s). A further example is perhaps if the agency has a group in which they would like to see more culturally relevant topics used in order to attract a more diverse group of clients. Students partnering with this agency could perform outreach to discover what clients would like to see at the group and any barriers, such as transportation, to attending this group. Another possibility for an SLP is for students to facilitate a group counseling experience for an agency or shelter for no cost to those participating in the group.

Conclusion

   SLPs have the potential to enhance the learning experiences of students within graduate counselor education programs. Although not previously emphasized within counselor training, SLPs may be developed and implemented within a variety of core counseling content areas as suggested by CACREP (2015). From an advocacy and social justice perspective, SLPs also may provide students with multiple opportunities to experience the needs of clients and identify barriers to providing counseling services with diverse client populations. Ultimately, by utilizing SLPs, counselor educators can help foster CITs' advocacy and social justice identities, preparing them for work as responsible citizens and effective counselors.

References

Alvarado, M., & Gonzalez, P. A. (2013). Experiences in service learning among counselor education students. *VISTAS Online*. https://www.counseling.org/docs/default-source/vistas/experiences-in-service-learning-among-counselor-education-students.pdf?sfvrsn=6

American Counseling Association. (2014). *ACA code of ethics*.

Arnold, R., & McMurtery, R. F. (2011). Integrating service learning into counselor education: Applications and implications. *The Researcher: An Interdisciplinary Journal*, *24*(1), 59–74.

Backer Condon, B., Grimsley, C., Knaack, L., Pitz, J., & Stehr, H. J. (2015). The art of service learning. *Nursing Science Quarterly*, *28*(3), 195–200. https://doi.org/10.1177/0894318415585624

Barbee, P. W., Scherer, D., & Combs, D. C. (2003). Prepracticum service-learning: Examining the relationship with counselor self-efficacy and anxiety. *Counselor Education and Supervision*, *43*(2), 108–119. https://doi.org/10.1002/j.1556-6978.2003.tb01835.x

Bergman, D. M. (2013). The role of government and lobbying in the creation of a health profession: The legal foundations of counseling. *Journal of Counseling & Development*, *91*(1), 61–67. https://doi.org/10.1002/j.1556-6676.2013.00072.x

Bjornestad, A., Mims, G. A., & Mims, M. (2016). Service learning in schools: Training counselors for group work. *Journal for Specialists in Group Work*, *41*(3), 190–208. https://doi.org/10.1080/01933922.2016.1186764

Blankson, A. N., Rochester, S. E., & Watkins, A. F. (2015). Service-learning and civic responsibility in a sample of African American college students. *Journal of College Student Development*, *56*(7), 723–734. https://doi.org/10.1353/csd.2015.0078

Bobby, C. L. (2013). The evolution of specialties in the CACREP standards: CACREP's role in unifying the profession. *Journal of Counseling & Development*, *91*(1), 35–43. https://doi.org/10.1002/j.1556-6676.2013.00068.x

Bringle, R. G., & Hatcher, J. A. (1995). A service-learning curriculum for faculty. *Michigan Journal of Community Service Learning*, *2*(1), 112–122. http://hdl.handle.net/2027/spo.3239521.0002.111

Burnett, J. A., Hamel, D., & Long, L. L. (2004). Service learning in graduate counselor education: Developing multicultural counseling competency. *Journal of Multicultural Counseling and Development*, *32*(3), 180–191. https://doi.org/10.1002/j.2161-1912.2004.tb00370.x

Burnett, J. A., Long, L. L., & Horne, H. L. (2005). Service learning for counselors: Integrating education, training, and the community. *Journal of Humanistic Counseling, Education and Development*, *44*(2), 158–167. https://doi.org/10.1002/j.2164-490X.2005.tb00028.x

Canfield, B. S., Low, L., & Hovestadt, A. (2009). Cultural immersion as a learning method for expanding intercultural competencies. *The Family Journal*, *17*(4), 318–322. https://doi.org/10.1177/1066480709347359

Cipolle, S. B. (2010). *Service-learning and social justice: Engaging students in social change*. Rowman & Littlefield.

Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP standards*.

Currie-Mueller, J. L., & Littlefield, R. S. (2018). Embracing service learning opportunities: Student perceptions of service learning as an aid to effectively learn course material. *Journal of the Scholarship of Teaching and Learning*, *18*(1), 25–42. https://doi.org/10.14434/josotl.v18i1.21356

Dotson-Blake, K. P., Dotson, L. K., Glass, J. S., & Lilley, B. D. (2010). Accountability in action: Service-learning partnerships in practice. *Journal of School Counseling*, *8*(29), 1–41.

Freire, P. (2000). *Pedagogy of the oppressed* (30th anniversary ed.). Bloomsbury.

Gehlert, N. C., Graf, A. D., & Rose, L. A. (2014). Benefits and best practices: Service-learning in counselor education. *Currents in Teaching & Learning*, *7*(1), 37–49.

George, T. P. (2015). Making an impact with service learning. *Nursing*, *45*(12), 21–24. https://doi.org/10.1097/01.NURSE.0000473146.91433.84

Havlik, S. A., Bialka, C., & Schneider, K. (2016). Theory to practice: Integrating service-learning into a pre-practicum Introduction to School Counseling course. *The Journal of Counselor Preparation and Supervision*, *8*(2). https://doi.org/10.7729/82.1168

Jett, S. T., & Delgado-Romero, E. A. (2009). Prepracticum service-learning in counselor education: A qualitative case study. *Counselor Education and Supervision*, *49*(2), 106–121.

Lee, K. A., & Kelley-Petersen, D. J. (2018). Service learning in human development: Promoting social justice perspectives in counseling. *The Professional Counselor*, *8*(2), 146–158. https://doi.org/10.15241/kal.8.2.146

Lee, K. A., & McAdams, C. R. (2019). Using service-learning to promote social justice advocacy and cognitive development during internship. *The Journal of Counselor Preparation and Supervision*, *12*(1). https://repository.wcsu.edu/jcps/vol12/iss1/8

Manis, A. A. (2012). A review of the literature on promoting cultural competence and social justice agency among students and counselor trainees: Piecing the evidence together to advance pedagogy and research. *The Professional Counselor*, *2*(1), 48–57. https://doi.org/10.15241/aam.2.1.48

McDonald, J., & Dominguez, L. A. (2015). Developing university and community partnerships: A critical piece of successful service learning. *Journal of College Science Teaching*, *44*(3), 52–56.

Midgett, A., Hausheer, R., & Doumas, D. M. (2016). Training counseling students to develop group leadership self-efficacy and multicultural competence through service learning. *The Journal for Specialists in Group Work*, *41*(3), 262–282. https://doi.org/10.1080/01933922.2016.1186765

Murray, C. E., Lampinen, A., & Kelley-Soderholm, E. L. (2006). Teaching family systems theory through service-learning. *Counselor Education and Supervision*, *46*(1), 46–58. https://doi.org/10.1002/j.1556-6978.2006.tb00011.x

Nikels, H. J., Mims, G. A., & Mims, M. J. (2007). Allies against hate: A school-based diversity sensitivity training experience. *The Journal for Specialists in Group Work*, *32*(2), 126–138. https://doi.org/10.1080/01933920701227117

Ratts, M. J., Singh, A. A., Nasar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and Social Justice Counseling Competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28–48. https://doi.org/10.1002/jmcd.12035

Sabo, S., de Zapien, J., Teufel-Shone, N., Rosales, C., Bergsma, L., & Taren, D. (2015). Service learning: A vehicle for building health equity and eliminating health disparities. *American Journal of Public Health*, *105*, S38–S43. https://doi.org/10.2105/AJPH.2014.302364

Scott, K. E., & Graham, J. A. (2015). Service-learning: Implications for empathy and community engagement in elementary school children. *Journal of Experiential Education*, *38*(4), 354–372. https://doi.org/10.1177/1053825915592889

Servaty-Seib, H. L., & Tedrick Parikh, S. J. (2014). Using service learning to integrate death education into counselor preparation. *Death Studies*, *38*(3), 194–202. https://doi.org/10.1080/07481187.2012.738774

Shannonhouse, L. R., Myers, J. E., & Barrio Minton, C. A. (2018). Cultural immersion in counselor education: Trends, prevalence, and common components. *Journal of Multicultural Counseling and Development*, *46*(4), 283–296. https://doi.org/10.1002/jmcd.12115

Stanton, T. K., & Wagner, J. (2010). Educating for democratic citizenship: Antecedents, prospects, and models for renewing the civic mission of graduate education at research universities. In H. E. Fitzgerald, C. Burack, & S. Seifer (Eds.), *Handbook of engaged scholarship: Contemporary landscapes, future directions. Vol. 1: Institutional change* (pp. 411–436). Michigan State University Press.

Tinkler, B., hannah, c. l., Tinkler, A., & Miller, E. (2015). The impact of a social justice service-learning field experience in a social foundations course. *Critical Questions in Education*, *6*(1), 16–29.

Toporek, R. L., & Worthington, R. L. (2014). Integrating service learning and difficult dialogues pedagogy to advance social justice training. *The Counseling Psychologist*, *42*(7), 919–945. https://doi.org/10.1177/0011000014545090

Urofsky, R. I. (2013). The Council for Accreditation of Counseling and Related Educational Programs: Promoting quality in counselor education. *Journal of Counseling & Development*, *91*(1), 6–14. https://doi.org/10.1002/j.1556-6676.2013.00065.x

 nbcc

Counselors' Perceptions of Ethical Considerations for Integrating Neuroscience With Counseling

Chad Luke, Eric T. Beeson, Raissa Miller, Thomas A. Field, Laura K. Jones

As with many advancements in science and technology, ethical standards regarding practice often follow innovation. The integration of neuroscience with counseling is no exception, as scholars are just beginning to identify important ethical concerns related to this shift in the profession. Results of an inductive thematic analysis exploring the perspectives of 312 participants regarding the ethics of integrating neuroscience with counseling are presented. This study is the first of its kind to explore mental health counselors', counselors-in-training's, and counselor educators' perceptions of neuroscience integration. The researchers identified a continuum of concern ranging from no concerns to grave concerns. In addition, they identified four specific ethical quandaries: a) neuroscience does not align with our counselor identity, b) neuroscience is outside the scope of counseling practice, c) challenges with neuroscience and the nature of neuroscience research, and d) potential for harm to clients. Implications include four key considerations for counselors prior to proceeding with integrating neuroscience into practice.

Keywords: neuroscience, integration, counselor identity, ethics, counseling practice

The integration of neuroscience with the mental health professions continues, and with this expansion comes the risks associated with any nascent area of innovation (Luke et al., 2019). Neuroscience integration, as used herein, is understood using Beeson and Field's (2017) definition of neurocounseling, a synonym for the integration of neuroscience with counseling:

> A specialty within the counseling field, defined as the art and science of integrating neuroscience principles related to the nervous system and physiological processes underlying all human functioning into the practice of counseling for the purpose of enhancing clinical effectiveness in the screening and diagnosis of physiological functioning and mental disorders, treatment planning and delivery, evaluation of outcomes, and wellness promotion. (p. 74)

Counselors and the counseling profession, under code C.2.b of the American Counseling Association's *ACA Code of Ethics* (2014), are charged with scrutinizing innovations and specialty areas prior to and throughout their use in clinical practice; this is a safeguard to protect clients from risky or poorly evidenced theory or practices. For example, some of these risks, as they pertain to neuroscience (i.e., the study of the brain and central nervous system) and neurobiology (i.e., literally, the biology of the neurons and the nervous system), include accuracy, embellishment, misapplication, and hype (Beeson & Field, 2017; Kim & Zalaquett, 2019; Luke, 2016).

Chad Luke, PhD, NCC, MAC, ACS, LPC/MHSP, is an associate professor at Tennessee Tech University. Eric T. Beeson, PhD, NCC, ACS, LPC, CRC, is a core faculty member at The Family Institute at Northwestern University. Raissa Miller, PhD, LPC, is an assistant professor at Boise State University. Thomas A. Field, PhD, NCC, CCMHC, ACS, LPC, LMHC, is an assistant professor at the Boston University School of Medicine. Laura K. Jones, PhD, MS, is an assistant professor at the University of North Carolina at Asheville. Correspondence may be addressed to Chad Luke, Clinical Mental Health Counseling, Tennessee Tech University, P.O. Box 5031, Cookeville, TN 38505, cluke@tntech.edu.

The first and perhaps most salient ethical concern in terms of counseling values is that neuroscience integration is not a unilaterally benevolent addition to counseling (Luke, 2019). Although limited research has focused specifically on mental health counselors, several authors have closely examined the effects of using neurobiological language and frameworks to explain and understand mental health disorders in other mental health fields (Fernandez-Duque et al., 2015; Haslam & Kvaale, 2015; Lebowitz et al., 2015; Luke et al., 2019; Nowack & Radecki, 2018). Haslam and Kvaale (2015) summarized the literature on the effects of brain-based explanations of mental health conditions, such as schizophrenia and depression. Their findings challenge long-held notions that biogenic and neurobiological explanations for mental health and psychopathology are singularly positive. The larger assumption in the profession has been that biomedical explanations can reduce self-blame and public shaming of individuals with substance use and other mental health disorders (Badenoch, 2008; Lebowitz & Appelbaum, 2017). Unfortunately, these biological explanations can at times carry unintended consequences that operate against this positive outcome. Clients may be less likely to invest in psychosocial treatments, believing that while on the one hand their biogenic (i.e., brain-based) condition (e.g., depression) is not their fault, it is also therefore out of their control (Lebowitz & Appelbaum, 2017). In other words, one risk of these biological explanations is that they may reduce outcome expectancy with counseling, while increasing the belief that only biological-based treatments (e.g., psychotropic medication) will work for them.

Mental health providers also seem to be similarly affected by these biased perceptions, at times experiencing less empathy for clients in cases framed as neurobiologically based (Lebowitz & Ahn, 2014). Lebowitz et al. (2015) demonstrated that these negative effects could be mitigated somewhat through training. However, Haslam and Kvaale (2015) asserted that it is imprudent to believe that training is sufficient, because "it is unlikely that all of the ill effects of biogenetic explanation can be reversed simply by educating laypeople about bioscience, or that the fundamental problem is their ignorance of neuroplasticity and epigenesis" (p. 402). It is notable that the research above did not include mental health counselors, so the extension of these concerns to counselors remains uncertain. Nevertheless, the concerns seem warranted regarding the allure of neuroscience conceptualizations (Beeson & Miller, 2019; Field et al., 2019; Luke, 2020). Fernandez-Duque et al. (2015) demonstrated how easily humans can be deceived based on the use of the "prestige of science" hypothesis (p. 926). In a series of experiments, the authors used superfluous neuroscientific jargon and images to fool participants into viewing the content as more veracious. Additionally, concerns about the encroachment of science-based reductionism on the humanistic ethos of counseling has begun to resound through the counseling literature (Beeson, Field, et al., 2019; Beeson & Miller, 2019; Field, 2019; Luke, 2019; Luke et al., 2018). Wilkinson (2018) offered a review of the threats of neuroscience to counseling by highlighting the perceived superiority of objective brain-based methods over the humanistic principles of the counseling profession.

Nowak and Radecki (2018) introduced a special issue in the *Consulting Psychology Journal: Practice and Research* focused on "neuro-mythconceptions." The authors explored the many ways that neurobiology might be exploited by professionals to justify their current practices. Their concern centered on how plausible neuroscience-based claims can sound. Such plausibility results in professionals passing along dubious information to clients in the name of cutting-edge advances in optimizing human performance. The risk of neuromyths also have been cited in the professions of counseling (Beeson, Kim, et al., 2019; Kim & Zalaquett, 2019) and education (Dekker et al., 2012; Deligiannidi & Howard-Jones, 2015; Gleichgerrcht et al., 2015; Karakus et al., 2015; Macdonald et al., 2017; Papadatou-Pastou et al., 2017; Simmonds, 2014).

Purpose of the Present Study

The potential concerns identified above highlight the need to consider potential ethical implications of counselors integrating neuroscience within their practice. Although ethical concerns regarding the implementation of neuroscience have been referenced anecdotally in conceptual reviews (e.g., Beeson & Miller, 2019; Field, 2019; Luke, 2019; Wilkinson, 2018), no studies were found that explored concerns of the counseling community regarding the broader ethical assumptions about the integration of neuroscience with practice. Therefore, this research is the first to empirically address this critical gap by eliciting the counseling community's perceptions of ethical concerns related to the integration of neuroscience and counseling. The research question guiding this study explored if counselors perceive ethical concerns pertaining to integrating neuroscience with their counseling practice, and if so, the nature of these concerns.

Method

This study utilized a survey-based qualitative methodology to explore counselors' perceived ethical concerns regarding the integration of neuroscience with their counseling practice (Merriam & Tisdell, 2016). A single open-ended survey question was selected for qualitative data analysis in this study. This question was part of a larger survey examining counselor perceptions of neuroscience and neuroscience integration with counseling. Given the exploratory nature of the study and the current status of neuroscience literature in the counseling profession, a thematic analysis of a single item from a larger survey was chosen. This methodology was best suited to obtain a general, broad understanding of the concerns within the profession. Use of thematic analysis is consistent with other research in which a standardized measure of the construct (i.e., ethical integration of neuroscience with counseling) does not exist (Bengtsson et al., 2007; Donath et al., 2011). A total of 458 participants completed the larger survey, with 312 participants (67.9%) responding to the question, "What ethical concerns do you have regarding the integration of neuroscience into clinical practice (if any)?"

Participants

Integration of neuroscience with counseling practice affects multiple professional roles within the counseling profession. As such, the survey was developed for counselors, counselor educators, and counselors-in-training. We sought to gain responses from counseling practitioners, counselor educators and supervisors, and current master's- and doctoral-level counseling students. Inclusion criteria for the study consisted of at least one of the following: (a) being licensed as a counselor, (b) belonging to a professional counseling organization, (c) being a current student in a counseling program, or (d) being a current faculty member in a counseling program. Participants who did not meet one of these four criteria were excluded from the study.

Participants varied in their educational attainment, with the highest percentage of participants having graduated with their master's degree and not pursued doctoral study (35.3%, $n = 110$). This group was followed by master's-level students (27.2%, $n = 85$), doctoral-level graduates (22.1%, $n = 69$), and doctoral-level students (15.4%, $n = 48$). Most of the sample (81.4%, $n = 254$) had attended programs accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP). Many participants (60.9%, $n = 190$) reported they were exposed to neuroscience in their graduate programs.

The majority of doctoral-level graduates (85.5%, $n = 59$) were full-time faculty members in counselor education programs. The other 10 doctoral-level graduates were either administrators of clinics, working in private practice, or retired. Of those 59 faculty members, 62.7% ($n = 37$) provided direct counseling services within the past year. In comparison, 81.0% ($n = 205$) of the non-faculty

participants provided direct counseling services in the past year. When combined, the majority of the sample (77.9%, *n* = 243) provided direct counseling services within the past year.

The mean number of years of counseling experience was 10.13 years, with a large amount of variance (*SD* = 10.87). The range for years of experience was 0 to 40 years. Doctoral graduates had the most years of experience on average (*M* = 19.91, *SD* = 11.04). They were followed by master's graduates who were not pursuing doctoral study (*M* = 11.70, *SD* = 10.42), doctoral students (*M* = 7.29, *SD* = 5.21), and current master's students (*M* = 1.74, *SD* = 4.98). A subset of the sample comprised full-time counselor educator faculty (18.9%, *n* = 59). Faculty members in the study had more counseling experience (*M* = 17.83 years, *SD* = 11.00) than non-faculty participants (*M* = 8.33, *SD* = 10.04). No age differences existed by education level. The mean age for the sample was 42.55 years (*SD* = 13.66) with a range from 21 to 82 years.

Approximately half (54.5%, *n* = 170) of participants were currently licensed as counselors or psychologists. In addition, 31.1% (*n* = 97) held the National Certified Counselor (NCC) certification. The majority of the sample (87.5%, *n* = 273) were members of counseling associations. Participants self-reported their gender identity, racial/ethnic identity, age, and number of years of counseling experience. The sample consisted of 73.3% (*n* = 229) females, 25.0% (*n* = 78) males, 1.0% (*n* = 3) non-binary, and 0.6% (*n* = 2) transgender. One person did not report gender identity. The survey gave participants the option to report multiple racial/ethnic identities. Fifteen percent of participants (*n* = 48) identified as multiracial, whereas 84.6% identified as Caucasian/White (*n* = 264, of which 45 were multiracial). Of the remaining participants, 8.0% identified as Asian or Asian American (*n* = 25, of which 19 were multiracial), 5.4% as African American/Black (*n* = 17, of which 13 were multiracial), 3.8% as Hispanic or Latinx (*n* = 12, of which 10 were multiracial), 1.0% as American Indian or Alaskan Native (*n* = 3, of which three were multiracial), and 0.3% as Arab/Arab American (*n* = 1, of which zero were multiracial). No participants identified as Pacific Islanders.

Procedure

The question addressed in this article was drawn from questions used in a larger study that explored training and attitudes related to neuroscience and counseling. The question used in this study was included intentionally as a means to gain a better understanding of perceptions of the ethics of neuroscience integration, recognizing it as a stand-alone construct for the purposes of analysis. The full survey was constructed by the authors, following a thorough review of the literature around the integration of neuroscience in counseling. All survey questions were constructed to conform to Patton's (2015) conventions and recommendations for qualitative questions, such as using open-ended and neutral questions, asking one question at a time, and avoiding "why" questions. The specific question analyzed and presented in this report was "What ethical concerns do you have regarding the integration of neuroscience into clinical practice (if any)?"

We utilized convenience and snowball sampling to recruit participants, which makes calculating response rate difficult. However, as the purpose of the project was exploratory and the method qualitative, the participants were not intended to be fully representative. The potential response bias inherent to this study could mean that participants were aware to some degree of the status of the profession with regard to integrating neuroscience into clinical practice, both positively and negatively. Following IRB approval, the authors electronically distributed the Survey Monkey– created online survey to the following: neuroscience interest networks in counseling, the counselor education listserv, CESNET-L, and direct emails to colleagues for distribution. A link to the informed consent and full questionnaire was included in the email. Interested participants clicked on the link and were asked to give their consent in order to continue to the survey. Three separate requests for

participants were disseminated, with each request coming 2 weeks apart. Participants who completed the survey in full had the option of submitting their email in a separate survey to be included in a drawing for two signed copies of neuroscience in counseling texts.

Role of the Researchers

To limit unconscious bias in the research process, we engaged in discussions throughout survey development, data collection, and data analysis. Such conversations detailed our respective passions, assumptions, histories, and visions of the profession. Several prior assumptions emerged in this recursive process. These ethical concerns largely mirrored the issues raised in existing literature and described in the introduction section of this article. The primary assumption included the belief that incorporating neuroscience into counseling is a largely positive endeavor but that counselors should follow ethical guidelines outlined by professional counseling organizations to avoid ethical concerns related to integration. One author explicitly assumed that participants would generally default to the *ACA Code of Ethics* in their response, such that responses might begin with, "According to the *ACA Code of Ethics* regarding new specialty areas of practice. . . ." One author assumed that most participants would preface their response with "It depends on what you mean by 'integration'" because integration was intentionally undefined in the survey. We continually challenged and actively reflected on these assumptions in order to understand the impact on the authors' relationship with the data and subsequent themes (Hays et al., 2016; Hunt, 2011). We also engaged in reflective writing, particularly through writing memos (Hunt, 2011), in order to maintain awareness of worldviews and potential for bias in coding. Commonly referred to as reflexivity, this process aided in being transparent about assumptions rather than trying to behave as if any researcher would be able to be free from biases in approaching a set of data (Hays et al., 2016). Additionally, we established an electronic audit trail that enabled returning to the data, tracking the process, and checking that the coding remained close to the words of the participants. Lastly, two of the authors served as auditors for the results, having familiarized themselves with the data, but refraining from engagement in analysis and theme development.

Data Analysis

We selected thematic analysis, grounded in a pragmatist framework (Duffy & Chenail, 2008), to guide the inquiry into perceptions regarding the ethics of integrating neuroscience and counseling. Clarke and Braun (2017) defined thematic analysis as "a method for identifying, analyzing, and interpreting patterns of meaning ('themes') within qualitative data" (p. 297). We reviewed literature related to content analysis and thematic analysis and found that there was significant overlap (and sometimes merging) of the two approaches in published literature. Our best understanding of the two related approaches is that they exist on a continuum, with content analysis stopping at the manifest level of analysis and thematic analysis continuing to identify broader meanings. Although we stayed very close to the participants' responses in coding, we did move beyond content analysis "categories" to extract some inductive-level themes across cases.

We followed Braun and Clarke's (2006) six-phase framework, utilizing an inductive and semantic approach to thematic analysis. Braun and Clarke described these connected approaches to analysis as "a process of coding the data without trying to fit it into a preexisting coding frame, or the researcher's analytic preconceptions . . . themes are identified within the explicit or surface meanings of the data" (pp. 83–84). Given that the data were obtained through an open-ended survey question versus an in-depth interview protocol that could capture greater context and meaning, we aimed to stay close to participants' exact words. In this way we resisted the urge to include guesses at participants' motivations or assumptions as part of themes. The emergent codes and themes reflect an inductive, descriptive account of participants' perceptions. We followed the subsequent steps in analyzing the data.

The first three authors served as members of the coding team for data analysis. We first familiarized ourselves with the data by reading all responses through several times and taking notes on general observations and personal reactions to the data (Braun & Clarke, 2006). Afterward, we met via videoconferencing and looked at all the responses together, line by line, to begin identifying initial codes. The average length of responses was one to two sentences; the range of responses was from one word to over 200 words (a paragraph).

We then searched for patterns in the data, noting frequently used words and phrases and commonly expressed ideas. Fourth, we identified connections and grouped codes into preliminary themes. In doing so, we further expanded the overarching themes into subthemes, capturing some of the nuance represented in participants' responses. We discussed and resolved differences in coding data via consensus.

Fifth, we reviewed the preliminary themes in light of the raw data and the research question, paying particular attention to our own perspectives and values. The third author re-read each participant response and matched each response to one of the theme groups. Parts of responses at times fell into different theme groups. For example, one participant wrote, "Ethical concerns would be keeping into consideration what the clinician's scope of practice is, the potential for any side effects or results of rapid growth and brain training, and what insurance companies will cover." The first part was coded in theme 2 (scope of practice) and the second part was coded in theme 4 (potential harm).

The first and second authors worked with the codes and themes in a more abstract and creative manner, developing thematic maps and conceptual continua that reflected relationships between and among participant responses. This process led to combining some themes and changing the title of other themes to better reflect the descriptive accounts of participants. Lastly, in refining the theme list, we discussed theme definitions and final theme names, attempting to capture the nature and essence of each thematic group (Braun & Clarke, 2006; Clarke & Braun, 2017). Clarke and Braun (2017) noted that "each theme has an 'essence' or core concept that underpins and unites the observations, much like characters have their own psychological makeup and motivations" (p. 108). In examining these underlying core concepts in our data, we identified questions that seemed to be illuminated through participants' expressed concerns. As an additional step, we calculated frequency counts to convey the saturation of each theme within the data. Because the purpose of tallying frequencies was to report the strength of qualitative findings rather than to specifically quantify the results, greater weight was given to qualitative data than quantitative frequencies.

Results

In reviewing the conceptual maps of participant responses, it appeared that participants varied in their degree of ethical concerns. To make meaning of this variation, the authors placed responses on a continuum from "none" to "yes." These items were coded based upon whether an ethical concern was reported and under what conditions the ethical concerns existed. Some participants (4.2%, $n = 13$) entered "n/a," but it could not be determined if these responses indicated whether they had any ethical concerns.

Continuum of Ethical Concerns
During the initial review of the data, the authors observed a response range that led to a further analysis of the continuum of responses. Most participants (78.2%, $n = 244$) indicated some level of ethical concern regarding the integration of neuroscience in counseling. These responses had various

degrees of certainty and conditions. Most responses (65.1%, *n* = 203) fell into the *yes, with no conditions* grouping. Example responses included: "Deeply concerned" and "There's a lot of misinformation out there! It's a complex subject and I have seen varying degrees of ability to explain things easily and correctly. Also I think sometimes people want it to provide answers that it can't or read more into the research than is truly there."

The second category identified was *yes, if/only* (3.5%, *n* = 11). One example response included in this subtheme was: "I would only be concerned if counselors use their knowledge of the brain to profess some magical or intellectual superiority in controlling a client." The third category was *none, but* (3.2%, *n* = 10). For example, responses included in this subtheme were: "none—except more research is needed," and "none other than the importance of competence."

The fourth category we identified was *just like any other* (3.2 %, *n* = 10). Some participants indicated that they had ethical concerns that were no different than for other methods of counseling. For example, one participant stated they felt "the same as with any other evidence-based practice: counselors need quality training and an understanding of what it means to be 'competent.'" A fifth category was *unethical not to integrate* (3.2%, *n* = 10). An example response included in this subtheme was: "At this point, it would be unethical NOT to formally integrate these studies" (emphasis in original). Nearly 20% of participants (19.9%, *n* = 62) believed there were *no ethical concerns* regarding the integration of neuroscience in counseling. Given the methods of the study, the "n/a" responses were kept separate from the *no ethical concerns* group, as the analysis aimed to stick close to the participants' actual words rather than infer their intention. Therefore, "n/a" could have been listed for any number of possible reasons that could not be determined in the current study. These responses were further divided into the following groups: (a) participants who believed there were explicitly no ethical concerns (13.8%, *n* = 43), (b) participants who believed there were no ethical concerns at the current moment (3.8%, *n* = 12), and (c) participants who believed there were no ethical concerns as long as certain conditions were met (2.2%, *n* = 7). This continuum provided a richer understanding of the emergent themes, as discussed below.

Themes of Participant Concerns

Most participants (78.2%, *n* = 244) identified ethical concerns. From the continuum above, these are the responses from the following groups: unethical not to integrate; no ethical concerns but; ethical concerns if/only; ethical concerns with no conditions; and ethical concerns just like any other. The analysis of these responses produced a total of four themes and ten subthemes and are summarized in Table 1. The four major themes were: *neuroscience does not align with our counselor identity*, *neuroscience is outside the scope of counseling practice*, *challenges with neuroscience and the nature of neuroscience research*, and *potential harm to clients*. For each subtheme, response frequencies are reported to provide a contextual understanding of how commonly the theme occurred. Subthemes all were deemed equally meaningful, regardless of the response frequency.

Theme 1: Neuroscience Does Not Align With Our Counselor Identity

The first theme was reflective of participants' concerns that integrating neuroscience into counseling might be inherently inconsistent with or even violate counselors' identity. Specifically, participants emphasized the loss of humanistic principles by either directly using the word "humanistic" or using terms consistent with humanistic principles (e.g., holism, human-first, subjective data, process, compassion, relationship, and wellness). Two subthemes related to the overarching theme were as follows: Subtheme 1.1) *overemphasis and/or overreliance* (*n* = 27), and Subtheme 1.2) *reductionism and/or*

determinism (*n* = 25). These connected, yet discrete, subthemes reflected participants' particular areas of apprehension. These areas of concern centered on either giving too much weight to biological, brain-based conceptualizations at the cost of clients' subjective worlds (e.g., "undervalue subjective experience") or reducing human experience in a way that neglected human agency (e.g., "reducing human experience to just science").

Theme 2: Neuroscience Is Outside the Scope of Counseling Practice

The second theme was reflective of participants' reservations that neuroscience was within counselors' scope of practice based on educational backgrounds, training, knowledge, and/or skills. Three subthemes were identified as follows: Subtheme 2.1) *training and education* (*n* = 59), Subtheme 2.2) *lack of standards for training and practice* (*n* = 21), and Subtheme 2.3) *competence* (*n* = 69). Sample responses from this theme included feeling "woefully untrained." Some participants focused more on academic background and elements of training (e.g., continuing education, supervision) as indicative of scope, whereas other participants highlighted counselors' understanding of neuroscience concepts, focusing more on knowledge and application skills. A smaller group of responses emphasized the absence of current training and/or practice standards (e.g., "inadequate training standards"). This line of responses included concerns around an absence of qualified trainers, certification opportunities, and/or general laws and regulations.

Theme 3: Challenges With Neuroscience and the Nature of Neuroscience Research

The third theme captured participants' varied reservations about the general field of neuroscience and the accurate translation of neuroscience research into clinical work. Participants expressing concerns in this area seemed to be asking, "How can we be sure this is done right or well?" Subtheme 3.1, *ever-changing and evolving* (*n* = 14), included responses related to challenges counselors might face in staying current with neuroscience findings. These concerns were centered around the vastness of the field and the fast pace at which research is emerging. Subtheme 3.2, *quality of research* (*n* = 23), included more critical commentary on the type of research being conducted in the neuroscience field (e.g., relevance of lab-based research to clinical practice, insufficient applied research). Subtheme 3.3, *interpreting and applying research* (*n* = 52), emphasized concerns with counselors overstating, speculating, misrepresenting, and misinforming clients of neuroscience research and concepts. Participants voiced concerns with "overhyping findings," "unknown practical use," and the "ever-changing and not fully understood" research base.

Theme 4: Potential for Harm to Clients

The fourth theme reflected participants' concerns that integrating neuroscience into counseling could put clients, and potentially counselors, at risk. A total of 18 participants used the exact phrase "potential harm" or the related idea of informed consent. Fourteen participants referred to concerns with potential harm, and four people noted concerns with informed consent. In Subtheme 4.1, *neuroscience information may be intentionally misused in a way that harms clients* (*n* = 21), participants feared counselors deliberately using "embellishment" and "manipulation." Subtheme 4.2, *unintended potential negative side effects* (*n* = 18), reflected ways that integration could inadvertently harm clients or harm counselors These concerns included giving false hope and creating problems with insurance claims to issues with liability and malpractice.

Table 1

Summary and Frequencies of Themes and Subthemes

Theme	Subtheme	Description	Frequency	Sample Statements
Theme One: Neuroscience does not align with our counselor identity	Sub 1.1 Overemphasis and/or overreliance	The integration of neuroscience in counseling may lead to counselors giving preference to non-humanistic aspects of the client and/or the treatment process (e.g., psychopharmacology, science, the brain).	$n = 27$	• Too reliant on brain • Science over compassion • Defaulting to neuro • Brain obsession • Undervalue subjective experience
	Sub 1.2 Reductionism and/or determinism	The integration of neuroscience in counseling may lead to counselors moving away from holistic conceptualizations and limiting human agency.	$n = 25$	• Oversimplification • Takes away focus on interpersonal • Reducing human experience to just science • Cultural bias
Theme Two: Neuroscience is outside the scope of counseling practice	Sub 2.1 Training and education	Counselors do not have sufficient training and/or educational backgrounds to ethically integrate neuroscience into counseling practice.	$n = 59$	• Insufficient training • Woefully undertrained • Not having qualifications • Scope of training • No formal supervision
	Sub 2.2 Lack of standards for training and practice	There are insufficient standards for guiding the training and practice of neuroscience integration.	$n = 21$	• Lack of laws, regulations, and guidelines • Standards for qualifications • Qualifications of trainers
	Sub 2.3 Competence	Counselors are integrating neuroscience into counseling practice without sufficient knowledge and/or skills.	$n = 69$	• Lack of knowledge • Scope of competence • Not being informed • Skill level of clinician
Theme Three: Challenges with neuroscience and the nature of neuroscience research	Sub 3.1 Ever-changing and evolving	The field of neuroscience is continuously evolving, serving as a barrier to counselors staying sufficiently up to date to ethically integrate principles into counseling practice.	$n = 14$	• Ever-changing and not totally understood • Staying current • Constantly evolving • Keeping up to date • Vastness of the field
	Sub 3.2 Quality of research	Neuroscience research is often too complex, poorly conducted, and/or insufficient for counselors to apply to their work.	$n = 23$	• More research needed • Poor research • Generalizability of research • Lack of scientific foundation of knowledge • Unknown practical use
	Sub 3.3 Interpreting and applying research	Neuroscience research is being misunderstood, misinterpreted, and/or inaccurately applied to clinical practice.	$n = 52$	• Accurately interpreting and applying • Overstatement • Misrepresenting science information • Giving incorrect information

Theme	Subtheme	Description	Frequency	Sample Statements
Theme Four: Potential for harm to clients	Sub 4.1 Manipulation	Neuroscience information may be intentionally misused in a way that harms clients.	*n* = 21	• Manipulation leading to damage • Misuse of knowledge • Controlling the client
	Sub 4.2 Unintended potential negative side effects	The integration of neuroscience into counseling may have unintended negative consequences on clients and/or counselors.	*n* = 18	• Jargon alienates – feeling inferior • Clients misperceiving counselor identity/role and not attending other appointments

Note. N = 312

Discussion

Counselors, counselor educators, and counselors-in-training reported a wide range of ethical concerns regarding the integration of neuroscience with clinical practice. These concerns largely reflected existing ethical guidelines (ACA, 2014) and existing literature related to neuroscience and counseling (e.g., Beeson & Miller, 2019; Field, 2019; Luke, 2019; Wilkinson, 2018). We developed four primary themes through the data analysis process. In reviewing these themes, we identified questions that participants seem to be asking through their expressed concerns. Each of the themes shared a meaningful connection, through implication and association, with major sections of the *ACA Code of Ethics* (ACA, 2014). These connections are discussed below.

Theme 1: Neuroscience Does Not Align With Our Counselor Identity

Humanistic concerns in this theme reflect counselor concerns that the integration of neuroscience may shift the profession away from wellness and focus on pathology. As already noted, other scholars have shared this concern (Wilkinson, 2018). However, other authors have alluded to the possibility for neuroscience to expand rather than reduce the client experiences and actually enhance counselor identity (Beeson, Field, et al., 2019; Beeson & Miller, 2019; Field et al., 2019; Ivey & Daniels, 2016).

Humanistic concerns are consistent with criticisms in the literature regarding essentialism (Schultz, 2018). *Essentialism*, in particular Schultz's *neuroessentialism*, is the process of reducing individuals down to mere brain function. This position reflects the positivist, materialist approach to science in general and neuroscience in particular. All human experience is based in neurobiological process (Kalat, 2019), which can feel deterministic and therefore diminish the hope that counselors are called to instill (Schwartz et al., 2016). This theme aligns with several ACA ethical codes, including counselor professional identity and values (Beeson & Miller, 2019). However, influential scholars in the counseling profession have elevated how neuroscience is an extension of the wellness perspective, akin to the professional identity of the counseling profession (Cashwell & Sweeney, 2016; Ivey et al., 2017; Russell-Chapin, 2016). Whereas this theme indicates that some counselors believe neuroscience poses ethical risks to professional identity, the reality remains unclear.

Theme Two: Neuroscience Is Outside the Scope of Counseling Practice

Concerns regarding the requisite knowledge or expertise of counselors aligns well with two specific ACA ethical code standards in this regard: C.2.a. Boundaries of Competence and C.2.b. New Specialty Areas of Practice. This theme assumes that there is a standard of competence that exists. In order for a counselor to be competent, there must be a standard to which they are compared. However, what qualifies a counselor to be competent integrating neuroscience is unclear. There are a few neuroscience-related standards outlined in the American Mental Health Counseling Association (AMHCA) *Standards for the Practice of Clinical Mental Health Counseling* (2020) pertinent to biological bases of behavior and CACREP practice standards (2015) pertinent to neurobiology. However, these standards are not widely known among counselors and lack recommendations for implementation (Beeson, Field, et al., 2019). This lack of explicit direction is similar to concerns regarding the implementation of other counseling standards, such as the Multicultural and Social Justice Counseling Competencies (Ratts et al., 2016).

Theme Three: Challenges With Neuroscience and the Nature of Neuroscience Research

The third theme highlighted the concern that understanding and applying the body of literature that undergirds integration are essential (Field et al., 2019; Luke, 2019). Neuroscience literature is ever-changing, ever-evolving. This rapid pace of change creates two challenges for counselors. First, counselors could have difficulty staying abreast of the state of the art of integration, leading to the potential for using outdated information in practice. Second, counselors might integrate early findings too quickly before there is enough evidence to support their integration. The quality of neuroscience-related research also appears to be a barrier to integration in that counselors may struggle to discern high-quality research from low-quality research (Gruber, 2017; Kim & Zalaquett, 2019). Related to this, counselors face the challenge of accurately interpreting and applying relevant research for practice. Results indicate a primary concern related to issues of accuracy, leading to misapplication, overstating implications, and misinforming clients. This concern is elevated by other research warning against presumed superiority in neuroscience research, given the potential for neuroscience to seduce, allure, and enchant consumers of literature (Coutinho et al., 2017; Lilienfeld, 2014; Weisberg et al., 2008). Concerns regarding the accuracy of neuroscience knowledge among counselors also have been cited (Kim & Zalaquett, 2019). However, counselors in at least one study indicated more accurate neuroscience knowledge and average endorsement of neuromyths when compared to educators, undergraduate students, and coaches (Beeson, Kim, et al., 2019).

These concerns align with several ACA ethical codes, including Section C: Professional Responsibility (2014). When counselors practice based on emergent literature with which they are only superficially familiar, they risk miscommunication with clients and damaging the veracity and integrity of the profession as it relates to client care. This finding is consistent with previous research (Bott et al., 2016; Luke, 2016) that highlights the risk of using information without great care.

Theme Four: Potential for Harm to Clients

The fourth theme has the highest salience for the profession, as safeguarding client safety and welfare are paramount (Kaplan et al., 2017). Results indicated that manipulation is a real concern among participants. Manipulation can occur through misuse, misrepresentation, embellishment, and controlling of clients through invoking neuroscience (Bott et al., 2016). Respondents reported that the actions leading to client harm may be overt. For example, in a desperate attempt to instill hope in a client, a counselor might overstate the concept of neuroplasticity. Similarly, in an effort to present as more competent than perhaps they feel, a counselor might use neuroscience-laden language with clients, resulting in alienation (Lebowitz et al., 2015). Harm may also occur through unintended consequences of integration. Clients may experience negative side effects such as false hope, deflected responsibility, and forgoing medical

consultation. Similar concerns have been found in recent literature (Haslam & Kvaale, 2015; Lebowitz & Applebaum, 2017). These authors note that although on the surface integration seems positive, harm is possible. This underscores the purpose and importance of the *ACA Code of Ethics* regarding new specialty areas: "Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and protect others from possible harm" (ACA, 2014, C.2.b).

Limitations

As with any qualitative data analysis, transferability is limited. The authors obtained the data from an online survey, using a convenience and snowball sampling method. Therefore, respondents may have had strong opinions regarding neuroscience and not necessarily be representative of the profession. Another limitation was the use of a single, open-ended question that did not allow for an in-depth follow-up. We made conservative inferences regarding the meaning and intent of the data in the discussion. However, interviews would have allowed for more context into participants' answers. This has long been viewed as a threat to trustworthiness and transferability (Creswell & Plano-Clark, 2018). The structure of the survey in general and the question also could have influenced this result. For example, there was insufficient information available from the responses to know respondent motivation for "n/a" or "none" responses. Although it is likely that respondents did not feel they had enough information to identify ethical concerns, other reasons for such a response are also possible. White females also were overrepresented in the survey sample. This representation is consistent with surveys of CACREP-accredited graduate programs, in which White females are also overrepresented in student and faculty composition (CACREP, 2017). The findings from this study may have been different had the sample been more diverse. The voice of counselors-in-training may be overrepresented in the data. This may also reflect the increasing interest in new counselors-in-training and counselor educators–in–training of neuroscience-informed counseling (Beeson, Field, et al., 2019; Kim & Zalaquett, 2019).

Implications for Practice and Research

This research highlights the need for continued debate and evolution of who we are as counselors and what role neuroscience integration plays in our professional identity, training, and practice. Remaining silent runs the risk of counselors indiscriminately, and perhaps unethically, integrating neuroscience without adequate consideration to counselor professional identity (Luke, 2020). Forgoing these discussions also introduces the risk that counselors may not ensure that such integration enhances rather than detracts from our professional identity. Failing to do so would further support concerns described in *20/20: A Vision for the Future of Counseling* (Kaplan & Gladding, 2011). The concerns highlight the consistent trend that best practices tend to be "dictated to counselors by other mental health professions" (p. 371).

A second implication is the need to clarify counselors' scope of practice with regard to neuroscience. Only one comprehensive set of standards related to neuroscience currently exists (AMHCA, 2020). Yet even with these standards there is little awareness or training around application. Understanding scope will support preventing client harm by ensuring the previous themes are addressed. In this way, counselors will better understand the strengths and limitations of integrating neuroscience information with practice. Further, counselors should continue to practice humility regarding neuroscience evidence. In doing so, they will ensure that they also will be maintaining values (e.g., humanistic orientation) that are hallmarks of the counseling profession.

The results of this study highlight the need for more training in accessing, interpreting, and being current in neuroscience research. This focus includes the need to increase resources to support high-

quality neuroscience-based studies in counseling. As scholars have asserted (e.g., Myers & Young, 2012), neuroscience provides a unique strategy to evaluate the outcomes of counseling services. The challenge, as we demonstrate in this article, is how the profession moves forward in view of these ethical standards. It is one thing to assert that counselors operate only within their scope of competence. It is another thing to articulate and circumscribe the limits of competence in an emergent area like neuroscience.

Determining ethical concerns regarding the integration of neuroscience in counseling requires several professional milestones to be met. This could begin with consensus building in the profession regarding neuroscience and counselor scope of practice. To accomplish this step, counselors need to define what it means to integrate neuroscience with practice. As noted in the current study, participants relied on their own operationalization of the integration of neuroscience. The resulting data seemed to indicate that most viewed this integration as neuroeducation (Miller, 2016) or technical applications (e.g., neurofeedback). Many have expressed more broad integration of neuroscience (e.g., Field et al., 2019) as a means to conceptualize client experiences and guide the selection and timing of various techniques.

Next, once integration is defined, there needs to be a clear standard for the training and practice of all master's-level students (e.g., how much neuroscience does a master's-level counselor need to know?). In addition, standards for advanced practice postgraduation also require consideration. It is unrealistic to think that master's-level programs can prepare counselors to be experts in any area of practice, including neuroscience. As such, the profession also needs to define how much training is enough to ethically practice technology-based (e.g., neurofeedback) and non–technology-based (e.g., using to guide case conceptualization and treatment planning) integration. In doing so, counseling will create the scope of practice that can be used as a gauge of competence and limit risks to practicing outside of one's scope.

Lastly, the counseling profession needs to develop an intentional research effort to validate training standards and therapeutic outcomes related to integration. Additional research is needed before we can appropriately discern future directions of integration. The current paucity of neuroscience literature in the counseling profession is concerning. Of particular concern is the lack of empirical and outcomes-based articles. The lack of training in how to design and evaluate research using emerging paradigms, such as the National Institutes of Health's Research Domain Criteria, further isolates counselors from participating in national discourse regarding the future classification of mental functioning and mental health diagnoses. As the profession accomplishes these tasks, we will promote ethical care, limit the potential for harm, and ultimately advance the profession as a whole.

References

American Counseling Association. (2014). *ACA code of ethics.* https://www.counseling.org/resources/aca-code-of-ethics.pdf

American Mental Health Counselors Association. (2020). *AMHCA standards for the practice of clinical mental health counseling.* https://www.amhca.org/publications/standards

Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology*. W. W. Norton.

Beeson, E. T., & Field, T. A. (2017). Neurocounseling: A new section of the *Journal of Mental Health Counseling*. *Journal of Mental Health Counseling*, *39*(1), 71–83. https://doi.org/10.17744/mehc.39.1.06

Beeson, E. T., Field, T. A., Reckner, J. L., Luke, C., & Jones, L. K. (2019). Neuroscience research, training, and practice: Adding to or subtracting from counselor identity? *Journal of Counselor Leadership and Advocacy*, *6*(2), 97–113. https://doi.org/10.1080/2326716X.2019.1617210

Beeson, E. T., Kim, S. R., Zalaquett, C. P., & Fonseca, F. D. (2019). Neuroscience attitudes, exposure, and knowledge among counselors. *Teaching and Supervision in Counseling*, *1*(2), 1–19. https://doi.org/10.7290/tsc010201

Beeson, E. T., & Miller, R. M. (2019). Grounding neuro-informed practice in a humanistic framework: A response to Wilkinson. *The Journal of Humanistic Counseling*, *58*(2), 95–107. https://doi.org/10.1002/johc.12099

Bengtsson, M., Ohlsson, B., & Ulander, K. (2007). Women with irritable bowel syndrome and their perception of a good quality of life. *Gastroenterology Nursing*, *30*(2), 74–82. https://doi.org/10.1097/01.SGA.0000267924.24180.1a

Bott, N. T., Radke, A. E., & Kiely, T. (2016). Ethical issues surrounding psychologists' use of neuroscience in the promotion and practice of psychotherapy. *Professional Psychology: Research and Practice*, *47*(5), 321–329. https://doi.org/10.1037/pro0000103

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Cashwell, C. S., & Sweeney, T. J. (2016). Jane E. Myers: Legacy of a life well lived. *Journal of Counselor Leadership and Advocacy*, *3*(1), 4–11. https://doi.org/10.1080/2326716X.2015.1092401

Clarke, V., & Braun, V. (2017). Thematic analysis. *The Journal of Positive Psychology*, *12*, 297–298. https://doi.org.10.1080/17439760.2016.1262613

Council for the Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP standards*. http://www.cacrep.org/wp-content/uploads/2017/08/2016-Standards-with-citations.pdf

Council for the Accreditation of Counseling and Related Educational Programs. (2017). *Annual report 2016*. http://www.cacrep.org/wp-content/uploads/2019/05/CACREP-2016-Annual-Report.pdf

Coutinho, J. F. P., Perrone-McGovern, K. M., & Gonçalves, Ó. F. (2017). The use of neuroimaging methodology in counselling psychology research: Promises, pitfalls, and recommendations. *Canadian Journal of Counselling*, *51*(4), 327–348. http://hdl.handle.net/1822/52248

Creswell, J. W., & Clark, V. L. P. (2018). *Designing and conducting mixed methods research* (3rd ed.). SAGE.

Dekker, S., Lee, N. C., Howard-Jones, P., & Jolles, J. (2012). Neuromyths in education: Prevalence and predictors of misconceptions among teachers. *Frontiers in Psychology*, *3*, 1–8. https://doi.org/10.3389/fpsyg.2012.00429

Deligiannidi, K., & Howard-Jones, P. A. (2015). The neuroscience literacy of teachers in Greece. *Procedia: Social and Behavioral Sciences*, *174*, 3909–3915. https://doi.org.10.1016/j.sbspro.2015.01.1133

Donath, C., Winkler, A., Graessel, E., & Luttenberger, K. (2011). Day care for dementia patients from a family caregiver's point of view: A questionnaire study on expected quality and predictors of utilization – Part II. *BMC Health Services Research*, *11*(76), 1–7. https://doi.org/10.1186/1472-6963-11-76

Duffy, M., & Chenail, R. J. (2008). Values in qualitative and quantitative research. *Counseling and Values*, *53*, 22–38. https://doi.org/10.1002/j.2161-007X.2009.tb00111.x

Fernandez-Duque, D., Evans, J., Christian, C., & Hodges, S. D. (2015). Superfluous neuroscience information makes explanations of psychological phenomena more appealing. *Journal of Cognitive Neuroscience*, *27*(5), 926–944. https://doi.org/10.1162/jocn_a_00750

Field, T. A. (2019). Bridging the brain-body divide: A commentary and response to Wilkinson. *The Journal of Humanistic Counseling*, *58*(2), 108–118. https://doi.org/10.1002/johc.12100

Field, T. A., Beeson, E. T., Luke, C., Ghoston, M., & Golubovic, N. (2019). Counselors' neuroscience conceptualizations of depression. *Journal of Mental Health Counseling*, *41*(3), 260–279. https://doi.org/10.17744/mehc.41.3.05

Gleichgerrcht, E., Luttges, B. L., Salvarezza, F., & Campos, A. L. (2015). Educational neuromyths among teachers in Latin America. *Mind, Brain, and Education*, *9*, 170–178. https://doi.org/10.1111/mbe.12086

Gruber, D. R. (2017). Three forms of neurorealism: Explaining the persistence of the "uncritically real" in popular neuroscience news. *Written Communication*, *34*(2), 189–223. https://doi.org/10.1177/0741088317699899

Haslam, N., & Kvaale, E. P. (2015). Biogenetic explanations of mental disorder: The mixed-blessings model. *Current Directions in Psychological Science*, *24*(5), 399–404. https://doi.org/10.1177/0963721415588082

Hays, D. G., Wood, C., Dahl, H., & Kirk-Jenkins, A. (2016). Methodological rigor in *Journal of Counseling & Development* qualitative research articles: A 15-year review. *Journal of Counseling & Development*, *94*(2), 172–183. https://doi.org/10.1002/jcad.12074

Hunt, B. (2011). Publishing qualitative research in counseling journals. *Journal of Counseling & Development*, *89*(3), 296–300. https://doi.org/10.1002/j.1556-6678.2011.tb00092.x

Ivey, A. E., & Daniels, T. (2016). Systematic interviewing microskills and neuroscience: Developing bridges between the fields of communication and counseling psychology. *International Journal of Listening*, *30*(3), 99–119. https://doi.org/10.1080/10904018.2016.1173815

Ivey, A. E., Daniels, T., Zalaquett, C. P., & Ivey, M. B. (2017). Neuroscience of attention: Empathy and counseling skills. In T. A. Field, L. K. Jones, & L. A. Russell-Chapin (Eds.), *Neurocounseling: Brain-based clinical approaches* (pp. 81–100). https://doi.org/10.1002/9781119375487.ch5

Kalat, J. W. (2019). *Biological psychology* (13th ed.). Cengage.

Kaplan, D. M., Francis, P. C., Hermann, M. A., Baca, J. V., Goodnough, G. E., Hodges, S., Spurgeon, S. L., & Wade, M. E. (2017). New concepts in the 2014 *ACA Code of Ethics*. *Journal of Counseling & Development*, *95*(1), 110–120. https://doi.org/10.1002/jcad.12122

Kaplan, D. M., & Gladding, S. T. (2011). A vision for the future of counseling: The 20/20 *Principles for Unifying and Strengthening the Profession*. *Journal of Counseling & Development*, *89*(3), 367–372. https://doi.org/10.1002/j.1556-6678.2011.tb00101.x

Karakus, O., Howard-Jones, P. A., & Jay, T. (2015). Primary and secondary school teachers' knowledge and misconceptions about the brain in Turkey. *Procedia: Social and Behavioral Sciences*, *174*, 1933–1940. https://doi.org.10.1016/j.sbspro.2015.01.858

Kim, S. R., & Zalaquett, C. (2019). An exploratory study of prevalence and predictors of neuromyths among potential mental health counselors. *Journal of Mental Health Counseling*, *41*(2), 173–187. https://doi.org/10.17744/mehc.41.2.06

Lebowitz, M. S., & Ahn, W.-K. (2014). Effects of biological explanations for mental disorders on clinicians' empathy. *Proceedings of the National Academy of Sciences*, *111*(50), 17786–17790. https://doi.org/10.1073/pnas.1414058111

Lebowitz, M. S., Ahn, W.-K., & Oltman, K. (2015). Sometimes more competent, but always less warm: Perceptions of biologically oriented mental-health clinicians. *International Journal of Social Psychiatry*, *61*(7), 668–676. https://doi.org/10.1177/0020764015573086

Lebowitz, M. S., & Appelbaum, P. S. (2017). Beneficial and detrimental effects of genetic explanations for addiction. *International Journal of Social Psychiatry*, *63*(8), 717–723. https://doi.org/10.1177/0020764017737573

Lilienfeld, S. O. (2014). The Research Domain Criteria (RDoC): An analysis of methodological and conceptual challenges. *Behaviour Research and Therapy*, *62*, 129–139. https://doi.org/10.1016/j.brat.2014.07.019

Luke, C. (2016). *Neuroscience for counselors and therapists: Integrating the sciences of mind and brain* (1st ed.). SAGE.

Luke, C. (2019). Response to Wilkinson: A neuro-informed humanistic perspective. *The Journal of Humanistic Counseling*, *58*(2), 86–94. https://doi.org/10.1002/johc.12098

Luke, C. (2020). *Neuroscience for counselors and therapists: Integrating the sciences of mind and brain* (2nd ed.). Cognella Academic Press.

Luke, C., Miller, R., & McAuliffe, G. (2019). Neuro-informed mental health counseling: A person-first perspective. *Journal of Mental Health Counseling*, *41*(1), 65–79. https://doi.org/10.17744/mehc.41.1.06

Luke, C., Redekop, F., & Jones, L. K. (2018). Addiction, stress, and relational disorder: A neuro-informed approach to intervention. *Journal of Mental Health Counseling*, *40*(2), 172–186. https://doi.org/10.17744/mehc.40.2.06

Macdonald, K., Germine, L., Anderson, A., Christodoulou, J., & McGrath, L. M. (2017). Dispelling the myth: Training in education or neuroscience decreases but does not eliminate beliefs in neuromyths. *Frontiers in Psychology*, *8*, 1314. https://doi.org/10.3389/fpsyg.2017.01314

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). Jossey-Bass.

Miller, R. M. (2016). Neuroeducation: Integrating brain-based psychoeducation into clinical practice. *Journal of Mental Health Counseling*, *38*(2), 103–115. https://doi.org/10.17744/mehc.38.2.02

Myers, J. E., & Young, J. S. (2012). Brain wave biofeedback: Benefits of integrating neurofeedback in counseling. *Journal of Counseling & Development*, *90*(1), 20–28. https://doi.org/10.1111/j.1556-6676.2012.00003.x

National Institutes of Health. (2014, September). *NIH awards initial $46 million for BRAIN Initiative research.* https://www.nih.gov/news-events/news-releases/nih-awards-initial-46-million-brain-initiative-research

Nowack, K., & Radecki, D. (2018). Introduction to the special issue: Neuro-mythconceptions in consulting psychology—Between a rock and a hard place. *Consulting Psychology Journal: Practice and Research*, *70*(1), 1–10. http://doi.org/10.1037/cpb0000108

Papadatou-Pastou, M., Haliou, E., & Vlachos, F. (2017). Brain knowledge and the prevalence of neuromyths among prospective teachers in Greece. *Frontiers in Psychology*, *8*(804), 1–13. https://doi.org/10.3389/fpsyg.2017.00804

Patton, M. Q. (2015). *Qualitative research and evaluation methods* (4th ed.). SAGE.

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and Social Justice Counseling Competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28–48. https://doi.org/10.1002/jmcd.12035

Russell-Chapin, L. A. (2016). Integrating neurocounseling into the counseling profession: An introduction. *Journal of Mental Health Counseling*, *38*(2), 93–102. https://doi.org/10.17744/mehc.38.2.01

Schultz, W. (2018). Neuroessentialism: Theoretical and clinical considerations. *Journal of Humanistic Psychology*, *58*(6), 607–639. https://doi.org/10.1177/0022167815617296

Schwartz, S. J., Lilienfeld, S. O., Meca, A., & Sauvigné, K. C. (2016). The role of neuroscience within psychology: A call for inclusiveness over exclusiveness. *American Psychologist*, *71*(1), 52–70. https://doi.org/10.1037/a0039678

Simmonds, A. (2014). *How neuroscience is affecting education: Report of teacher and parent surveys*. Wellcome Trust. https://wellcome.ac.uk/sites/default/files/wtp055240.pdf

Weisberg, D. S., Keil, F. C., Goodstein, J., Rawson, E., & Gray, J. R. (2008). The seductive allure of neuroscience explanations. *Journal of Cognitive Neuroscience*, *20*, 470–477. https://doi.org/10.1162/jocn.2008.20040

Wilkinson, B. D. (2018). The limits of neuroscience in counseling: A humanistic perspective and proposed model. *The Journal of Humanistic Counseling*, *57*(1), 70–78. https://doi.org/10.1002/johc.12067

nbcc

Stigma, Help Seeking, and Substance Use

Daniel Gutierrez, Allison Crowe, Patrick R. Mullen,
Laura Pignato, Shuhui Fan

Researchers used path analysis to examine self-stigma, help seeking, and alcohol and other drug (AOD) use in a community sample of individuals (*N* = 406) recruited through the crowdsourcing platform MTurk. Self-stigma of help seeking contributed to AOD use and was mediated by help-seeking attitudes. We discuss the implications for advocacy and stigma reduction in substance use treatment. Counselors and counselor educators can implement and advocate for interventions and training that increase positive attitudes toward seeking help, such as providing appropriate training with supervisees and counselors-in-training, providing clients and the community with mental health literacy, and engaging in more advocacy. Moreover, they can challenge thoughts of seeking help as weakness, normalize seeking psychological help, and discuss the benefits of counseling and therapy to address the development and effects of self-stigma of help seeking for individuals with substance use issues.

Keywords: alcohol and drug use, self-stigma, help seeking, help-seeking attitudes, stigma reduction

In 2015, approximately 20.1 million people over the age of 12 suffered from an alcohol or substance use disorder (SUD) in the United States (Bose et al., 2016). However, only 3.8 million people (1 in 5) who needed treatment received any substance use counseling (Bose et al., 2016). Barriers to receiving substance use treatment include the location of the program, legal fears, peer pressure, family impact, concerns about loss of respect, and stigma (Masson et al., 2013; Stringer & Baker, 2018; Winstanley et al., 2016). Of these concerns, stigma is arguably the most complex and the least understood. In response, substance use prevention and mental health care researchers have begun to turn their attention to stigma and how it influences counseling treatment and recovery (Livingston et al., 2012; Mullen & Crowe, 2017; Stringer & Baker, 2018). Researchers have found that individuals with SUDs experience higher levels of stigma than individuals with any other health concern (Livingston et al., 2012). However, more research on the intersection of stigma, help seeking, and alcohol and other drug (AOD) use is still warranted. Thus, this article delves further into these concepts and describes a study that examined the relationships between these variables.

Stigma and Substance Use

Individuals with substance use concerns report high levels of public stigma in the form of negative labeling, discrimination, and prejudice by others (Crapanzano et al., 2019; Goffman, 1963). Prejudice against people with substance use problems is common and widespread on individual, interpersonal, and institutional levels (Barry et al., 2014). There remains a substantial public belief that those using illicit substances simply need to *take responsibility* for their choices (Barry et al., 2014). As a result, individuals with SUDs report experiencing judgment, mockery, inappropriate comments, overprotection, and hostility from the public (Mora-Ríos et al., 2017). Even health professionals hold negative perceptions toward patients using substances, believing them to be dangerous, violent, manipulative, irresponsible, aggressive, rude, and lazy (Ford, 2011).

Daniel Gutierrez, PhD, NCC, LPC, CSAC, is an assistant professor at the College of William & Mary. Allison Crowe, PhD, NCC, LPCS, is an associate professor at East Carolina University. Patrick R. Mullen, PhD, NCC, is an assistant professor at the College of William & Mary. Laura Pignato is a doctoral student at the College of William & Mary. Shuhui Fan, NCC, is a doctoral student at the College of William & Mary. Correspondence may be addressed to William & Mary, Daniel Gutierrez, School of Education, P.O. Box 8795, Williamsburg, VA 23187-8795, dgutierrez@wm.edu.

People who perceive this stigma from their health or mental health professionals show a higher treatment attrition rate, less treatment satisfaction, and less perceived access to care (Barry et al., 2014). People with substance use concerns may also experience perceived stigma from the impressions they receive from society and through their own and others' past experiences (Smith et al., 2016). Perceived stigma is also related to low self-esteem, high levels of depression and anxiety, and sleep issues (Birtel et al., 2017). Individuals who experience public stigma can develop self-stigma (i.e., stigma that is internalized), which impacts help-seeking attitudes (Vogel et al., 2007). For example, an individual could see a person struggling with alcohol use disorder portrayed in the media as being malicious, selfish, and incompetent and begin to believe those stereotypes about themselves.

Additionally, researchers have demonstrated that public stigma is a predictor of self-stigma over time (Vogel et al., 2013). Self-stigma initially develops from stereotype awareness, resulting in stereotype agreement and self-concurrence, which lead to self-esteem decrement (Schomerus et al., 2011). Self-stigma can increase maladaptive coping strategies such as avoidance that can deter seeking treatment, applying for jobs, and interacting with others in social settings (da Silveira et al., 2018). Luoma et al. (2014) also suggested that people with a higher level of self-stigma have lower levels of self-efficacy and tend to remain longer in residential substance abuse treatment.

Role of Stigma and Help Seeking in Relationship to SUDs

The role of public stigma on seeking and receiving psychological help for substance use treatment has been well established by researchers (Birtel et al., 2017; Smith et al., 2016), but the influence of negative perceptions remains less understood (Center for Behavioral Health Statistics and Quality, 2018). Researchers have asserted the importance of examining negative public attitudes toward seeking psychological help; such attitudes act as a catalyst for the development of self-stigma incurred by individuals struggling with SUDs (Vogel et al., 2013). Also, recent reports indicate that the self-stigma of seeking psychological help may be a major contributor to the treatment utilization gap (i.e., the dearth of individuals receiving substance use treatment despite substance misuse and use disorders becoming a public health crisis). The U.S. Department of Health and Human Services, Office of the Surgeon General (2018) reported that ingrained public attitudes have hindered the delivery of medications used to treat SUDs, such as methadone and buprenorphine, because of misconceptions and prejudices surrounding these medications. Other factors they found contributing to the treatment gap include the view of substance use as a moral failing rather than a disease and the belief that the person simply has a "character flaw" (p. 12). Consequently, policymakers and researchers have emphasized the importance of understanding the effect of negative public attitudes on the delivery of substance use treatment and the decision to seek psychological help for mental health concerns involving AOD (Bose et al., 2018; Corrigan, 2011).

To illustrate, the Substance Abuse and Mental Health Services Administration (SAMHSA; Bose et al., 2018) recently stated that 1.0 million (5.7%) of the 18.2 million individuals aged 12 years or older who reported experiencing an SUD perceived a need for treatment for their illicit drug or alcohol use. However, these respondents reported not seeking specialty substance use treatment because they believed getting treatment would have a negative impact on their job (20.5%) and cause their neighbors or community to have a negative opinion of them (17.2%). Additionally, out of the 4.9 million adults aged 18 or older that reported an unmet mental health service need for a serious mental illness, over a third had not received any mental health services in the previous year. Respondents gave the following reasons for avoiding seeking help: concern about being committed or having to take medicine (20.6%); the risk of it having a negative effect on their jobs (16.4%); the belief that treatment would not help

(16.1%); the possibility that their neighbors or community would have negative opinions (15.7%); concern about confidentiality (15.3%); and not wanting others to find out (12.6%).

Given these responses and statistics, it is logical to infer that the commonly held public perception of seeking help for mental health concerns and substance use is still very negative and that many still experience significant fear of discrimination from others (e.g., loss of job or a negative impact on social opportunities) as a result of seeking help for AOD issues. The responses also indicate the harmful influence this public stigma has on individuals' decisions regarding whether to seek psychological treatment for substance use. Furthermore, these findings suggest that respondents possibly internalized negative public attitudes toward seeking professional help for both mental health and substance use concerns, resulting in self-stigma. The respondents' decision not to receive needed substance use treatment in the previous year in order to avoid negative reactions from others and their lack of belief in the utility of treatment indicate self-stigma surrounding help seeking. This corresponds to previous literature reporting the effects of self-stigma on help-seeking behaviors and attitudes (Vogel & Wade, 2009).

Purpose of the Present Study

The existing research is clear that stigma has some influence on substance use and recovery. However, there is a lack of research explicating the causal pathways that shape this influence. Another area that is unexplored is the relationship between self-stigma and AOD use, and there is no research that we know of that explores the relationship between help-seeking attitudes and AOD use. Given that self-stigma for mental illness and self-stigma for help seeking are often related in the literature (Mullen & Crowe, 2017), and that a large portion of individuals with SUDs have a co-occurring mental illness (39.1%; Center for Behavioral Health Statistics and Quality, 2015), it is reasonable to suspect that the stigma of mental illness influences help seeking in AOD users. A greater understanding of the relationships between these constructs will allow counselors and other helping professionals to develop better strategies for combatting substance abuse by addressing issues related to stigma and attitudes toward help seeking. Therefore, the aim of this study was to examine the relationships between self-stigma of mental health concerns, attitudes toward help seeking, and AOD use. Specifically, we tested the following research hypotheses: *Hypothesis 1*—Self-stigma toward mental health concerns will have a negative direct effect on attitudes toward help seeking and a positive indirect effect on drug and alcohol use as mediated by attitudes toward help seeking; *Hypothesis 2*—Self-stigma of help seeking will have a negative direct effect on attitudes toward help seeking and a positive indirect effect on drug and alcohol use as mediated by attitudes toward help seeking; and *Hypothesis 3*—Attitudes toward help seeking will have a negative direct effect on drug and alcohol use.

Method

Participants

We acquired 406 participants using Amazon's Mechanical Turk (MTurk). Most of the participants were male ($n = 213$; 52.5%) followed by female ($n = 191$; 47.0%) and transgender/gender nonconforming ($n = 2$; 0.5%). The mean age of the participants was 34.39 years ($SD = 10.02$, range = 20 to 67). In addition, most participants indicated they lived in the United States at the time of the study ($n = 349$, 86%) with 57 (14%) participants who lived internationally. As for ethnicity, participants included American Indian or Alaska Native ($n = 12$; 3%), Asian ($n = 79$; 19.5%), Black or African American ($n = 24$; 5.9%), Hispanic or Latino ($n = 20$; 4.9%), Multiracial ($n = 5$; 1.2%), Other ($n = 2$; 0.5%), Native Hawaiian or Other Pacific Islander ($n = 1$; 0.2%), and White ($n = 263$; 64.8%). Table 1 displays additional demographic information.

Table 1

Participant Characteristics

Demographic Characteristics	*n* (%)
Clinical cutoff for alcohol use	
Met criteria for problematic drinking	203 (50.0%)
Did not meet criteria for problematic drinking	203 (50.0%)
Clinical cutoff for drug use	
Did not meet criteria for problematic drug use	281 (69.2%)
Met criteria for problematic drug use	125 (30.8%)
Individual yearly income	
Less than $30,000	173(42.6%)
Between $30,000 and $50,000	124 (30.8%)
More than $50,000	108 (26.6%)
Education level	
Bachelor's degree	169 (41.6%)
Some college (no degree)	82 (20.2%)
Master's degree	59 (14.5%)
Associate degree	49 (12.1%)
High school diploma	34 (8.4%)
Doctoral degree	8 (2.0%)
Some high school (no degree)	3 (0.7%)
Other	2 (0.5%)
Marital status	
Married	201 (49.5%)
Single	139 (34.2%)
Cohabitation	45 (11.1%)
Divorced	17 (4.2%)
Widowed	2 (0.5%)
Separated	2 (0.5%)
Employment status	
Full-time	290 (71.4%)
Part-time	53 (13.1%)
Unemployed (looking for work)	18 (4.4%)
Full-time caregiver	14 (3.4%)
Unemployed (disabled)	10 (2.5%)
Student	6 (1.5%)
Other	6 (1.5%)
Unemployed (not looking for work)	3 (0.7%)
Unemployed (volunteer work)	1 (0.2%)

Note. N = 406

Procedures

Prior to starting this research investigation, approval from our Institutional Review Board was received. To collect data for a community sample, we employed the use of MTurk, which is an online crowdsourcing platform used for survey research (Follmer et al., 2017). Researchers have found evidence that supports the data quality of MTurk for studies trying to sample diverse community populations that include individuals with substance abuse concerns (Al-Khouja & Corrigan, 2017; Kim & Hodgins, 2017). We placed the consent form, measures, and demographic questions for this study in a Qualtrics survey management site. Then, we created an MTurk portfolio that linked to the Qualtrics survey. The study was advertised to all MTurk participants, and we offered a 50-cent incentive for participation. Participants were screened to allow only individuals who actively engage in the recreational use of drugs and/or alcohol. A total of 406 participants completed the study before it was closed. Participants who took the survey spent an average of 18 minutes completing it.

Measures

Self-Stigma of Mental Illness

Researchers used the Self-Stigma of Mental Illness scale (SSOMI; Tucker et al., 2013) to measure participants' self-stigma of mental illness. The SSOMI is a self-reported, unidimensional measure consisting of 10 items on a 5-point Likert-type scale that ranges from 1 (*strongly disagree*) to 5 (*strongly agree*). Sample items include "If I had a mental illness, I would be less satisfied with myself." We summed the items and calculated a mean score after accounting for the reverse-scored items, with higher scores indicating greater self-stigma of mental illness. Prior research has shown strong reliability with a Cronbach's alpha of .93 on participants' SSOMI scores collected through an online survey (Mullen & Crowe, 2017). In our study, we found good internal consistency reliability, with a Cronbach's alpha of .91 for participants' scores on the SSOMI.

Self-Stigma of Help Seeking

Researchers used the Self-Stigma of Help Seeking scale (SSOHS; Vogel et al., 2006) to measure participants' self-stigma of seeking psychological help. The SSOHS is a self-reported, unidimensional measure that contains 10 items on a 5-point Likert-type scale that ranges from 1 (*strongly disagree*) to 5 (*strongly agree*). Sample items include "I would feel inadequate if I went to a therapist for psychological help." After reverse scoring items, we summed and averaged the scores, with higher values indicating greater self-stigma of seeking psychological help. Scores on the SSOHS have indicated good internal reliability, with Cronbach's alphas ranging from .89 to .92 in prior research (Tucker et al., 2013; Vogel et al., 2006). In our study, we found good internal consistency reliability for scores on the SSOHS, with a Cronbach's alpha of .86.

Attitudes Toward Help Seeking

To measure attitudes toward help-seeking, researchers used the Attitudes Toward Seeking Professional Psychological Help–Short Form scale (ATSPPH-SF; Fischer & Farina, 1995). The ATSPPH is a self-reported, unidimensional measure that contains 10 items scored on a 4-point Likert-type scale from 0 (*disagree*) to 3 (*agree*). Sample items include "I might want to have psychological counseling in the future." Participants' total scores were calculated by summing all items together after reverse scoring items. We averaged the scores on the ATSPPH-SF to help in interpretation, with higher total scores indicating that a participant had a more positive attitude toward psychological treatment. Higher scores on the ATSPPH-SF have been associated with decreased treatment-related stigma and a higher likelihood of future help seeking (Elhai et al., 2008). Prior research has shown good internal consistency reliability for scores on the ATSPPH-SF, with Cronbach's alphas ranging from .84 to .86

(Fischer & Farina, 1995; Karaffa & Koch, 2016). In the current study, the scores on the ATSPPH-SF provided good internal consistency reliability, with a Cronbach's alpha of .84.

Alcohol Use

The Alcohol Use Disorders Identification Test (AUDIT; Saunders et al., 1993) was used to measure respondents' alcohol use and screen for problematic drinking behaviors. The AUDIT is a 10-item, self-reported measure that gathers information on an individual's alcohol use and provides a clinical cutoff score for harmful drinking. Participants rated their alcohol consumption and related experiences over the past year in response to a series of 3- or 5-point Likert-type scale questions. Sample items include "How often do you have a drink containing alcohol?" with a 5-point scale from 0 (*never*) to 4 (*four or more times a week*). Total scores were calculated by summing the items with scores ranging from 0 to 40. We used a total score of 8 or higher as a clinical cutoff point to identify problematic drinking (see Table 1). Prior research has reported good internal consistency reliability of the AUDIT scores with a Cronbach's alpha value of .88 (Kim & Hodgins, 2017). For this study, the Cronbach's alpha was .89, indicating good internal consistency reliability.

Drug Use

The Drug Abuse Screening Test (DAST-20; Skinner & Goldberg, 1986) assessed participants' degree of drug use and potential drug abuse over the past year. The DAST-20 is a 20-item, self-reported measure that provides a total score used to calculate the severity of drug use. The DAST-20 includes 20 nominal items in which participants select *Yes* or *No* (with values of 1 and 0, respectively) to a series of questions. Sample questions include, "Can you get through the week without using drugs?" (reverse scored). Total scores were calculated by summing the participants' item responses after reverse scoring items 4 and 5 with a range from 0 to 20. We used a cutoff score of 6 or higher to indicate problematic drug use (see Table 1). Scores on the DAST-20 have demonstrated good internal consistency reliability with Cronbach's alphas ranging from .74 to .95 (Yudko et al., 2007). In the current study, we identified a Cronbach's alpha of .92 for DAST-20 scores, indicating good internal consistency reliability.

Data Analysis

To address the questions in this study, we facilitated a path analysis with the data to test the a priori model with a community sample acquired through MTurk. The recommended fit indexes (Kline, 2005) used in this study included the chi-square statistics (*p*-value, > .05 indicates fit), comparative fit index (CFI, ≥ .90 indicates fit), standardized root mean square residual (SRMSR, ≤ .08 indicates fit), and root mean square error of approximation (RMSEA, ≤ .08 indicates fit). In addition, the Bollen-Stine bootstrapping procedure was used with 5,000 samples as an additional assessment of model fit. The path analysis was performed in AMOS (Version 24; Arbuckle, 2012) using a maximum likelihood estimation approach. The direct effects are displayed as standardized regression weights (*β*).

Results

Preliminary Analysis

We examined and screened the data prior to analysis. No outliers were identified, and the data met statistical assumptions associated with path analysis (e.g., multivariate normality, low multicollinearity, and linearity; Hair et al., 2006; Tabachnick & Fidell, 2007). The correlation coefficients between the variables in this path model (see Table 2) were lower than .8, meaning there was a low chance of collinearity problems. We identified no issues of multicollinearity, as the variance inflation factors for the constructs in the path model were lower than 10 (Hair et al., 2006; Tabachnick

& Fidell, 2007). Table 2 also includes the means and standard deviations for the variables in this model. Various guidelines were reviewed as a means for determining the appropriate sample size for this investigation. Jackson (2003) and Kline (2005) stated that a 20:1 ratio of sample size to parameters is preferable, and our current study exceeded this recommendation.

Table 2

Correlations, Means, and Standard Deviations for the Variables in the Path Analysis

Variables	1	2	3	4	5	6
1. Self-Stigma of Mental Illness	-					
2. Self-Stigma of Help Seeking	.54**	-				
3. Attitudes Toward Help Seeking	-.28**	-.62	-			
4. Drug Use	-.02	.11	-.16*	-		
5. Alcohol Use	-.01	.12	-.14*	.68**	-	
6. Age	.08	-.01	.05	-.27	-.26**	-
M(SD)	3.23(.89)	2.74(.81)	1.71(.61)	4.31(5.07)	9.79(8.01)	34.39(9.99)

Note. Measures used in this study include the Self-Stigma of Mental Illness Scale (SSOMI; Tucker et al., 2013), the Self-Stigma of Help Seeking Scale (SSOHS; Vogel et al., 2006), Attitudes Toward Seeking Professional Psychological Help – Short Form (ATSPPH-SF; Fischer & Farina, 1995), the Alcohol Use Disorders Identification Test (AUDIT; Saunders et al., 1993), and Drug Abuse Screening Test-20 (DAST-20; Skinner & Goldberg, 1986).
[*] = $p < .01$, [**] = $p < .001$.

We examined the variables in this study (i.e., self-stigma of mental illness and help-seeking, attitudes toward help-seeking, and drug and alcohol use) to evaluate for potential control variables. Specifically, we conducted several correlations comparing the variables in this study with demographic characteristics. For dichotomous variables, we utilized point-biserial correlations. These analyses indicated that age had significant relationships with both drug and alcohol use; thus, we included age in the path analysis as a control variable.

Model Specifications

The a priori hypothesized model tested in this path analysis included a total of six observed variables that were placed in a causal directional structure that we developed from our understanding of the literature. The exogenous variables included self-stigma of mental illness (as measured by the SSOMI; Tucker et al., 2013) and self-stigma of help seeking (as measured by the SSOHS; Vogel et al., 2006). In addition, attitude toward help-seeking (as measured by the ATSPPH-SF; Fischer & Farina, 1995) was both an exogenous and endogenous variable. Lastly, alcohol use (as measured by the AUDIT; Saunders et al., 1993) and drug use (as measured by the DAST-20; Skinner & Goldberg, 1986) and were endogenous. We correlated self-stigma of mental illness and self-stigma of help seeking along with the error terms for alcohol and drug use. In the model, we examined the direct effect of self-stigma of mental illness and self-stigma of help seeking on attitudes toward help-seeking. Furthermore, we examined the direct effect of attitudes toward help seeking on drug and alcohol use. We included age in this model as a control

variable as we examined its direct effect on attitudes toward help seeking, drug use, and alcohol use. A total of 5,000 bias-corrected bootstrapped samples were created (Fritz & MacKinnon, 2007) to examine the indirect effect of self-stigma of mental illness and self-stigma of help seeking on drug use and alcohol use, with attitudes toward help seeking as the mediator.

Path Analysis

The model (see Figure 1) produced excellent fit: $\chi^2(6, N = 406) = 6.85$, $p = .34$; $\chi^2/df = 1.14$; CFI = .99; RMSEA = .02; SRMSR = .01, Bollen-Stine bootstrap, $p = .21$. Self-stigma of mental illness did not have a direct effect on attitudes toward help seeking ($\beta = .07$, $SE = .03$, $p > .05$) whereas self-stigma of help seeking did have a negative direct effect on attitudes toward help seeking ($\beta = -.66$, $SE = .04$, $p < .001$). Attitudes toward help seeking had a negative direct effect on both drug use ($\beta = -.15$, $SE = .02$, $p < .01$) and alcohol use ($\beta = -.13$, $SE = .06$, $p < .01$). The control variable of age had a negative direct effect on drug use ($\beta = -.27$, $SE = .00$, $p < .001$) and alcohol use ($\beta = -.25$, $SE = .00$, $p < .001$) but not attitudes toward help seeking ($\beta = .04$, $SE = .00$, $p > .05$). The residuals of self-stigma of mental illness and self-stigma of help seeking had a positive correlation ($r = .54$, $SE = .04$, $p < .001$) along with drug and alcohol use ($r = .64$, $SE = .01$, $p < .001$). These findings indicated that higher self-stigma of help seeking was associated with a more negative attitude toward help seeking, and more positive attitudes toward help seeking were associated with lower drug and alcohol use. It is also important to note that the effect sizes in the model ranged from small to large (Sink & Stroh, 2006).

Figure 1

Path Model With Age as a Control Variable
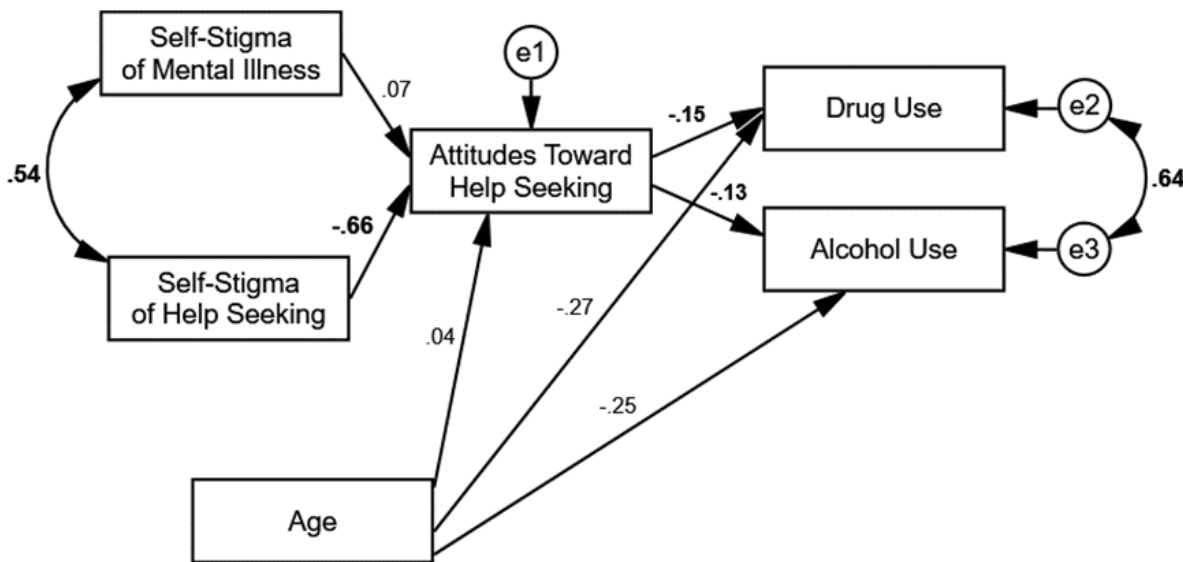
The mediated path analysis results indicated that self-stigma of mental illness did not have an indirect effect on drug use ($\beta = -.01$, $SE = .05$, $p = .14$, 95% BC [-.03, .00]) nor alcohol use ($\beta = -.01$, $SE = .01$, $p = .14$, 95% BC [-.03, .00]) through attitudes toward help seeking. The mediated path analysis results also indicated that self-stigma of help seeking had an indirect effect on drug use ($\beta = .10$, $SE = .03$, $p < .001$, 95% BC [.05, .15]) and alcohol use ($\beta = .08$, $SE = .03$, $p < .001$, 95% BC [.03, .14]) through attitudes toward help seeking.

Discussion

Research has indicated the importance of decreasing stigma surrounding substance use treatment in order to address the public health issue of so many individuals lacking treatment in the United States (Bose et al., 2016; Clement et al., 2015). Although the effects of self-stigma on help-seeking behaviors (Crowe et al., 2016; Mullen & Crowe, 2017), attitudes toward seeking psychological help (Cheng et al., 2018), and AOD use (Luoma et al., 2008) have been well documented, there remains a gap in the counseling literature explicating the relationship between the above constructs. In this study, the proposed theoretical causal model (see Figure 1) suggested that self-stigma of mental illness and self-stigma of help seeking would have a direct effect on attitudes toward help seeking and a positive indirect effect on drug and alcohol use mediated by attitudes toward help seeking; moreover, it suggested that attitudes toward help seeking would have a negative direct effect on AOD use.

By using the online platform MTurk for a community sample of 406 participants, the results from a path analysis indicated an excellent fit model with significant standardized regression coefficients that revealed a complex relationship between self-stigma of mental illness, self-stigma of help-seeking, attitudes toward psychological help seeking, AOD use, and age. Although the results of the present study did not support all three initial hypotheses, the findings did show a statistically significant indirect relationship among the six variables.

The first hypothesis was *not* supported by data because self-stigma of mental illness did not have a direct effect on attitudes toward help seeking or an indirect effect on AOD use. However, self-stigma of mental illness did correlate with self-stigma of help seeking, which included a large effect size that indicated a strong relationship between these variables. The lack of direct effect between self-stigma of mental illness and attitudes toward help seeking may have resulted from a moderating influence caused by the direct effect of self-stigma of help seeking on attitudes toward help seeking. Based on these findings, we concluded that self-stigma of help seeking is a stronger predictor of attitudes toward help seeking when paired with self-stigma of mental illness. However, more research is needed to replicate these findings, and specifically the potential moderating effect of self-stigma of help seeking on self-stigma of mental illness.

In contrast, the results from the path analysis provided evidence for our second hypothesis. Specifically, participants who reported high levels of self-stigma of help seeking had less positive attitudes toward seeking psychological help as well as higher alcohol use or drug use. This finding is consistent with findings from prior research that revealed participants who reported high levels of stigma had decreased adaptive coping skills such as help-seeking behaviors (Crowe et al., 2016) and increased maladaptive coping skills such as drug use (Etesam et al., 2014). It is possible that participants turned to drinking or drug use as a method of coping rather than seeking formal support. However, we cannot determine if that is the case from the current study. The direct relationship of an individual's reported stigma of help seeking with less positive attitudes toward seeking psychological help also confirms previous theoretical descriptions of the relationship between self-stigma of help seeking and attitudes toward help seeking (Tucker et al., 2013; Vogel et al., 2007; Wade et al., 2011).

Lastly, participants who reported more positive attitudes toward help seeking had significantly lower AOD use, which provided support for our third hypothesis. These findings suggest that regardless of age, participants who had a positive attitude toward seeking help reported significantly lower AOD use. In addition to the unique findings uncovered through mediation analysis, this study

further supports the argument that self-stigma of mental illness and self-stigma of help seeking are two theoretically and empirically distinct constructs (Tucker et al., 2013). Moreover, the significantly direct effect of an individual's self-stigma of help seeking on attitudes toward seeking psychological help confirms the need that treatments must address more than one component of self-stigma and that addressing self-stigma of mental illness alone may not improve attitudes toward help seeking (Tucker et al., 2013; Wade et al., 2011). The findings may also suggest the benefit of increased advocacy and health promotion as it relates to help-seeking and combatting stigma.

Implications for Counselor Education and Counselors

Given that we found an individual's attitudes toward seeking psychological help negatively relate to AOD use, it behooves counselors to address factors that impede help seeking. Equally important, the present findings and prior evidence reporting public stigma as a predictor of the development of self-stigma over time (Vogel et al., 2013) have important implications for the advocacy work needed by counselors and counselor educators on both an individual level and a systemic level to fully address the development of self-stigma of help seeking that subsequently affects an individual's attitudes toward seeking psychological help. On an individual level, counselors can implement and advocate for interventions that increase an individual's positive attitudes toward seeking help that may lower the individual's substance use through mental health literacy (Cheng et al., 2018). Moreover, they can challenge thoughts of seeking help as weakness (Wade et al., 2011), normalize seeking psychological help, and discuss the benefits of therapy to address the development and effects of self-stigma of help seeking for individuals with substance use issues. Counselors can also empower clients by cultivating awareness and reflection of internalized negative beliefs developed from experiences of discrimination and prejudice that contribute to the self-stigma of help seeking. Moreover, efforts to deliver healthier messages about help seeking for mental health concerns from the media or faith-based organizations can assist with decreasing self-stigma that still exists.

In adherence to advocacy competency standards set forth by the American Counseling Association (Lewis et al., 2003), counselors should also consider using their position of power to address, on a systemic level, the enacted and perceived stigma experienced by individuals with substance use issues as well as the detrimental impact on attitudes toward seeking psychological help. For example, counselors can disseminate information that dispels myths surrounding help seeking and substance use to the public or create multimedia materials such as public service announcements that explain the impact of stigma on those with SUDs in the United States, making sure to include affirmative language about seeking psychological help and individuals reporting AOD use (Corrigan, 2011). Counselors also can lobby to make changes to workplace policies and practices to increase mental health support for those with AOD concerns, as supportive policies and practices can also decrease the stigmas associated with AOD concerns.

Additionally, counselors and counselor educators can improve attitudes toward help seeking as well as decrease the stigma of individuals with substance use issues by intentionally using person-first language on administered surveys, academic scholarship, and provided resources to clients and the community (Tucker et al., 2013). For example, Granello and Gibbs (2016) found that participants reported higher tolerance and less stigmatized attitudes when the language on surveys was changed from "mentally ill" to "people with mental illness." In the current study, we used person-first language in order to model correct terminology and would suggest that future researchers do the same. By disseminating knowledge and material to the public in less stigmatizing language, counselors and counselor educators can counter negative group stereotypes that lead to self-stigma of individuals with substance use issues (Al-Khouja & Corrigan, 2017; Rao et al., 2009).

For counselor educators and supervisors training beginning counselors, this study suggests the importance of increased awareness of their own attitudes toward individuals reporting AOD use because of the effects of internalized public stigma, which increases maladaptive coping skills such as treatment avoidance (Crowe et al., 2016) and AOD use (Etesam et al., 2014). To illustrate, counselor educators and supervisors may ask beginning counselors to reflect on their personal beliefs regarding seeking psychological help and individuals with substance use issues, as well as how these beliefs may have been learned based on public perceptions or knowledge of information regarding substance use. Classroom strategies that encourage reflection and increase an ethic of care may address previous findings of implicit bias, internalized negative public attitudes, or stigmatizing behaviors by health professionals that lower positive attitudes toward psychological help seeking for individuals with substance use issues (Ford, 2011). Lastly, counselor educators can further promote beginning counselors' advocacy competencies through creative and engaging assignments that challenge students to develop ways of encouraging help seeking in the general public and dispel public myths about substance use or the stigma of seeking psychological help—for instance, the creation of fact and resource brochures distributed within the community.

This study also further supported the use of MTurk for reliable and valid data in an accessible community sample (Kim & Hodgins, 2017). The anonymity, convenience, and incentive offered to participants via MTurk while reporting behaviors stigmatized by the general public may contribute to the gathering of reliable and valid data (Kim & Hodgins, 2017). Additionally, this study supports MTurk as a tool to identify clinical populations with alcohol use problems (Al-Khouja & Corrigan, 2017). The use of MTurk as a sampling method is currently limited in counselor education literature and may lead to more representative samples that resemble targeted community populations beyond the commonly accessed university samples by researchers.

Limitations

This study has several limitations. First, although the study used a community sample, the sample included only individuals accessible through MTurk, and research on the representativeness of samples drawn from MTurk is limited (Al-Khouja & Corrigan, 2017; Kim & Hodgins, 2017). The sample employed through MTurk was gathered widely from the community and previous studies have shown evidence of validity and reliability of MTurk as a recruiting tool with substance-using populations (Kim & Hodgins, 2017). However, because MTurk uses an online platform, it is subject to the same classic limitations associated with online data collection, such as representativeness and technical difficulties (Granello & Wheaton, 2004). Therefore, the current sample showed diversity among participants, but researchers could not confirm whether MTurk samples were representative of the populations from which they were drawn. Specifically, the sample consisted primarily of White and Asian participants, thereby limiting generalizability to people of other race/ethnicity classifications. Another limitation of this study is the absence of inattentive screening items. Additionally, this investigation used correlational data analysis methods to examine the proposed model; therefore, the findings could not indicate causality among the variables (Gall et al., 2007). Finally, although we wanted to know about stigma related to SUDs, we used scales that were designed to measure stigma in general. Although all instruments demonstrated strong psychometric properties in the current study, it is worth noting that stigma of SUDs may be different from stigma related to mental health concerns with no substance use.

Future Research

Considering the limitations, these findings provide significant implications for future research. We suggest replication of the present findings on future groups through the MTurk platform and other sampling methods (Al-Khouja & Corrigan, 2017). Additionally, researchers are encouraged

to conduct experimental studies implementing potential substance use treatments that disrupt and measure the internalized negative group stereotypes that individuals with substance use issues may incorporate into their identity, substance usage, and treatment efficacy or length (Luoma et al., 2014; Tucker et al., 2013). Researchers have emphasized identity as a diagnostic moderator of self-stigma incurred by individuals with mental illness and substance use issues (Al-Khouja & Corrigan, 2017; Yanos et al., 2010), which suggests the importance of countering negative group stereotypes and public stigma for vulnerable groups such as individuals with substance use issues who report high levels of self-stigma. Further, counselor educators are encouraged to explore the relationship between identity, self-stigma of help seeking, and attitudes toward seeking psychological help with individuals reporting substance use issues as well. Lastly, counselor educators may examine the use of MTurk to gather a community sample, explore behaviors and attitudes considered socially unacceptable by the general public, and recruit individuals meeting the clinical criteria for substance use, who are often a hidden population because of enacted and perceived stigma.

Conclusion

The current study examined the complex and understudied relationship between AOD use, self-stigma of help seeking, self-stigma of mental illness, and attitudes toward seeking psychological help. The findings suggest the unique, indirect relationship between self-stigma of help seeking, a positive attitude toward seeking psychological help, and AOD use, regardless of participant age ranges. Previous conceptualization of the interdependence between self-stigma and group stereotypes (Al-Khouja & Corrigan, 2017) as well as the unique findings of the current study suggest that counselors and substance use interventions need to counter group stereotypes that individuals with substance use internalize, which decrease positive attitudes toward seeking psychological help and help-seeking behaviors for mental illness (Crowe et al., 2016; Tucker et al., 2013; Wade et al., 2011). By countering group stereotypes through methods targeting attitudes toward help seeking and the self-stigma of help seeking, counselors and counselor educators can potentially combat the negative attitudes toward seeking psychological help that become internalized treatment barriers for individuals with substance use issues (Luoma et al., 2008) and help lower AOD use.

References

Al-Khouja, M. A., & Corrigan, P. W. (2017). Self-stigma, identity, and co-occurring disorders. *The Israel Journal of Psychiatry and Related Sciences*, *54*(1), 56–61.

Arbuckle, J. R. (2012). *AMOS users guide version 24.0* [User manual]. IBM Corp.

Barry, C. L., McGinty, E. E., Pescosolido, B. A., & Goldman, H. H. (2014). Stigma, discrimination, treatment effectiveness, and policy: Public views about drug addiction and mental illness. *Psychiatric Services*, *65*(10), 1269–1272. https://doi.org/10.1176/appi.ps.201400140

Birtel, M. D., Wood, L., & Kempa, N. J. (2017). Stigma and social support in substance abuse: Implications for mental health and well-being. *Psychiatry Research*, *252*, 1–8. https://doi.org/10.1016/jpsychres.2017.01.097

Bose, J., Hedden, S. L., Lipari, R. N., & Park-Lee, E. (2018). *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSUDH Series H-53). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf

Bose, J., Hedden, S. L., Lipari, R. N., Park-Lee, E., Porter, J. D., & Pemberton, M. R. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf

Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf

Center for Behavioral Health Statistics and Quality. (2018). *2017 National Survey on Drug Use and Health: Methodological summary and definitions*. https://www.samhsa.gov/data/report/2017-methodological-summary-and-definitions

Cheng, H.-L., Wang, C., McDermott, R. C., Kridel, M., & Rislin, J. L. (2018). Self-stigma, mental health literacy, and attitudes toward seeking psychological help. *Journal of Counseling & Development*, *96*(1), 64–74. https://doi.org/10.1002/jcad.12178

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(1), 11–27. https://doi.org/10.1017/S0033291714000129

Corrigan, P. W. (2011). Strategic stigma change (SSC): Five principles for social marketing campaigns to reduce stigma. *Psychiatric Services*, *62*(8), 824–826. https://doi.org/10.1176/ps.62.8.pss6208_0824

Crapanzano, K. A., Hammarlund, R., Ahmad, B., Hunsinger, N., & Kullar, R. (2019). The association between perceived stigma and substance use disorder treatment outcomes: A review. *Substance Abuse and Rehabilitation*, *10*, 1–12. https://doi.org/10.2147/SAR.S183252

Crowe, A., Averett, P., & Glass, J. S. (2016). Mental illness stigma, psychological resilience, and help seeking: What are the relationships? *Mental Health & Prevention*, *4*(2), 63–68. https://doi.org/ 10.1016/j.mhp.2015.12.001

da Silveira, P. S., Casela, A. L. M., Monteiro, É. P., Ferreira, G. C. L., de Freitas, J. V. T., Machado, N. M., Noto, A. R., & Ronzani, T. M. (2018). Psychosocial understanding of self-stigma among people who seek treatment for drug addiction. *Stigma and Health*, *3*(1), 42–52. https://doi.org/10.1037/sah0000069

Elhai, J. D., Schweinle, W., & Anderson, S. M. (2008). Reliability and validity of the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form. *Psychiatry Research*, *159*(3), 320–329. https://doi.org/10.1016/j.psychres.2007.04.020

Etesam, F., Assarian, F., Hosseini, H., & Ghoreishi, F. S. (2014). Stigma and its determinants among male drug dependents receiving methadone maintenance treatment. *Archives of Iranian Medicine*, *17*(2), 108–114.

Fischer, E. H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *Journal of College Student Development*, *36*(4), 368–373.

Follmer, D. J., Sperling, R. A., & Suen, H. K. (2017). The role of MTurk in education research: Advantages, issues, and future directions. *Educational Researcher*, *46*(6), 329–334. https://doi.org/10.3102/0013189X17725519

Ford, R. (2011). Interpersonal challenges as a constraint on care: The experience of nurses' care of patients who use illicit drugs. *Contemporary Nurse*, *37*(2), 241–252. https://doi.org/10.5172/conu.2011.37.2.241

Fritz, M. S., & MacKinnon, D. P. (2007). Required sample size to detect the mediated effect. *Psychological Science*, *18*(3), 233–239. https://doi.org/10.1111/j.1467-9280.2007.01882.x

Gall, M. D., Gall, J. P., & Borg, W. R. (2007). *Education research: An introduction* (8th ed.). Allyn & Bacon.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.

Granello, D. H., & Gibbs, T. A. (2016). The power of language and labels: "The mentally ill" versus "people with mental illnesses." *Journal of Counseling & Development*, *94*(1), 31–40. https://doi.org/10.1002/jcad.12059

Granello, D. H., & Wheaton, J. E. (2004). Online data collection: Strategies for research. *Journal of Counseling & Development*, *82*(4), 387–393. https://doi.org/10.1002/j.1556-6678.2004.tb00325.x

Hair, J. F., Black, W. C., Babin, B. J., Anderson, R. E., & Tatham, R. L. (2006). *Multivariate data analysis* (6th ed.). Pearson.

Jackson, D. L. (2003). Revisiting sample size and number of parameter estimates: Some support for the N:q hypothesis. *Structural Equation Modeling, 10*(1), 128–141. https://doi.org/10.1207/S15328007SEM1001_6

Karaffa, K. M., & Koch, J. M. (2016). Stigma, pluralistic ignorance, and attitudes toward seeking mental health services among police officers. *Criminal Justice and Behavior*, *43*(6), 759–777. https://doi.org/10.1177/0093854815613103

Kim, H. S., & Hodgins, D. C. (2017). Reliability and validity of data obtained from alcohol, cannabis, and gambling populations on Amazon's Mechanical Turk. *Psychology of Addictive Behaviors*, *31*(1), 85–94. https://doi.org/10.1037/adb0000219

Kline, R. (2005). *Principles and practice of structural equation modeling.* (2nd ed.). Guilford.

Lewis, J. A., Arnold, M. S., House, R., & Toporek, R. L. (2003). *ACA advocacy competencies.* https://www.counseling.org/knowledge-center/competencies

Livingston, J. D., Milne, T., Fang, M. L., & Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review. *Addiction*, *107*(1), 39–50. https://doi.org/10.1111/j.1360-0443.2011.03601.x

Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., Bunting, K., & Rye, A. K. (2008). Reducing self-stigma in substance abuse through acceptance and commitment therapy: Model, manual development, and pilot outcomes. *Addiction Research & Theory*, *16*(2), 149–165. https://doi.org/10.1080/16066350701850295

Luoma, J. B., Kulesza, M., Hayes, S. C., Kohlenberg, B., & Larimer, M. (2014). Stigma predicts residential treatment length for substance use disorder. *The American Journal of Drug and Alcohol Abuse*, *40*(3), 206–212. https://doi.org/10.3109/00952990.2014.901337

Masson, C. L., Shopshire, M. S., Sen, S., Hoffman, K. A., Hengl, N. S., Bartolome, J., McCarty, D., Sorensen, J. L., & Iguchi, M. Y. (2013). Possible barriers to enrollment in substance abuse treatment among a diverse sample of Asian Americans and Pacific Islanders: Opinions of treatment clients. *Journal of Substance Abuse Treatment*, *44*(3), 309–315. https://doi.org/10.1016/j.jsat.2012.08.005

Mora-Ríos, J., Ortega-Ortega, M., & Medina-Mora, M. E. (2017). Addiction-related stigma and discrimination: A qualitative study in treatment centers in Mexico City. *Substance Use & Misuse*, *52*(5), 594–603. https://doi.org/10.1080/10826084.2016.1245744

Mullen, P. R., & Crowe, A. (2017). Self-stigma of mental illness and help seeking among school counselors. *Journal of Counseling & Development*, *95*(4), 401–411. https://doi.org/10.1002/jcad.12155

Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A., & Luty, J. (2009). A study of stigmatized attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric and Mental Health Nursing*, *16*(3), 279–284. https://doi.org/10.1111/j.1365-2850.2008.01369.x

Saunders, J. B., Aasland, O. G., Babor, T. F., de la Fuente, J. R., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption-II. *Addiction*, *88*(6), 791–804. https://doi.org/10.1111/j.1360-0443.1993.tb02093.x

Schomerus, G., Corrigan, P. W., Klauer, T., Kuwert, P., Freyberger, H. J., & Lucht, M. (2011). Self-stigma in alcohol dependence: Consequences for drinking-refusal self-efficacy. *Drug and Alcohol Dependence*, *114*(1), 12–17. https://doi.org/10.1016/j.drugalcdep.2010.08.013

Sink, C. A., & Stroh, H. R. (2006). Practical significance: The use of effect sizes in school counseling research. *Professional School Counseling*, *9*(4), 401–411. https://doi.org/10.1177/2156759X0500900406

Skinner, H. A., & Goldberg, A. E. (1986). Evidence for a drug dependence syndrome among narcotic users. *British Journal of Addiction*, *81*(4), 479–484. https://doi.org/10.1111/j.1360-0443.1986.tb00359.x

Smith, L. R., Earnshaw, V. A., Copenhaver, M. M., & Cunningham, C. O. (2016). Substance use stigma: Reliability and validity of a theory-based scale for substance-using populations. *Drug and Alcohol Dependence*, *162*(1), 34–43. https://doi.org/10.1016/j.drugalcdep.2016.02.019

Stringer, K. L., & Baker, E. H. (2018). Stigma as a barrier to substance abuse treatment among those with unmet need: An analysis of parenthood and marital status. *Journal of Family Issues*, *39*(1), 3–27. https://doi.org/10.1177/0192513x15581659

Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics* (5th ed.). Allyn and Bacon.

Tucker, J. R., Hammer, J. H., Vogel, D. L., Bitman, R. L., Wade, N. G., & Maier, E. J. (2013). Disentangling self-stigma: Are mental illness and help-seeking self-stigmas different? *Journal of Counseling Psychology*, *60*(4), 520–531. https://doi.org/10.1037/a0033555

U.S. Department of Health and Human Services, Office of the Surgeon General. (2018). *Facing addiction in America: The Surgeon General's spotlight on opioids*. https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf

Vogel, D. L., Bitman, R. L., Hammer, J. H., & Wade, N. G. (2013). Is stigma internalized? The longitudinal impact of public stigma on self-stigma. *Journal of Counseling Psychology*, *60*(2), 311–316. https://doi.org/10.1037/a0031889

Vogel, D. L., & Wade, N. G. (2009). Stigma and help-seeking. *The Psychologist*, *22*, 20–23. https://thepsychologist.bps.org.uk/volume-22/edition-1/stigma-and-help-seeking

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, *53*(3), 325–337. https://doi.org/10.1037/0022-0167.53.3.325

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology*, *54*(1), 40–50. https://doi.org/10.1037/0022-0167.54.1.40

Wade, N. G., Post, B. C., Cornish, M. A., Vogel, D. L., & Tucker, J. R.. (2011). Predictors of the change in self-stigma following a single session of group counseling. *Journal of Counseling Psychology*, *58*(2), 170–182. https://doi.org/10.1037/a0022630

Winstanley, E. L., Clark, A., Feinberg, J., & Wilder, C. M. (2016). Barriers to implementation of opioid overdose prevention programs in Ohio. *Substance Abuse*, *37*(1), 42–46. https://doi.org/10.1080/08897077.2015.1132294

Yanos, P. T., Roe, D., & Lysaker, P. H. (2010). The impact of illness identity on recovery from severe mental illness. *American Journal of Psychiatric Rehabilitation*, *13*(2), 73–93. https://doi.org/10.1080/15487761003756860

Yudko, E., Lozhkina, O., & Fouts, A. (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *Journal of Substance Abuse Treatment*, *32*(2), 189–198. https://doi.org/10.1016/j.jsat.2006.08.002

nbcc

Examining Individual and Organizational Factors of School Counselor Burnout

Heather J. Fye, Ryan M. Cook, Eric R. Baltrinic, Andrea Baylin

Burnout is a statistically significant phenomenon for school counselors, correlated with various individual and organizational factors, which have been studied independently. Therefore, we investigated both individual and organizational factors of burnout conceptualized as a multidimensional phenomenon with 227 school counselors. Multidimensional burnout was measured by the five subscales of the Counselor Burnout Inventory, which included Exhaustion, Incompetence, Negative Work Environment, Devaluing Clients, and Deterioration in Personal Life. Using hierarchal regression analyses, we found individual and organizational factors accounted for 66.6% of the variance explained in Negative Work Environment, 38.3% of the variance explained in Deterioration in Personal Life, 36.7% of the variance explained in Incompetence, 35.1% of the variance explained in Exhaustion, and 14.0% of the variance explained in Devaluing Clients. We discuss implications of the findings for school counselors and supervisors. Identifying the multidimensions of burnout and its correlates, addressing self-care and professional vitality goals, communicating defined school counselor roles, providing mentoring opportunities, and increasing advocacy skills may help alleviate burnout.

Keywords: stress, burnout, job satisfaction, coping processes, school counselors

In addition to providing counseling services, school counselors are charged with performing multiple non-counseling duties in their schools (Bardhoshi et al., 2014). These multiple and competing demands place them at risk for experiencing burnout (Mullen et al., 2018). Accordingly, it is important to identify factors that contribute to burnout to promote school counselors' psychological well-being (Kim & Lambie, 2018), which in turn reinforces school counselors' ability to support students' well-being (Holman et al., 2019).

Burnout is a workplace-specific complex construct characterized by feelings of exhaustion, cynicism, and detachment, and a lack of accomplishment and effectiveness (Maslach & Leiter, 2017). Others have conceptualized counselor burnout as a multidimensional construct, featuring the interaction between the individual and work environment (Lee et al., 2007). Given the complex, multidimensional, and interactional nature of burnout, the Counselor Burnout Inventory (CBI) was developed to measure the construct with five subscales: Exhaustion, Incompetence, Negative Work Environment, Devaluing Clients, and Deterioration in Personal Life (Lee et al., 2007). Specific to school counselors, Kim and Lambie (2018) suggested that burnout occurs to varying degrees across individual and organizational factors. Individual factors include perceived stress (Fye et al., 2018; Mullen et al., 2018; Mullen & Gutierrez, 2016; Wilkerson, 2009; Wilkerson & Bellini, 2006) and coping processes (Fye et al., 2018; Wilkerson, 2009; Wilkerson & Bellini, 2006). Organizational factors include perceived job satisfaction (Baggerly & Osborn, 2006; Bryant & Constantine, 2006; Mullen et al., 2018) and role stress (Bardhoshi et al., 2014; Coll & Freeman, 1997; Culbreth et al., 2005).

Researchers of school counselor burnout have studied individual and organizational factors of this phenomenon using a unidimensional structure such as the CBI scale score (Mullen et al., 2018). Other

Heather J. Fye, PhD, NCC, LPC, is an assistant professor at the University of Alabama and a certified PK–12 school counselor. Ryan M. Cook, ACS, LPC, is an assistant professor at the University of Alabama. Eric R. Baltrinic, LPCC-S, is an assistant professor at the University of Alabama. Andrea Baylin, NCC, PEL, is a doctoral student at the University of Alabama. Correspondence may be addressed to Heather Fye, Box 870231, Graves Hall 315B, Tuscaloosa, AL 35487, hjfye@ua.edu.

researchers (e.g., Bardhoshi et al., 2014; Moyer, 2011) studied organizational factors, including caseload and administrative (non-counseling) duties, within the multidimensional structure of the CBI (Lee et al., 2007). However, researchers have not yet comprehensively studied these known individual and organizational factors within the context of a multidimensional structure of school counselor burnout. For example, Mullen et al. (2018) investigated the relationships between perceived stress, perceived job satisfaction, and school counselor burnout. However, they did not examine organizational factors such as role stress (e.g., clerical duties), which are also significant to understanding school counselor burnout (Bardhoshi et al., 2014). Thus, we sought to extend the research findings by examining several individual factors (i.e., perceived stress, coping processes) and organizational factors (i.e., perceived job satisfaction, role stress) within a multidimensional structure of school counselor burnout.

Individual Factors

Individual factors related to school counselor burnout include psychological constructs and demographic factors (Kim & Lambie, 2018). The two psychological constructs included in the current study were *perceived stress* (Mullen et al., 2018) and *coping processes* (Fye et al., 2018). Researchers have previously found contradictory results for the relationship between years of experience and school counselor burnout (Mullen et al., 2018; Wilkerson, 2009). Therefore, the factor of years of experience was included in the current study.

Perceived Stress

Perceived stress is theorized as an individual's ability to appraise a threatening or challenging event in relation to the availability of coping resources (Lazarus & Folkman, 1984). To that end, a transactional model of stress and coping suggests that stress is a response that occurs when perceived demands exceed one's coping abilities. For school counselors, perceived stress may occur regularly because of various factors, including non-counseling duties, excessive paperwork and administrative duties, and work overload (Bardhoshi et al., 2014).

Researchers have described a positive relationship between stress and burnout among school counselors (Mullen et al., 2018; Mullen & Gutierrez, 2016). Specifically, higher levels of stress and burnout were related to lower levels of job satisfaction and delivery of direct student services (Mullen et al., 2018; Mullen & Gutierrez, 2016). Others have reported increased emotional responses alongside increased burnout (Wilkerson & Bellini, 2006). For example, school counselors who attempted to deal with stress emotionally may be at greater risk for developing symptoms of burnout including emotional exhaustion, depersonalization, and lower levels of personal accomplishment (Wilkerson, 2009). Additionally, school counselors reported higher levels of emotional exhaustion than other mental health professionals, which can negatively impact their delivery of school counseling services (Bardhoshi et al., 2014). The correlation between stress and burnout further highlights the importance of assessing the components of stress and the ways school counselors are coping with these factors.

Coping Processes

Coping processes are defined as the cognitive and behavioral processes used to manage stressful situations (Folkman & Moskowitz, 2004). There are several coping processes, including *problem-focused coping*, *active-emotional coping*, and *avoidant-emotional coping* (Folkman & Lazarus, 1985). For example, *problem-focused coping* is defined as an action-oriented approach to stress in which one believes the stressors are controllable by personal action (Lazarus, 1993). *Active-emotional coping* is an adaptive response to unmanageable stressors and *avoidant-emotional coping* is described as a maladaptive response to those stressors (Folkman & Lazarus, 1985).

Among school counselors, Fye et al. (2018) studied the relationship between perfectionism, burnout, stress, and coping. These authors found that maladaptive perfectionists engaged more frequently in avoidant-emotional coping and relatedly experienced higher levels of burnout. Moreover, adaptive perfectionists experienced less stress and burnout and reported higher levels of problem-focused coping. Overall, for school counseling professionals, emotional-focused coping is positively related to burnout (Wilkerson, 2009). Given these findings, it is imperative for school counselors to be aware of their coping processes, including the degree to which they are affecting their levels of stress and burnout (Wilkerson, 2009).

Organizational Factors

In addition to individual factors such as stress and coping (Fye et al., 2018; Mullen et al., 2018; Wilkerson, 2009), school counseling researchers noted several organizational factors as contributing to school counselor burnout (Holman et al., 2019; Kim & Lambie, 2018). Accordingly, researchers in the current study examined organizational factors, including *perceived job satisfaction* and *role stress* (i.e., role ambiguity, role incongruity, and role conflict; Culbreth et al., 2005). Additionally, because previous researchers found a relationship between the organizational factor of school district (e.g., urban setting) and burnout (Butler & Constantine, 2005), this variable was included in the present study.

Perceived Job Satisfaction

 Perceived job satisfaction refers to the degree of affective or attitudinal reactions one experiences relative to their job (Spector, 1985). Understanding the extent of school counselors' perceived job satisfaction may be one way to buffer the effects of stress and burnout. This is because, according to Bryant and Constantine (2006), job satisfaction predicted life satisfaction for school counselors.

Perceived job satisfaction and its relationship with stress and burnout have received increased attention in the school counseling literature (Mullen et al., 2018). Among the contributing factors, higher levels of role balance and increased perceived job satisfaction resulted in greater overall life satisfaction (Bryant & Constantine, 2006). Higher perceived job satisfaction has been aligned with school counselors engaging in appropriate roles. For example, Baggerly and Osborn (2006) found that school counselors who frequently performed roles aligned with comprehensive school counseling programs were more satisfied and more committed to their careers. Similarly, higher perceived job satisfaction was directly related to the school counselor's ability to provide direct student services within their schools (Kolodinsky et al., 2009). Conversely, school counselors who did not intend to return to their jobs the following year reported higher levels of demand and stress because of non-counseling duties, such as excessive paperwork and administrative disruptions (McCarthy et al., 2010). As a result, those who are not satisfied are at risk for disengagement (Mullen et al., 2018), while school counselors who are satisfied with their jobs may have increased student connections (Kolodinsky et al., 2009).

Role Stress

 Role stress refers to the levels of *role incongruity*, *role conflict*, and *role ambiguity* experienced by school counselors (Culbreth et al., 2005; Freeman & Coll, 1997). *Role incongruity* may occur when there are structural conflicts, including inadequate resources for school counselors and engagement in ineffective tasks (Freeman & Coll, 1997). Several authors noted that inappropriate or non-counseling duties contributed to burnout, including excessive paperwork, administrative duties, and testing coordinator roles (Bardhoshi et al., 2014; Moyer, 2011, Wilkerson, 2009). Moyer (2011) found that school counselors who engaged in increased non-counseling duties also had increased feelings of exhaustion and incompetence, had decreased feelings toward work environment, and were less likely to show empathy toward students. Furthermore, school counselors who were assigned inappropriate

roles reported higher levels of frustration and resentment toward the school system. Overall, authors emphasized the importance of educating administrators on the appropriate and inappropriate roles for school counselors to decrease burnout (Bardhoshi et al, 2014; Cervoni & DeLucia-Waack, 2011; Moyer, 2011).

Role conflict occurs when school counselors experience multiple external demands from different stakeholders (Holman et al., 2019). Role conflict examples for school counselors include: (a) whether school counselors should focus on the education goals or mental health needs of students first (Paisley & McMahon, 2001) and (b) whether a school counselor should engage in an actual role given by an administration or supervisor (e.g., testing coordinator) or preferred role (e.g., classroom guidance activity; Wilkerson, 2009). As such, school counselors can feel overwhelmed and often engage in inappropriate duties, according to the American School Counselor Association (ASCA) National Model (2019). In turn, school counselors experience stress and burnout (Mullen et al., 2018).

Role ambiguity is the discrepancy between actual and preferred counseling duties (Scarborough & Culbreth, 2008). Role ambiguity has been linked to burnout because of school counselors' stress from lacking an understanding of their professional roles and being misinformed about the realities of the job (Culbreth et al., 2005). For example, school counselors face challenges of navigating mixed messages about role expectations across stakeholders (Coll & Freeman, 1997). This confusion may lead to school counselors experiencing role ambiguity (Scarborough & Culbreth, 2008). When school counselors interact with stakeholders who have conflicting ideas about their roles, it creates stress. It is especially difficult for school counselors when stakeholders' conceptualization of their roles clashes with what school counselors learned during graduate training (Culbreth et al., 2005). When school counselors are assigned duties that conflict with their own understandings of their roles, they are not able to operate in alignment with their professional mandates (Holman et al., 2019). Overall, school counselors experiencing role ambiguity also report higher levels of stress, both of which have been linked to burnout (Kim & Lambie, 2018).

Purpose of the Present Study

Despite prevalence in the school counseling burnout literature regarding individual and organizational factors of burnout, we were unable to locate a study that holistically researched these variables. To align our findings with a theoretical understanding of school counselor burnout, we examined these phenomena as a multidimensional construct. Additionally, we controlled for years of experience (Mullen et al., 2018; Wilkerson, 2009; Wilkerson & Bellini, 2006) and school district (Butler & Constantine, 2005). Therefore, we answered the research question: What is the relationship between individual (i.e., perceived job stress, problem-focused coping, avoidant-emotional coping, and active-emotional coping) and organizational (i.e., perceived job satisfaction, role incongruity, role conflict, and role ambiguity) factors after controlling for years of experience and school district, with the subscales of school counselor burnout: (1) Exhaustion, (2) Incompetence, (3) Negative Work Environment, (4) Devaluing Clients, and (5) Deterioration in Personal Life?

Method

Sample

A total of 227 school counselors participated in the study. Ages ranged from 26 to 69 (*M* = 46.21; *SD* = 10.26; four declined to answer). The sex of participants included females (*n* = 166, 73.1%) and males (*n* = 61, 26.9%). The race and ethnicity of participants included White (*n* = 185, 81.5%), African American/Black (*n* = 20, 8.8%), Hispanic (*n* = 7, 3.1%), Asian/Pacific Islander (*n* = 3, 1.3%), American

Indian/Alaskan Native (*n* = 1, 0.4%), and Biracial/Multiracial (*n* = 9, 4.0%), and two participants (0.9%) declined to answer. Participants held a master's degree in school counseling (*n* = 175, 77.1%), a PhD or EdD (*n* = 33, 14.5%), or a master's degree in another counseling or mental health specialty area (*n* = 19, 8.4%). The years of experience ranged from 2 to 41 years (*M* = 13.68, *SD* = 7.49). Participants reported working in suburban (*n* = 97, 42.7%), rural (*n* = 76, 33.5%), and urban (*n* = 54, 23.8%) settings. Regarding level of practice, participants worked in an elementary school (i.e., grades K–6; *n* = 80, 35.2%), middle school (i.e., grades 7–8; *n* = 14, 6.2%), high school (i.e., grades 9–12; *n* = 59, 26.0%), or multiple grade levels (e.g., K–8, K–12, etc.; *n* = 74, 32.6%). A power analysis was completed in G*Power 3.1 before beginning the study (Faul et al., 2009). The necessary sample size was determined to be at least 200, with a power of .80, assuming a moderate effect size of .15 in the multiple regression analyses, and with an error probability or alpha of .05 (J. Cohen, 1992).

Procedures

Institutional Review Board approval was obtained prior to beginning the study. The first author sent recruitment emails to 4,000 school counselors who were professional members of the ASCA online membership directory. Specifically, approximately 20% of school counselors in each of the 50 states and District of Columbia were chosen from the membership directory to receive the recruitment emails. The emails included a brief introduction to the study and an anonymous link that took potential participants to the online survey portal in Qualtrics. Potential participants first reviewed the informed consent. Once they consented to the survey, participants completed the demographics questionnaire and instruments. A convenience sample was obtained based upon voluntary responses to the survey (Dimitrov, 2009).

Instruments

The first author constructed a brief demographics survey to gather information about the participants (e.g., age, sex, race and ethnicity, degree, and years of experience) and their work environment (e.g., school district, grade level). The Perceived Stress Scale (PSS; S. Cohen et al., 1983) and Brief COPE (Carver, 1997) were used to measure individual factors. The Job Satisfaction Survey (JSS; Spector, 1985) and Role Questionnaire (RQ; Rizzo et al., 1970) were used to measure organizational factors. The CBI (Lee et al., 2007) was used to measure the dimensions of school counselor burnout.

Perceived Stress Scale (PSS)

The PSS (S. Cohen et al., 1983) is a 14-item inventory designed to measure an individual's perceived stress within the past month. In the present study, we used the PSS-4, which is a subset of items from the original 14-item scale. The PSS was normed on a large sample of individuals from across the United States (S. Cohen et al., 1983). Participants responded to a 5-point Likert-type scale ranging from 0 (*never*) to 4 (*very often*). Scores on the PSS-4 ranged from 0 to 20. An example question of the PSS-4 is: "In the past month, how often have you felt difficulties were piling up so high that you could not overcome them?" The PSS-4 was determined to be a suitable brief measure of stress perceptions, based upon adequate factor structure and predictive validity (S. Cohen & Williamson, 1988). Reliability has been upheld (e.g., S. Cohen & Williamson, 1988) with test-retest reliability at .85 after 2 days (S. Cohen et al., 1983). For the present study, the internal consistency reliability was calculated at α = .76. Correlations between the perceived stress total score and CBI subscales ranged from *r* = .19 to .55.

Brief COPE

The Brief COPE (Carver, 1997) is a 28-item inventory designed to measure coping responses or processes and includes 14 subscales. We followed previous researchers' (e.g., Deatherage et al., 2014) grouping of the 14 subscales into three coping processes (i.e., problem-focused, active-emotional, and avoidant-emotional). Therefore, problem-focused coping contained the Active Coping, Planning,

Instrumental Support, and Religion subscales. Active-emotional coping contained the Venting, Positive Reframing, Humor, Acceptance, and Emotional Support subscales. Avoidant-emotional coping contained the Self-Distraction, Denial, Behavioral Disengagement, and Self-Blame subscales. For the present study, the items pertaining to participants' alcohol and illegal drug use as coping responses were omitted because of their sensitive nature. Therefore, 26 items were included in the present study. The inventory uses a 4-point Likert-type scale with scores ranging from 0 (*I haven't been doing this at all*) to 3 (*I've been doing this a lot*). A sample item on the Brief COPE is "I've been turning to work or other activities to take my mind off things." Construct validity has been upheld with the three coping processes (e.g., Deatherage et al., 2014). Test-retest reliability for the three subscale groups has been upheld over a year timespan (Cooper et al., 2008). For the present study, the internal consistency reliability was calculated for problem-focused coping at α = .84, avoidant-emotional coping at α = .70, and active-emotional coping at α = .81. Correlations between problem-focused coping and the CBI subscales ranged from r = .00 to .13, correlations between avoidant-emotional coping and CBI subscales ranged from r = .20 to .48, and correlations between active-emotional coping and CBI subscales ranged from r = .01 to .16.

Job Satisfaction Survey (JSS)

The JSS (Spector, 1985) is a 36-item inventory intended to measure an individual's perceived job satisfaction or attitudes and aspects of the job. The JSS contains nine subscales: Pay, Promotion, Supervision, Fringe Benefits, Contingent Rewards, Operating Procedures, Coworkers, Nature of Work, and Communication. The inventory uses a 6-point Likert-type scale with scores ranging from 1 (*disagree very much*) to 6 (*agree very much*). Total scores range from 36 to 216 with the higher the score, the higher job satisfaction experienced. An example item on the JSS is "My job is enjoyable" (Spector, 1985, p. 711). The JSS was constructed for, and normed on, social service, education, and mental health professionals (Spector, 1985, 2011). Spector (1985) established convergent validity with the Job Descriptive Index (Smith et al., 1969), and produced scores ranging from .61 to .80. Strong reliability has been established for the JSS, including a Cronbach coefficient alpha of .91 for all factors combined, and at 18 months, the test-retest reliability score was .71 (Spector, 1985). For the present study, the internal consistency reliability was calculated for the total scores at α = .91. Correlations between the perceived job satisfaction total score and CBI subscales ranged from r = -.13 to -.75.

Role Questionnaire (RQ)

The RQ (Rizzo et al., 1970) is a 14-item inventory designed to measure the level of role conflict and role ambiguity an individual has about a job. The RQ has been factor analyzed with school counselors (Freeman & Coll, 1997) and found to have three distinct factors (i.e., role incongruity, role conflict, and role ambiguity). The inventory uses a 7-point Likert-type scale with scores ranging from 1 (*very false*) to 7 (*very true*). Role incongruity refers to conflicts with the structure of the system and allocation of resources (Freeman & Coll, 1997). The role incongruity factor comprises items 1–4. Total scores range from 8 to 32, with the higher the score, the higher role incongruity experienced. A sample item for role incongruity is "I receive an assignment without adequate resources and materials to execute it." Role conflict refers to the contradictory requests of work expectations with varying groups (Freeman & Coll, 1997). The role conflict factor comprises items 5–8. The higher the score, the higher role conflict experienced, which can range from 8 to 32. A sample item for role conflict is "I receive incompatible requests from two or more people." The role ambiguity factor, which measures a lack of clarity on the job, is negatively worded; therefore, the lower the score, the higher the role ambiguity experienced. The role ambiguity factor comprises items 9–14, and total scores range from 6 to 42. A sample item for role ambiguity is "Explanation is clear of what has to be done." Construct validity for the three factors with school counselors was established by Freeman and Coll (1997). Reliability of the three factors have been upheld for school counselor participants

(Culbreth et al., 2005; Wilkerson, 2009; Wilkerson & Bellini, 2006). For the present study, the internal consistency reliability was calculated for role incongruity at $\alpha = .82$, role conflict at $\alpha = .79$, and role ambiguity at $\alpha = .90$. Correlations between role incongruity and CBI subscales ranged from $r = .14$ to .65, correlations between role conflict and CBI subscales ranged from $r = .14$ to .53, and correlations between role ambiguity and CBI subscales ranged from $r = -.22$ to -.56.

Counselor Burnout Inventory (CBI)

The CBI (Lee et al., 2007) is a 20-item inventory designed to measure counselors' burnout levels. The CBI includes five subscales, with four questions for each subscale: Exhaustion, Incompetence, Negative Work Environment, Devaluing Clients, and Deterioration in Personal Life. The CBI uses a 5-point Likert-type scale ranging from 1 (*never true*) to 5 (*always true*). Total scores on each subscale range from 5 to 20, with the higher the score, the higher level of burnout. A sample item from the Exhaustion subscale is "Due to my job as a counselor, I feel tired most of the time." A sample item from the Incompetence subscale is "I am not confident in my counseling skills." A sample item from the Negative Work Environment subscale is "I am treated unfairly in my workplace." A sample item from the Devaluing Clients subscale is "I am not interested in my clients and their problems." A sample item from the Deterioration in Personal Life subscale is "I feel I have poor boundaries between work and my personal life." Two independent samples composed of counselors from a variety of settings across the United States were used to explore and confirm the factor structure (Lee et al., 2007). Gnilka et al. (2015) upheld the CBI five-factor structure with a confirmatory factor analysis in a sample of school counselors. Cronbach's alpha for the total CBI was .88, with scores ranging from .73 to .85 for the subscales (Lee et al., 2007). For the present study, internal consistency reliability for the CBI subscales were calculated and ranged from $\alpha = .78$ to .89.

Results

Prior to conducting the primary analyses, we used SPSS (Version 25.0) to clean the data, impute missing data values, and test the assumptions of the primary analyses (i.e., hierarchal regressions), as recommended by Tabachnick and Fidell (2013). We used expectation-maximization (EM) to impute missing data (Cook, 2020), after we tested the randomness of the missing values with Little's missing completely at random (MCAR). All missing values were determined to be MCAR, except for the active-emotional coping of the Brief COPE and the JSS: $\chi^2(40, N = 227) = 79.13$, $p = .000$, and $\chi^2(671, N = 227) = 836.57$, $p = .000$, respectively. Because the missing values for the active-emotional coping and JSS were less than 1%, expectation-maximization was an appropriate imputation method (Cook, 2020). Less than 5% of values were imputed for the PSS-4, the factors of the RQ (role ambiguity, role incongruity, and role conflict), and the five subscales of the CBI (Exhaustion, Incompetence, Negative Work Environment, Devaluing Clients, and Deterioration in Personal Life), and less than 1% of the values were imputed for the problem-focused and avoidant-emotional processes of the Brief COPE.

To answer the research question, we used three-step hierarchical regression models to analyze the individual and cumulative contributions for demographic, individual, and organizational factors with each subscale of the CBI. Qualities of the instruments are provided in Table 1. In Step 1, we entered the demographic factors (i.e., years of experience and school district). In Step 2, we entered the individual factors (i.e., perceived stress, problem-focused coping, avoidant-emotional coping, and active-emotional coping). In Step 3, we entered the organizational factors (i.e., perceived job satisfaction, role incongruity, role conflict, and role ambiguity). Completed assumption checks showed no outliers or influential data points, as concluded by an examination of the Q-Q plots, histograms, scatterplots, and Mahalanobis

distance. We checked multicollinearity and found it to be an issue for school district (tolerance < .01). Therefore, we removed the school district variable and reentered years of experience in Step 1. To control for Type I error, we used the Bonferroni method to adjust the family-wise alpha (Darlington & Hayes, 2017), which resulted in .01 as the cutoff for statistical significance for Step 2 (i.e., individual factors) and .0056 as the cutoff for statistical significance for Step 3 (i.e., organizational factors). Results for each of these models are presented in Table 2.

Table 1

Qualities of Instrumentation

Instrumentation	Scores	M	SD	α
Perceived Stress Scale-4 Total Score	4–19	8.24	2.86	.76
Problem-Focused Coping	8–32	22.55	5.29	.84
Avoidant-Emotional Coping	8–24	12.48	3.03	.70
Active-Emotional Coping	10–38	25.74	5.56	.81
Job Satisfaction Scale Total Score	82–204	143.25	25.28	.91
Role Ambiguity	7–42	29.67	7.25	.90
Role Incongruity	4–28	15.47	5.77	.82
Role Conflict	4–26	15.18	5.58	.79
Exhaustion	4–20	11.54	3.97	.89
Incompetence	4–17	8.77	2.96	.78
Negative Work Environment	4–20	9.87	3.75	.85
Devaluing Client	4–13	5.61	2.08	.80
Deterioration in Personal Life	4–19	8.65	3.32	.78

Table 2

Results of Hierarchal Regression Analyses of School Counselor Burnout

	Exhaustion	Incompetence	Negative Work Environment	Devaluing Clients	Deterioration in Personal Life
Step 1					
Years of Experience	-.038	-.233*	-.072	-.190*	-.047
R^2	.001	.054	.005	.036	.002
F	.323	12.89**	1.17	8.46*	.500
Step 2					
Years of Experience	.030	-.151**	-.042	-.155	.001
Perceived Stress	.392**	.184	.283**	.093	.491**
Avoidant-Emotional Coping	.160	.360**	.025	.180	.103
Active-Emotional Coping	.030	.087	.026	.131	.151
Problem-Focused Coping	-.043	-.151	.081	-.229**	-.105
R^2	.240	.284	.109	.116	.323
ΔR^2	.239	.229	.104	.080	.321
ΔF	17.34**	17.69**	6.43**	4.98**	26.24**
Step 3					
Years of Experience	.056	-.097	.052	-.125	.025
Perceived Stress	.303†	.150	.057	.070	.437†
Avoidant-Emotional Coping	.170	.338†	.025	.165	.077
Active-Emotional Coping	.034	.126	.050	.151	.155
Problem-Focused Coping	-.064	-.180	.042	-.243†	-.127
Perceived Job Satisfaction	-.198	.080	-.489†	.032	.029
Role Ambiguity	.014	-.276†	-.122	-.147	-.029
Role Incongruity	.207	.190	.220†	.069	.172
Role Conflict	-.014	-.096	.106	-.018	.188
R^2	.351	.367	.666	.140	.383
ΔR^2	.111	.092	.652	.024	.060
ΔF	9.29**	8.03**	90.43**	1.51	5.26**

Note. N = 227
* $p < .05$. ** $p < .01$. † $p < .0056$.

Exhaustion

The hierarchical regression model for Exhaustion revealed that years of experience was not statistically significant: $F(1, 225) = .323$, $p > .05$. Introducing individual factors explained 23.9% of the variation in Exhaustion, and this change in R^2 was significant: $F(5, 221) = 13.96$, $p < .001$. The inclusion of organizational factors explained an additional 11.1% of the variation in Exhaustion, and this change in R^2 was significant: $F(9, 217) = 13.05$, $p < .001$. However, the β values revealed that the only statistically significant factor of Exhaustion was perceived stress ($\beta = .303$, $p < .001$). Together the independent variables accounted for 35.1% of the variance in Exhaustion.

Incompetence

For Incompetence, years of experience explained 5.4% of its variation and was significant: $F(1, 225) = 12.89$, $p < .001$. Adding individual factors explained an additional 22.9% of the variation in Incompetence, and this change in R^2 was significant: $F(5, 221) = 17.50$, $p < .001$. Including organizational factors explained an additional 9.2% of the variation in Incompetence, and this change in R^2 was significant: $F(9, 217) = 14.53$, $p < .001$. The statistically significant factors of Incompetence were avoidant-emotional coping ($\beta = .338$, $p < .001$) and role ambiguity ($\beta = -.276$, $p < .001$). Together the independent variables accounted for 36.7% of the variance in Incompetence.

Negative Work Environment

For Negative Work Environment, years of experience was not statistically significant: $F(1,225) = 1.17$, $p > .05$, $R^2 = .005$. Adding individual factors explained 10.9% of the variation in Negative Work Environment, and this change in R^2 was significant: $F(5, 221) = 5.40$, $p < .001$. Including organizational factors explained an additional 65.2% of the variation in Negative Work Environment, and this change in R^2 was significant: $F(9, 217) = 48.05$, $p < .001$. In the final model, perceived job satisfaction ($\beta = -.489$, $p = .000$) and role incongruity ($\beta = .220$, $p = .000$) significantly explained Negative Work Environment. Together the independent variables accounted for 66.6% of the variance in Negative Work Environment.

Devaluing Clients

For Devaluing Clients, years of experience contributed significantly to the model and accounted for 3.6% of its variation: $F(1, 225) = 8.46$, $p < .05$. Including individual factors explained an additional 8.0% of the variation in Devaluing Clients, and this change in R^2 was significant: $F(5, 221) = 5.80$, $p < .01$. Adding the organizational factors in the third step was significant: $F(9, 217) = 3.92$, $p < .001$, $R^2 = .140$. However, the inclusion of the organizational variables did not explain a significantly different equation: $\Delta F(4, 217) = 1.51$, $p > .05$, $\Delta R^2 = .024$. Therefore, we interpreted the β values of the second step, and the statistically significant factor of Devaluing Clients was problem-focused coping ($\beta = -.229$, $p = .009$).

Deterioration in Personal Life

Finally, for Deterioration in Personal Life, years of experience was not significant: $F(1, 225) = .500$, $p > .05$, $R^2 = .002$. Including individual factors explained 32.1% of the variation in Deterioration in Personal Life, and the change in R^2 was significant: $F(5, 221) = 21.14$, $p < .001$. Including the organizational factors explained an additional 6.0% of the variation in Deterioration in Personal Life, and this change in R^2 was significant: $F(9, 217) = 14.98$, $p < .001$. An examination of the β values revealed that only perceived stress was a statistically significant variable for Deterioration in Personal Life ($\beta = .437$, $p = .000$). Together the independent variables accounted for 38.3% of the variance in Deterioration in Personal Life.

Discussion

The present study illustrates an expanded understanding of individual and organizational factors associated with the subscales of school counselor burnout (i.e., Exhaustion, Incompetence, Negative Work Environment, Devaluing Clients, and Deterioration in Personal Life; Lee et al., 2007). We intended to control for years of experience but found that before adding the individual and organizational factors, it was a statistically significant variable and negatively related with Incompetence and Devaluing Clients. School counselor researchers have reported contradictory findings between years of experience and burnout. Similar to our findings, Wilkerson and Bellini (2006) and Mullen et al. (2018) reported a negative relationship between years of experience and burnout—essentially describing that those earlier in their careers have a higher risk of experiencing burnout. In contrast, Butler and Constantine (2005) and Wilkerson (2009) reported burnout happening over time (i.e., a positive relationship between years of experience and burnout). Our study underscores the vulnerability school counselors may experience earlier in their careers (Mullen et al., 2018). Our results also provide a unique finding in that fewer years of experience as a school counselor is associated with the burnout dimensions of Incompetence and Devaluing Clients.

In the present study, we found individual factors (i.e., perceived stress, problem-focused coping, and avoidant-emotional coping) significantly related to Exhaustion, Incompetence, Devaluing Clients, and Deterioration in Personal Life. School counselor scholars (e.g., Mullen et al., 2018; Mullen & Gutierrez, 2016) reported a statistically significant positive relationship between school counselors' perceived stress and burnout. Our results provide unique findings in that stress was positively related with the Exhaustion and Deterioration in Personal Life dimensions of burnout. Other school counselor scholars (e.g., Bardhoshi et al., 2014; Moyer, 2011) found the stress-related variable of engagement in non-counseling duties was significantly related to Exhaustion and Deterioration in Personal Life.

For the coping processes, avoidant-emotional coping was positively related to Incompetence and problem-focused coping was negatively related to Devaluing Clients. These findings provide two distinct understandings of school counselor burnout. First, and notably, school counselor participants who were experiencing Incompetence were also engaging in increased avoidant-emotional coping. This finding is similar to those of Fye et al. (2018), who found maladaptive perfectionists were more frequently engaging in avoidant-coping processes. We did not research perfectionism in the present study; however, our findings may expand an understanding of a positive relationship between avoidant-emotional coping and burnout dimensions for school counselors regardless of perfectionism types. Second, we discovered school counselor participants' problem-focused coping was negatively related to Devaluing Clients. This is a promising finding from our study because participants were likely to incorporate increased problem-focused coping alongside valuing students. As previously discussed, it appears that these school counselor participants were maintaining high levels of positive regard and empathy for students (Gnilka et al., 2015; Mullen & Gutierrez, 2016). Engaging in problem-focused coping may be beneficial to their engagement in student care and maintaining professional vitality.

The organizational factors of role ambiguity, role incongruity, and perceived job satisfaction were significantly related to the Incompetence and Negative Work Environment dimensions of burnout. Specifically, role ambiguity was positively related to Incompetence. Our results confirm that when school counselors' roles are increasingly unclear, they are experiencing higher levels of burnout (Mullen et al., 2018), and specifically Incompetence. Perceived job satisfaction was negatively related to Negative Work Environment, while role incongruity was positively related to Negative Work

Environment. Consistent with previous research, our findings support the significant relationships between organizational factors (i.e., administrative and clerical duties contributing to role stress) and Negative Work Environment (Bardhoshi et al., 2014). Other scholars have studied perceived job satisfaction as an outcome and potential preclusion to school counselor burnout (Baggerly & Osborn, 2006; Bryant & Constantine, 2006). School counseling scholars have found that burnout mediated the relationship between perceived stress and perceived job satisfaction (Mullen et al., 2018). In the present study, the perceived job satisfaction factor had the highest β at -.489. It appears that perceived job satisfaction is an important factor alongside school counselors' specific experiences of Negative Work Environments. Perceived stress was a statistically significant factor in Step 2 with Negative Work Environment, but insignificant in the context of the organizational variables. This is an important finding because burnout, by definition, is a function of one's work context (Lee et al., 2007; Maslach & Leiter, 2017), and we found that organizational factors explained a large amount of the variance (i.e., 65.2%) for the Negative Work Environment dimension of burnout. Overall, our findings support the complex and multidimensional nature of school counselor burnout.

Limitations and Future Research

We attempted to research multidimensional burnout with a nationally representative and diverse sample of ASCA member school counselors. Despite our efforts, the response rate was 5.68%. The majority of our participants identified as White and female, which is similar to the reported demographics of professional school counselor members (ASCA, 2018). However, caution may be warranted when generalizing our findings to all school counselors. Expanding research efforts (i.e., qualitative methods) to increase understanding of the burnout experiences of school counselors unrepresented by our participant sample is warranted. Last, it is unknown whether or not participants answered sensitive questions, such as those about burnout, in a socially desirable manner.

Future research should seek to understand additional individual and organizational variables related to the burnout dimensions for school counselors (Lee et al., 2007). For example, the Devaluing Clients dimension has been viewed by school counseling scholars as a complicated construct that has functioned differently from the other dimensions of burnout (Bardhoshi et al., 2014; Mullen & Gutierrez, 2016). Additional research is needed to understand this burnout dimension with school counselors. Kim and Lambie (2018) discussed the need for research to focus on burnout interventions. We concur and believe the distinction of individual and organizational factors within the dimensions of school counselor burnout should be considered when constructing these interventions, which may be important because burnout may not be an end state; instead, it may be a mediator of other important outcomes, such as work and health (Maslach & Leiter, 2017). It may be helpful to expand research that studies relationships between school counselor burnout and physical and mental health outcomes.

Implications for the School Counseling Profession

Our findings have implications for school counselors, school counselors-in-training, and counselor educators and supervisors. They illustrate the importance of conceptualizing the ecological relationship between individual and organizational factors with school counselor burnout. School counselors may have more control over individual factors, and supervisors may have more control over organizational factors. Despite these considerations, it is important to share the responsibility of burnout prevention within the school system. This is important because despite one's efforts to increase helpful coping, self-care, or wellness practices, it appears that continued exposure to negative work environments will continue to place school counselors at risk for burnout.

Because school counselors are responsible for providing counseling services that align with professional and ethical standards (Kim & Lambie, 2018), it is imperative for them to recognize, monitor, and address their symptoms of burnout (ASCA, 2016). Therefore, it may be helpful for school counselors and supervisors to identify and understand the dimensions of burnout experienced and their relationships with individual and organizational factors. By using the instruments from this study, school counselors can identify contributions of individual and organizational factors with their burnout scores. This would allow supervisees to understand the relationships between these factors and burnout dimensions. During supervision, time could be dedicated to setting personal goals for maintaining self-care and professional vitality. This may be important, especially in identifying and decreasing avoidant-emotional coping, alongside increasing problem-focused coping processes. In general, school counselors should monitor their own self-care in relation to work context stressors and perceived job satisfaction. Our results may provide support to the potential limitations that wellness practices have on decreasing burnout within the Negative Work Environment (Puig et al., 2012)—meaning, wellness practices may be important in alleviating the individual factors related to burnout (i.e., high perceived stress, coping responses) but may have limited ability to decrease factors out of school counselors' control (i.e., work context practices and policies).

Despite best practice guidelines, the reality remains that school counselors engage in various non-counseling duties (Bardhoshi et al., 2014; Gutierrez & Mullen, 2016), which contributes to role stress. To lessen organizational stressors, as early as graduate school, counselor educators and supervisors should allow space in the learning process for students to learn the various counseling and related duties expected of school counselors within the school environment. Providing learning contexts for graduate students to explore these various roles may set the stage for lessened role stress. Specifically, assignments should be included in the curriculum that allow graduate students to explore school counselors' professional identity and the real and ideal roles of the school counselor. These discussions should be engaged in along with conversations of how these varying roles can affect burnout (specifically role incongruity and role ambiguity), especially for those earlier in their careers. These dialogues should be reinforced during the practicum and internship experiences and include personal sources of perceived job satisfaction. In schools, supervisors can help to facilitate school counselors' competence by clearly defining expectations through measurable outcomes. For example, school counselors and supervisors can use the ASCA National Model's (ASCA, 2019) Annual Administrative Conference Template (p. 60) and Annual Calendar Template (p. 70) to open communication between the school counselors and their supervisors and document their duties. This discussion may additionally open communication regarding the adequacy of funding, resources, materials, and staff available to school counselors (Freeman & Coll, 1997). If inadequate, school counselors may use the opportunity to advocate for increased support from supervisors and administrators.

It is important to note that in the present study, school counselors earlier in their careers reported higher levels of Incompetence and Devaluing Clients. School counselor supervisors should understand these relationships. Mentoring of school counselors who are earlier in their careers by those with significant experience may help the younger professionals build their professional identities and student-focused work. Last, recognizing dimensions of burnout in relation to individual and organizational factors may not be enough to maintain professional vitality. The school counseling profession may find it helpful to train school counselors and graduate students in advocacy skills. Trusty and Brown (2005) outlined advocacy competencies for school counselors, which include dispositional statements, knowledge, and skills necessary to becoming effective advocates. The self-advocacy model prepares school counselors to have the communication (oral and written) necessary to maintain effective advocacy roles.

Conclusion

In conclusion, our results provide an expansion of findings related to relative contributions for individual and organizational factors with school counselor multidimensional burnout. In short, burnout dimensions are uniquely related to personal and work context factors. It is difficult to conceive of burnout absent its relationship to some aspect of the work setting. School counselors and supervisors can use our results to conceptualize burnout from a multidimensional perspective, which may in turn help them find new ways to remain professionally vital to themselves, their students, and their school community.

References

American School Counselor Association. (2016). *ASCA ethical standards for school counselors.* https://www.schoolcounselor.org/asca/media/asca/Ethics/EthicalStandards2016.pdf

American School Counselor Association. (2018). *ASCA membership demographics.* https://www.schoolcounselor.org/asca/media/asca/home/Member-Demographics.pdf

American School Counselor Association. (2019). *The ASCA national model: A framework for school counseling programs* (4th ed.).

Baggerly, J., & Osborn, D. (2006). School counselors' career satisfaction and commitment: Correlates and predictors. *Professional School Counseling, 9*(3), 197–205. https://doi.org/10.1177/2156759X0500900304

Bardhoshi, G., Schweinle, A., & Duncan, K. (2014). Understanding the impact of school factors on school counselor burnout: A mixed-methods study. *The Professional Counselor*, 4(5), 426–443. https://doi.org/10.15241/gb.4.5.426

Bryant, R. M., & Constantine, M. G. (2006). Multiple role balance, job satisfaction, and life satisfaction in women school counselors. *Professional School Counseling*, 9(4), 265–271. https://doi.org/10.1177/2156759X0500900403

Butler, S. K., & Constantine, M. G. (2005). Collective self-esteem and burnout in professional school counselors. *Professional School Counseling*, 9(1), 55–62. https://doi.org/10.1177/2156759X0500900107

Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the Brief COPE. *International Journal of Behavioral Medicine*, 4(1), 92–100. https://doi.org/10.1207/s15327558ijbm0401_6

Cervoni, A., & DeLucia-Waack, J. (2011). Role conflict and ambiguity as predictors of job satisfaction in high school counselors. *Journal of School Counseling*, 9(1), 1–30. http://www.jsc.montana.edu/articles/v9n1.pdf

Cohen, J. (1992). A power primer. *Psychological Bulletin*, 112(1), 155–159. https://doi.org/10.1037/0033-2909.112.1.155

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 24(4), 385–396. https://doi.org/10.2307/2136404

Cohen, S., & Williamson, G. (1988). Perceived stress in a probability sample of the United States. In S. Spacapan & S. Oskamp (Eds.), *The social psychology of health: The Claremont symposium on applied social psychology* (2nd ed., pp. 31–67). SAGE.

Coll, K. M., & Freeman, B. (1997). Role conflict among elementary school counselors: A national comparison with middle and secondary school counselors. *Elementary School Guidance & Counseling*, 31(4), 251–261.

Cook, R. M. (2020). Addressing missing data in quantitative counseling research. *Counseling Outcome Research and Evaluation.* https://doi.org/10.1080/21501378.2019.1711037

Cooper, C., Katona, C., & Livingston, G. (2008). Validity and reliability of the Brief COPE in carers of people with dementia: The LASER-AD Study. *The Journal of Nervous and Mental Disease*, *196*(11), 838–843. https://doi.org/10.1097/NMD.0b013e31818b504c

Culbreth, J. R., Scarborough, J. L., Banks-Johnson, A., & Solomon, S. (2005). Role stress among practicing school counselors. *Counselor Education and Supervision*, *45*(1), 58–71. https://doi.org/10.1002/j.1556-6978.2005.tb00130.x

Darlington, R. B., & Hayes, A. F. (2017). *Regression analysis and linear models: Concepts, applications, and implementation* (1st ed.). Guilford.

Deatherage, S., Servaty-Seib, H. L., & Aksoz, I. (2014). Stress, coping, and internet use of college students. *Journal of American College Health*, *62*(1), 40–46. https://doi.org/10.1080/07448481.2013.843536

Dimitrov, D. M. (2009). *Quantitative research in education: Intermediate and advanced methods*. Whittier.

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods*, *41*(4), 1149–1160. https://doi.org/10.3758/BRM.41.4.1149

Folkman, S., & Lazarus, R. S. (1985). If it changes it must be a process: Study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology*, *48*(1), 150–170. https://doi.org/10.1037/0022-3514.48.1.150

Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annual Review of Psychology*, *55*(1), 745–774. https://doi.org/10.1146/annurev.psych.55.090902.141456

Freeman, B., & Coll, K. M. (1997). Factor structure of the Role Questionnaire (RQ): A study of high school counselors. *Measurement & Evaluation in Counseling and Development*, *30*(1), 32–39. https://doi.org/10.1080/07481756.1997.12068915

Fye, H. J., Gnilka, P. B., & McLaulin, S. E. (2018). Perfectionism and school counselors: Differences in stress, coping, and burnout. *Journal of Counseling & Development*, *96*(4), 349–360. https://doi.org/10.1002/jcad.12218

Gnilka, P. B., Karpinski, A. C., & Smith, H. J. (2015). Factor structure of the Counselor Burnout Inventory in a sample of professional school counselors. *Measurement and Evaluation in Counseling and Development*, *48*(3), 177–191. https://doi.org/10.1177%2F0748175615578758

Holman, L. F., Nelson, J., & Watts, R. (2019). Organizational variables contributing to school counselor burnout: An opportunity for leadership, advocacy, collaboration, and systemic change. *The Professional Counselor*, *9*(2), 126–141. https://doi.org/10.15241/lfh.9.2.126

Kim, N., & Lambie, G. W. (2018). Burnout and implications for professional school counselors. *The Professional Counselor*, *8*(3), 277–294. http://doi.org/10.15241/nk.8.3.277

Kolodinsky, P., Draves, P., Schroder, V., Lindsey, C., & Zlatev, M. (2009). Reported levels of satisfaction and frustration by Arizona school counselors: A desire for greater connections with students in a data-driven era. *Professional School Counseling*, *12*(3), 193–199. https://doi.org/10.1177%2F2156759X0901200307

Lazarus, R. S. (1993). Coping theory and research: Past, present, and future. *Psychosomatic Medicine*, *55*(3), 234–247. https://doi.org/10.1097/00006842-199305000-00002

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer.

Lee, S. M., Baker, C. R., Cho, S. H., Heckathorn, D. E., Holland, M. W., Newgent, R. A., Ogle, N. T., Powell, M. L., Quinn, J. J., Wallace, S. L., & Yu, K. (2007). Development and initial psychometrics of the Counselor Burnout Inventory. *Measurement and Evaluation in Counseling and Development*, *40*(3), 142–154. https://doi.org/10.1080/07481756.2007.11909811

Maslach, C., & Leiter, M. P. (2017). Understanding burnout: New models. In C. L. Cooper & J. C. Quick (Eds.), *The handbook of stress and health: A guide to research and practice* (1st ed., pp. 36–56). Wiley-Blackwell.

McCarthy, C., Van Horn Kerne, V., Calfa, N. A., Lambert, R. G., & Guzmán, M. (2010). An exploration of school counselors' demands and resources: Relationship to stress, biographic, and caseload characteristics. *Professional School Counseling*, *13*(3), 146–158. https://doi.org/10.1177%2F2156759X1001300302

Moyer, M. (2011). Effects of non-guidance activities, supervision, and student-to-counselor ratios on school counselor burnout. *Journal of School Counseling*, *9*(5), 1–30. http://www.jsc.montana.edu/articles/v9n5.pdf

Mullen, P. R., Blount, A. J., Lambie, G. W., & Chae, N. (2018). School counselors' perceived stress, burnout, and job satisfaction. *Professional School Counseling*, *21*(1), 1–10. https://doi.org/10.1177/2156759X18782468

Mullen, P. R., & Gutierrez, D. (2016). Burnout, stress and direct student services among school counselors. *The Professional Counselor*, *6*(4), 344–359. http://doi.org/10.15241/pm.6.4.344

Paisley, P. O., & McMahon, H. G. (2001). School counseling for the 21st century: Challenges and opportunities. *Professional School Counseling*, *5*(2), 106–115.

Puig, A., Baggs, A., Mixon, K., Park, Y. M., Kim, B. Y., & Lee, S. M. (2012). Relationship between job burnout and personal wellness in mental health professionals. *Journal of Employment Counseling*, *49*(3), 98–109. https://doi.org/10.1002/j.2161-1920.2012.00010.x

Rizzo, J. R., House, R. J., & Lirtzman, S. I. (1970). Role conflict and ambiguity in complex organizations. *Administrative Science Quarterly*, *15*(2), 150–163. https://doi.org/10.2307/2391486

Scarborough, J. L, & Culbreth, J. R. (2008). Examining discrepancies between actual and preferred practice of school counselors. *Journal of Counseling & Development*, *86*(4), 446–459. https://doi.org/10.1002/j.1556-6678.2008.tb00533.x

Smith, P. C., Kendall, L. M., & Hulin, C. L. (1969). *Measurement of satisfaction in work and retirement: A strategy for the study of attitudes.* Rand McNally.

Spector, P. E. (1985). Measurement of human service staff satisfaction: Development of the Job Satisfaction Survey. *American Journal of Community Psychology*, *13*(6), 693–713. https://doi.org/10.1007/bf00929796

Spector, P. E. (2011). *Job Satisfaction Survey norms.* https://shell.cas.usf.edu/~pspector/scales/jssnorms.html

Tabachnick, B. G., & Fidell, L. S. (2013). *Using multivariate statistics* (6th ed.). Pearson.

Trusty, J., & Brown, D. (2005). Advocacy competencies for professional school counselors. *Professional School Counseling*, *8*(3), 259–265.

Wilkerson, K. (2009). An examination of burnout among school counselors guided by stress-strain-coping theory. *Journal of Counseling & Development*, *87*(4), 428–437. https://doi.org/10.1002/j.1556-6678.2009.tb00127.x

Wilkerson, K., & Bellini, J. (2006). Intrapersonal and organizational factors associated with burnout among school counselors. *Journal of Counseling & Development*, *84*(4), 440–450. https://doi.org/10.1002/j.1556-6678.2006.tb00428.x

nbcc

Agency Responses to Counselor Survivors of Client Suicide

Nathaniel J. Wagner, Colleen M. L. Grunhaus, Victor E. Tuazon

According to recent research, counselors may benefit from a variety of supports offered by mental health agencies after a client dies by suicide. Research is sparse concerning how often agency supports and outreach are offered to counselors and what supports counselors find to be the most helpful after a client suicide. In this cross-sectional survey research study, the researchers recruited a sample of counselors ($N = 228$) who self-identified as having experienced a client suicide. The authors examined relationships between perceived organizational support, supervisory alliance, and the impact of the event on counselors. The authors also examined the use and perceived helpfulness of agency policies regarding counselor-oriented support after client suicide. Results highlight the need for more counselor training around suicide, increased empathy for counselor survivors, and the need for agency policies related to postvention.

Keywords: client suicide, supervision, agency policies, counselor survivors, postvention

According to McAdams and Foster (2000), approximately 23% of counselors are *counselor survivors*, meaning the counselor has had a client die by suicide. These client suicides impact counselor survivors personally and professionally. Counselors can feel sad at work and lose professional confidence in the aftermath of client suicides (Draper et al., 2014). Some counselor survivors demonstrate a fear of working with clients who present with suicidal ideations and are reluctant to accept subsequent suicidal clients (Hendin et al., 2000). Counselors also may experience various emotions, including anger, betrayal, fear of blame, grief, guilt, self-doubt, shame, and shock (Draper et al., 2014; Hendin et al., 2000). In addition, counselor survivors may become more sensitive to client suicidal ideation and experience heightened stress (e.g., Draper et al., 2014; Fairman et al., 2014; McAdams & Foster, 2000, 2002).

McAdams and Foster (2002) reported that counselor survivors found the support of a supervisor helpful in the recovery process. However, counselors further along in their professional experience, or practicing independently, might not have access to supervisory support. According to Fairman et al. (2014), after a client suicide, counselors benefitted from the following: (a) facilitated debriefing, (b) informal group support, (c) individual counseling, (d) paid leave of absence, and (e) continuing education activities. A dearth of research exists regarding how often employers offer the above supports to counselor survivors of client suicide. Considering the deleterious impact of client suicide on the personal and professional functioning of counselor survivors, researchers have implored mental health organizations to provide supportive actions to the distressed individual (e.g., Michel, 1997).

For this study, we recruited a sample of counselor survivors who identified as having a client who completed suicide during their professional career. We explored the effect of supervisory and organizational support on participants' perception of the impact of client suicide. Participants also described the responses of their colleagues, supervisors, and agencies, and reported which responses participants viewed to be the most and least helpful for counselor survivors coping with client suicide.

Nathaniel J. Wagner, PhD, LMHC, is an assistant professor at Indiana State University. Colleen M. L. Grunhaus, PhD, NCC, ACS, LPC, is an assistant professor at the University of the Cumberlands. Victor E. Tuazon, PhD, NCC, LPC, is an assistant professor at New Jersey City University. Correspondence may be addressed to Nathaniel Wagner, 401 N. 7th Street, Terre Haute, IN 47809, nathaniel.wagner@indstate.edu.

Suicide is the 10th leading cause of death in the United States, and for younger populations (ages 15–24), suicide is the second leading cause of death (McIntosh & Drapeau, 2020). In a study of 5,894 deaths by suicide, Ahmedani et al. (2014) found that nearly one-third (29%) of individuals who completed suicide were enrolled in mental health services in the year prior to their death. In this same study, 45% of those who completed suicide had an appointment with a health professional resulting in a mental health diagnosis within the month prior to their completed suicide. In a national comorbidity survey (*N* = 5,692), Nock et al. (2010) found that 44.1% of those who attempted suicide were diagnosed with an anxiety disorder and 43% were diagnosed with a mood disorder. In total, Nock et al. estimated that 76% of people who attempt suicide have a mental disorder of some kind. Unsurprisingly, counselors are highly likely to work with clients who complete suicide. Approximately 25% of counselors will experience a client suicide (McAdams & Foster, 2002), and the vast majority of mental health professionals will encounter clients with presentations of suicidality or suicide attempts throughout the course of their career (Kleespies & Dettmer, 2000; McAdams & Foster, 2002; Rogers et al., 2001).

Counselors have some training to assess and respond to suicide risk through required trainings on models and strategies of suicide prevention as well as methods of suicide risk assessment (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015). Despite this experience and exposure, counselor survivors often reported feeling overwhelmed and unprepared, substantial emotional distress, and reduced work performance when a client suicide occurs (Ellis & Patel, 2012). Identifying avenues of support for affected counselors is paramount to address the harmful effects to counselor well-being and effectiveness.

The Impact of Client Suicide

The profound emotions counselor survivors experience when a client dies by suicide may be moderated by the length and quality of the therapeutic relationship (Grad & Michel, 2004; Luoma et al., 2002). Researchers found that counselor survivors experienced shock, disbelief, or numbness upon learning of a client suicide (Darden & Rutter, 2011; Sanders et al., 2005). Counselor survivors described strong emotions in the context of losing control; for example, some felt angry toward a mental health system that presumably failed the deceased client along with emotions related to grief and sadness (Christianson & Everall, 2009; Knox et al., 2006). Sadness was associated both with the loss of the client and regret that the client was unable to thrive (Sanders et al., 2005). Other counselor survivors experienced fear of litigation or guilt related to holding some responsibility for the death (Christianson & Everall, 2009; Grad & Michel, 2004). Shame impacted counselor survivors' self-conception as competent counselors and may have prevented them from admitting their fears to family and intimate partners (Darden & Rutter, 2011; Grad & Michel, 2004).

Behaviorally, counselor survivors often changed their professional practices after experiencing a client suicide. Some counselor survivors refused to see clients they perceived as potentially suicidal (Hendin et al., 2000). Knox et al. (2006) found that counselor survivors' sensitivity to suicide risk and client suicidal ideation may be heightened after client suicide. Loss of a client can lead to increased feelings of self-doubt. Darden and Rutter (2011) determined that approximately half of counselor survivors who participated in their study experienced increased self-doubt when working with clients who presented with suicidal ideations or intent. Similarly, Sanders et al. (2005) found that counselor survivors felt like professional failures after client suicide. On the other hand, counselor growth may also accompany the loss of a client. For example, some counselor survivors indicated using the pain of the experience to grow in their understanding and approach with suicidal clients (Grad & Michel, 2004; Sanders et al., 2005). This growth included greater self-confidence in clinical instincts because of what they learned from the suicide event (Sanders et al., 2005). Counselor survivors can also grow through external supportive resources such as supervision and support groups.

Supportive Resources

Researchers found that counselor survivors often look to the professionals around them (e.g., colleagues, supervisors, mental health professionals) to provide a response, support, or assistance in processing bereavement (Grad & Michel, 2004; Knox et al., 2006; Sanders et al., 2005). Counselor survivors' complex emotions and perception of failing as a professional can leave survivors grasping for assistance to make sense of the event. Professional responses to survivors vary and include chart audits (Grad & Michel, 2004), debriefing (Ting et al., 2006), or avoidance (Christianson & Everall, 2009; Darden & Rutter, 2011; Grad & Michel, 2004).

Organizational Support

Counselor survivors can benefit from organizational support and outreach in the wake of client suicide. Often, survivors experience frustration and isolation in unsupportive organizational contexts (Hendin et al., 2000). Counselor survivors indicated that institutional responses such as case reviews were rarely helpful and instead increased counselor survivor self-doubt and distress, particularly when these reviews included blame for the client suicide or false reassurance that the suicide was inevitable (Hendin et al., 2000).

On the other hand, supportive contexts that allow for increased social connection with colleagues and debriefing can be helpful (Ting et al., 2006). Michel (1997) suggested that debriefing sessions for the team may be beneficial for coping with client loss. Fairman et al. (2014) stated that when coping with a patient suicide, hospice clinical staff found team-based support strategies and debriefings supported counselor recovery. Alternatively, Michel reported that counselor survivors may find it difficult to disclose intimate and personal feelings to colleagues, especially in a team setting and without reassurance of confidentiality; these counselors may only disclose emotional problems to a personal therapist. Hendin et al. (2000) suggested that team-based debriefings may inhibit insight when they include platitudes such as "it's not your fault." Similarly, counselor survivors felt isolated by client suicide when coworkers offered empty assurances. On the other hand, counselor survivors felt supported and less isolated when coworkers shared their own experiences and demonstrated empathy (Hendin et al., 2000).

Counselor survivors may perceive organizational and collegial support as helpful, but researchers have not described the extent to which professional organizational support ameliorates the impact of the suicide event. Further research is needed to explore this interaction. In addition, further inquiry is needed to clarify what forms of organizational support are frequently offered to survivors of client suicide and which resources are most and least helpful.

Supervisory Support

Supervisors play a critical role in preparing for and responding to client suicidal behavior (Ellis & Patel, 2012). Knox et al. (2006) found that counselors-in-training who survived a client suicide appreciated when supervisors created a safe place to discuss the event, self-disclosed their experiences with client suicide, and provided reassurance that the suicide was not the fault of the counselor-in-training. Conversely, counselor survivors found conversations that were particularly critical of their actions prior to the client suicide, or insensitive to the counselors' experience of the loss, as prohibitive to coping (Knox et al., 2006). Ellis and Patel (2012) recommended that supervisors actively guide supervisees toward self-care (e.g., support-seeking, personal counseling) and reduced workloads, rather than expecting them to know how to manage their grief and professional concerns simultaneously.

Darden and Rutter (2011) found that counselor survivors without a direct supervisor perceived lack of supervision as a barrier to recovery from the loss. Alternatively, counselor survivors in training

programs can feel inhibited in fully processing grief and other emotional reactions with a supervisor who also is responsible for their professional evaluation (Gill, 2012). Counselor survivors without a strong supervisory relationship prior to the client suicide typically have limited access to effective and cathartic supervision experiences and to other professional support networks. Depending on the approach of the supervisor and the relationship between the supervisor and supervisee, supervision can be helpful or harmful. Further empirical research is needed to determine the effect of the supervisory relationship on the impact of the suicide event. In addition, more specific information related to agency and supervisory practices and policies that are helpful for counselor survivor recovery would provide further clarification.

Purpose of the Present Study

The following research questions guided our study: (a) Does the perceived support from a supervisor or an organization impact counselor survivors' experiences of client suicide?; (b) Which policies are most frequently utilized by agencies when a counselor experiences client suicide?; and (c) What interpersonal and agency responses are perceived to be most and least helpful for counselor survivors?

Method

Participants

Prior to data collection, the researchers were granted Institutional Review Board approval to conduct the research. We utilized Qualtrics as a survey management website to conduct a web-based survey to collect data from practicing counselors. We invited 9,521 counselors to participate; however, eligible participants were only counselors who experienced a client suicide, and many invited participants did not meet this study requirement. Potential participants' names and email addresses were accessed from the Florida licensing board and publicly available state counseling association directories, including those from Alabama, Connecticut, Georgia, Illinois, Kentucky, Maine, Missouri, New Hampshire, New Jersey, Rhode Island, Texas, and Wyoming. We distributed the survey through an initial email that provided a description of the study and included a link to the web-based survey. Potential participants who did not complete the survey and did not choose to opt out of the survey received a second email. Finally, participants who did not respond after the first two emails received a final email reminder. Emails and survey materials were developed according to the Tailored Design Method (Dillman et al., 2014). No incentive was provided for participation in this study.

Of the 9,521 potential participants contacted, 980 of the addresses provided were invalid. In addition, 172 individuals responded to the invitation and indicated that they had not experienced a client suicide. Out of the resulting 8,369 potential participants, 228 participants completed the survey (2.7% useable response rate). The response rate was low; however, only counselors who had experienced a client suicide were appropriate for the survey and it is likely that approximately 75% of those surveyed did not meet the qualifications for this survey (McAdams & Foster, 2002). Also, Dillman et al. (2014) noted that low response rates may be acceptable for niche populations that are difficult to directly access. We used an a priori power analysis (Balkin & Sheperis, 2011) with a power of .8, an alpha error probability of .05, and a .25 effect size, resulting in a required sample size of 200 for the most robust statistical test we used in our data analysis.

Our participants (*N* = 228) were predominately Caucasian females. Also, participants had a mean age of 49.1 (*SD* = 11.6, *Mdn* = 48) with 15.5 years of experience (*SD* = 10, *Mdn* = 14). Table 1 describes additional demographics of our participants, including their race/ethnicity, licensure status, professional orientation, and the agency type that employed them.

Table 1

Participant Demographics

Variable	*n*	%
Gender		
Female	175	76.8
Male	51	22.4
Other	2	0.9
Race/Ethnicity		
Caucasian	174	76.3
Black or African American	21	9.2
Hispanic or Latino	19	8.3
Multiracial	9	3.9
Asian	3	1.3
Native Hawaiian or Other Pacific Islander	1	0.4
Other	1	0.4
Professional Orientation		
Licensed professional counselors (LMHC, LPC etc.)	159	69.7
School counselors	43	18.9
Marriage and family therapists	7	3.1
Clinical psychologists	8	3.5
Social workers	3	1.3
Other	8	3.5
License Level		
Fully licensed	190	83.3
Provisional license	23	10.1
Other	15	6.6
Employment setting		
Outpatient	58	25.4
K–12 schools	54	23.7
Inpatient	43	18.9
Private practice	35	15.4
Community mental health	8	3.5
Corrections	8	3.5
College counseling	6	2.6
Intensive in-home	4	1.7
Social services	4	1.7
Government	4	1.8
Shelter and domestic violence	2	0.9
Telephone counseling	1	0.4
Religious-based counseling	1	0.4

Note. N = 228

Measures

For the purpose of this study, three measures were utilized: (a) the Short Supervisory Relationship Questionnaire (S-SRQ; Cliffe et al., 2016), (b) the Survey of Perceived Organizational Support (SPOS; Eisenberger et al., 1986), and (c) the Impact of Event Scale–Revised (IES-R; Weiss & Marmar, 1997). We also used open-response questions to ask about client suicide experiences and perceptions of agency responses. Participants completed a demographics form that queried participants' personal information (e.g., age, race, ethnicity, and gender) as well as professional experiences (e.g., discipline, years of experience, and agency responses).

S-SRQ

Cliffe et al. (2016) created the S-SRQ scale, which is an 18-item self-report scale to measure an individual's perception of their supervisory relationship with their supervisor. Respondents identified their level of agreement to each item on a 7-point Likert scale that ranged from *strongly disagree* to *strongly agree*. Sample statements on the S-SRQ include "my supervisor was approachable," "my supervisor encouraged me to reflect on my practice," and "supervision sessions were focused." Evidence for reliability was described by Cliffe et al., including internal consistency (α = .96), and test-retest reliability (r = .94). In the present study, the measure had excellent internal consistency as measured by Cronbach's alpha (α = .95).

SPOS

The SPOS is a one-factor scale created by Eisenberger et al. (1986). The SPOS scale measures whether individuals believe their organizations care about their well-being. The original scale had 32 items; however, we utilized the eight-item short form self-report measure. Respondents rated their agreement to each statement on a 7-point Likert scale (*strongly disagree* to *strongly agree*). The SPOS includes statements such as "The organization values my contribution to its well-being" and "Even if I did the best job possible, the organization would fail to notice." For scoring purposes, we reverse-scored negatively worded items and summed all items to find a final score. With the full scale, Eisenberger et al. found evidence of internal consistency (α = .97). The current sample had high internal consistency (α = .95).

IES-R

Weiss and Marmar (1997) created the IES-R scale to examine stress responses or PTSD symptoms following an event. The IES-R has 22 items and consists of three subscales, Intrusion (eight items), Avoidance (eight items), and Hyperarousal (six items). Participants responded to items asking about the degree of distress they have been experiencing in the previous 7 days. The IES consists of items such as "Other things kept making me think about it" and "I stayed away from reminders of it." Responses are on a 5-point Likert scale from 0 (*not at all*) to 4 (*extremely*). Participants took the scale twice—once as recommended relating to current experiences (IES-Rc) and once as they remembered their experiences during the first 7 days after the client suicide happened (IES-Rp). Weiss and Marmar reported evidence for good internal consistency for Intrusion (α = .89), Avoidance (α = .84), and Hyperarousal (α = .82). The current sample resulted in Cronbach's alphas of .90, .86, and .87 respectively. The adapted scale had similar Cronbach's alphas to the original scale, .90, .88, and .88, respectively.

Open-Ended Responses

We used open-ended questions to assess information not captured by the previous instruments and to gain insight into factors participants believed were helpful or unhelpful in the experience. We asked four open-ended questions: (a) "At the time of your first client suicide, what was most helpful in this experience?" (b) "At the time of your first client suicide, what was least helpful in this experience?" (c) "Thinking back on your experience of your first client suicide, what more could your

agency have done that you might have found helpful?" and (d) "Thinking back on your first client suicide, what would you have liked the agency to have done less of, or differently?"

Agency Policies

We asked participants to choose from a list of possible agency policies for responding to client suicide that their agency had in place at the time of the suicide. We also asked participants if they perceived these policies to be helpful in their coping with the event. Policy options included extra supervision, mandated counseling, mandated debriefing, mandated time off, additional paperwork, an option to select "other" along with a text box to explain, and an option for "no policy." Participants were encouraged to select all options that applied.

Data Analysis

A cross-sectional research design was utilized for this study. Upon completion of data collection, numerical data was transferred to SPSS (Version 23) to conduct statistical analyses. To assess responses to the open-ended questions, we followed Brown's (2009) method to individually code participants' responses into categorical themes and clusters. We then compared codes and negotiated results to come to a consensus on categories (Creswell & Poth, 2018). We assessed frequencies and descriptive statistics of these themes to determine the most prevalent participant responses. We examined statistical assumptions (e.g., independence of cases, normality, and homoscedasticity; Tabachnick & Fidell, 2007) for each measure, including the Kolmogorov-Smirnov measure for normality. Data were analyzed with frequencies and descriptive statistics, Pearson's correlations, one-way analysis of variance (ANOVA), and a simple linear regression (SLR), independent samples t-test, and chi-square goodness-of-fit and tests of independence.

Results

Our first research question examined the impact of supervision and organizational supports as moderators of the impact of client suicide on counselor survivors. More specifically, we wanted to determine whether or not the supervisory relationship (S-SRQ; Cliffe et al., 2016) and counselors' perceptions of organizational support (SPOS; Eisenberger et al., 1986) predicted the impact of client suicide on the counselor survivor at the time of the event (IES-Rp; Weiss & Marmar, 1997) and at the present (IES-Rc; Weiss & Marmar, 1997). The findings of this research question are reported below.

Participants who reported being under supervision when they experienced a client suicide (n = 118) completed the S-SRQ (M = 96.9, SD = 25) as a measure of their supervisory relationship, and the IES-Rp (M = 45.1; SD = 15.9) and IES-Rc (M = 26.6; SD = 8.4). An SLR was calculated to predict the impact of events at the time of the event based on the counselor survivor's supervisory relationship at the time of the event. A significant regression equation was found ($F[1,116]$ = 6.9, p = .01) with an R^2 of .06. Participants' impact of events at the time of the event decreased .15 for each point increase in supervisory relationships. This indicates that a strong supervisory relationship at the time of a client suicide may help mitigate counselor survivors' symptoms. An SLR was also calculated to examine the impact of events at the present with their supervisory relationship at the time of the event. However, the findings were not significant ($F[1,116]$ = 57.53, p = .37), suggesting that any differences found between supervisory relationship and the current impact of events may be attributed to chance.

All respondents (N = 228) completed the SPOS (M = 23.9, SD = 3.5), the IES-Rp (M = 43.7, SD = 16.1), and the IES-Rc (M = 26.8, SD = 9.4). Bivariate correlations revealed a lack of significance between SPOS and either impact of events scale (p = .6 for each). We also conducted an ANOVA to examine the

effect of perceived level of support based on agency type and found no significant difference in SPOS scores based on agency type ($F[7, 220] = 1.084$, $p = .4$). Contrary to expectations, SPOS did not seem to affect the counselor survivors' experience of client suicide.

Agency Responses
    Our second research question inquired about agency policies governing responses to the counselor survivor at the time of a client suicide. Possible agency policies that respondents could choose from included no policy; debriefing of the event; required paperwork; extra supervision; mandated personal counseling; mandated time off; and a final category, "other," which allowed respondents to fill in an answer that was not listed in the choices. Respondents were provided with the opportunity to choose as many responses as applied; thus, the responses cumulatively totaled over 100%. The most frequently indicated response for agency-initiated policies was no policy ($n = 118$, 52%). This was followed by mandated debriefing of the event ($n = 63$, 28%), required paperwork ($n = 57$, 25%), extra supervision ($n = 16$, 7%), mandated counseling ($n = 8$, 4%), and mandated time off ($n = 4$, 2%). Fourteen respondents (6%) chose "other" to indicate that the agency enforced a policy not listed in the choices. Write-in responses that differed from the listed choices included group debriefing ($n = 6$), psychological autopsy ($n = 2$), notification of administrators ($n = 2$), crisis team intervention ($n = 1$), and liability review ($n = 1$).

    We conducted a chi-square test of independence to determine if agency type differed according to the presence of an agency policy for counselor support at the time of suicide. Because of insufficient group size of some of the agency types, only participant responses from agency types that had over five participants (outpatient [$n = 59$], K–12 schools [$n = 54$], private practice [$n = 34$], acute psychiatric [$n = 26$], and residential [$n = 16$]) were included in the analysis. A significant difference was detected with this test ($\chi^2 = 14.3$, $p < .01$), which indicated that some agency types may be more likely to have a policy in place than others. We then followed up with multiple chi-square goodness-of-fit tests, which revealed that participants who worked in acute psychiatric settings ($n = 26$, $\chi^2 = 5.6$, $p < .05$) were significantly more likely to have a policy in place than other agency types, and participants who worked in private practice settings ($n = 34$, $\chi^2 = 5.77$, $p < .05$) were significantly more likely to have no policy in place than participants who worked in other settings.

Helpfulness of Agency Responses
    Regarding our third research question, participants ($N = 228$) were asked to rate the level of helpfulness of responses to client suicide. Of the participants who reported receiving counseling after client suicide ($n = 99$, 43%), 54 (55%) participants reported that this agency response was either very helpful or extremely helpful. Additionally, 28 (28%) participants reported counseling as moderately helpful, 13 (13%) reported counseling as a little helpful, and four (4%) participants reported counseling as not helpful at all.

    Over one-third ($n = 77$, 34%) of participants reported that they took time off work after a client suicide. Most of the participants who reported taking time off reported it was very helpful or extremely helpful ($n = 41$, 53%). This was followed by those who found time off as moderately helpful ($n = 15$, 20%), a little helpful ($n = 12$, 16%), and not helpful at all ($n = 9$, 12%).

    Participant responses to our questions inquiring about agency policies and mandated responses differed from responses to perceived helpfulness of agency responses. For example, only eight individuals indicated that their agency mandated personal counseling, whereas 99 individuals indicated that they engaged in personal counseling after the event and rated the perceived helpfulness of the counseling. Similarly, only four participants indicated their agency required they

take time off, whereas 77 participants reported that they took time off and rated the helpfulness of this response. These discrepancies are likely due to the wording of "mandated" in the item choices related to agency policy responses, as most participants ($n = 118$, 52%) indicated that their agencies had no formal policy.

Participants described debriefing discussions related to the counselors' emotional experience of the event ($n = 140$, 61%) and the actions of the counselor leading up to the event ($n = 136$, 59%). Sixty-three (45%) participants described debriefings related to the emotions of the experience as very helpful or extremely helpful. Other participants expressed that emotional debriefing was moderately helpful ($n = 31$, 22%), a little helpful ($n = 36$, 26%), or not helpful at all ($n = 10$, 7%). Debriefings related to the actions of the counselor were reported by 60 (44%) participants to be very helpful or extremely helpful, whereas 34 (25%) participants identified them as moderately helpful, and 42 participants indicated that debriefing of the actions of the counselor was either a little helpful ($n = 26$, 19%) or not helpful ($n = 16$, 12%).

Participants ($n = 92$, 40%) also described their perception of audits of the client's chart. About half of the respondents ($n = 47$, 51%) described their audit experience as only a little helpful or not helpful. Fewer ($n = 24$, 26%) found audits to be very helpful or extremely helpful and 13 (14%) respondents indicated audits as moderately helpful.

Some participants ($n = 72$, 32%) reported agencies providing additional training for counselors when there was a suicide in the agency. Additional training was reported as very helpful or extremely helpful 63% of the time ($n = 45$). Twenty-four (33%) participants described additional training as moderately helpful, whereas three (4%) participants indicated receiving additional training as not helpful at all. Only 25% ($n = 58$) of participants were provided with increased supervision. Twenty-five (43%) of these participants found it very helpful or extremely helpful, 11 (19%) viewed their additional supervision as moderately helpful, and 22 participants (38%) reported increased supervision as only a little helpful or not helpful at all.

Strategies to Improve Agency Responses
We asked participants open-ended questions regarding agency responses that should be improved, changed, or reduced to improve care of future counselor survivors and categorized these into themes. The most frequent response, which occurred in 29% ($n = 94$) of responses, indicated that increased empathy and acknowledgement of the traumatic nature of the experience would be most helpful. Sample statements from participants included "more focus on the emotional impact on the clinicians," "reacted to me as a person and as someone who was also grieving instead of just someone who needed to do their job," "given me some attention and validation for my distress," "the school I was at never asked about my wellness," and "I felt like the suicide was viewed as an unfortunate part of being a counselor." Some participants ($n = 51$, 18%) described a need for more thorough debriefing and discussion of the event (e.g., "provide a more thorough debriefing," "been more open to processing the issue").

Many participants ($n = 37$, 11%) indicated feeling unprepared to deal with client suicide and recommended further training and resources so that they would be better prepared if they or others were to face a similar situation again. Similarly, participants reported that it would be helpful if their employers had clearer policies and procedures about how to handle client suicide. Participants expressed a desire for agencies to provide policies and procedures ($n = 34$, 11%) and indicated that these policies should not focus solely on "pointing the finger" or assigning blame ($n = 17$, 5%) but on the emotional impact of the death on counselor wellness.

Discussion

Client suicide is a painful personal and professional experience for counselors (Ellis & Patel, 2012). Unfortunately, client suicide is not a rare occurrence for counselors (McAdams & Foster, 2000). For the purpose of our study, we examined how organizational and supervisory support might mitigate the impact of the client suicide on counselor well-being. We also examined the supports offered in various work environments and the perceived helpfulness of this outreach in counselor survivor coping.

Supervisory Support

Our first research question was related to the effect of supervisor and organizational support on the impact of client suicide on the counselor survivor. Based on our findings, stronger supervisor relationships seemed to help participants process their experience of client suicide. This may align with Knox et al. (2006), who suggested that negative interactions with supervisors can prohibit the counselor's coping. Conversely, supportive supervisory interactions, such as those actions that address counselor survivors' grief and loss experiences (e.g., accepting responses, openly discussing the loss and trauma, creation of a safe environment), could have a lasting impact on the counselor survivors' recovery (Ellis & Patel, 2012). According to Broadbent (2013), supportive supervision assisted grieving counselors in experiencing greater empathy and connectedness within their future therapeutic relationships. Effective supervision included developing a safe place in which supervisees felt "heard and witnessed" and affirmed (Broadbent, 2013, p. 268).

We did not find supervisory relationships to have a significant impact on participants' experience at the present. We suspect that one reason for the lack of impact of supervisory relationships on the current impact of events was that the grief and trauma may have changed and lessened over time, as evidenced by a dramatic reduction in mean scores between IES-Rp and IES-Rc (45 and 27 respectively). Similarly, other life events may have influenced the counselor survivors between the suicide of their client and the present which could serve to diminish the impact of the supervisory relationship on how participants perceived client suicide.

Implications for Mental Health Organizations

Surprisingly, we found no effect of organizational support and the impact of the event on counselor survivors. A number of questions from the SPOS were focused on the employee's contribution, accomplishments, and effort. However, when coping with client suicide participants reported a desire for emotional care and support. Based on our quantitative data, the support participants perceived from agencies did not influence the IES scores, but participants' qualitative responses revealed they valued agency responses that demonstrated support for the counselor as a person (e.g., additional counseling, empathy, debriefings related to the counselor's experience).

Participants expressed a desire for agencies to treat them more holistically, and to recognize that they had experienced a trauma. Other researchers also indicated need for empathic support for the clinician following a client suicide. For example, Ellis and Patel (2012) expressed that "clinicians and supervisors should recognize the right (and responsibility) to engage in self-care activities following a client's suicide" (p. 285). In contrast, our participants reported finding administrative responses focused on agency liability (e.g., chart audit, debriefings related to the actions of the counselor survivor) as unhelpful.

Nearly half of participants indicated that debriefings were helpful. Participant responses to open-ended questions indicated that debriefings were helpful when focused on the emotional experience of the event. In practice, agencies can work to enhance the debriefing procedures they use. The authors

encourage agencies to carefully avoid blaming or finger pointing within debriefing procedures, as these responses often have deleterious effects on counselor survivors. Instead, agencies can provide an environment in which the client suicide can be discussed safely and openly, and offer an opportunity for learning and growth.

Despite relatively infrequent agency utilization, counselor survivors who received trainings related to suicide prevention reported these trainings as one of the most helpful responses to client suicide. Many participants reported not feeling prepared for a client suicide and a desire that their agency would have provided additional trainings that could have prepared them for the loss or helped them better respond to the suicidal client. Trainings may include a wide variety of topics such as factors to look for to recognize suicidal ideation, development of a concrete method of responding to expressions of suicidal ideation/intent, discussion of consultation practices, possible steps that a counselor may take when facing client suicidal ideation, when to explore hospitalization, and how to increase the network of people who know about the client's suicidal ideations. Participants reported that increased trainings would heighten their self-efficacy in working with clients experiencing suicidal ideation, intent, and planning. Additional training may help counselors feel more prepared to work with suicidal clients and thereby reduce client suicide while also increasing the counselor's feelings of competence (e.g., Ellis & Patel, 2012).

Training should not only include knowledge and skills, but also the development of appropriate attitudes around client suicide (Ellis & Patel, 2012; Michel, 1997). Considering the lack of self-efficacy identified by our participants in response to client suicide, when developing additional trainings, we suggest consideration of Bandura's theory of self-efficacy which holds that mastery experiences, vicarious experiences, and verbal persuasion can be used to increase confidence (Bandura, 1986). Trainings developed with bolstering self-efficacy in mind can help counselors develop beliefs that they can effectively work with suicidal clients. Best practice indicates that trainings should occur after the counselor survivor has time to recover, whereas supportive resources to assist with grief reactions can be offered immediately following the event (Dransart et al., 2017).

Agencies and supervisors must develop a realistic sense of the extent and limits of a clinician's responsibilities regarding client suicide (Ellis & Patel, 2012), but they must do so in an empathic manner. Our participants often reported feeling ill-prepared for client suicide, and then blamed, questioned, or challenged about their treatment of the client; this unempathetic response was prohibitive to counselor coping. Agencies and supervisors can instead offer more helpful supportive resources such as emotional debriefing, time off, and personal counseling, and then implement suicide prevention trainings to bolster self-efficacy after the counselor survivor has stabilized. Suicide prevention training is effective in preventing suicide and in reducing self-doubt and questioning when a suicide occurs (Dransart et al., 2017).

Suicide Response Policy

Over 50% of respondents shared that their agency did not have a formal policy of response to the counselor survivor. Although we found no effect of this lack of protocol on participants' IES scores, participants from this study, along with researchers in other studies, have suggested that agency responses can be valuable supports to counselor survivors (e.g., Hendin et al., 2000; Michel, 1997; Ting et al., 2006). Counselor survivors in our study reported that organized and empathic agency responses were helpful for their recovery. We found that organizations that predominantly treat higher acuity cases (i.e., acute psychiatric) may be more likely to have a policy in place, perhaps because of the frequency of suicide. However, even agencies less likely to experience client suicide would benefit from a pre-planned agency response policy.

Although organizations and supervisors may have informal responses to counselor survivors and clinical teams, researchers (e.g., Michel, 1997; Ting et al., 2006) have argued that a formal policy can have some beneficial effects. Postvention is an organized response that provides "psychological support, crisis intervention and other forms of assistance" to survivors of suicide (Higher Education Mental Health Alliance, 2018, p. 6). Based on our findings, helpful formal postvention policies include debriefing of the counselor survivor's emotional experience, suggested time off for self-care and personal counseling, and recommended follow-up trainings for handling future suicidality in clients.

Larger mental health treatment teams such as community mental health agencies or university counseling centers may develop a postvention team that creates a hierarchy and communication chain for informing appropriate parties (including the counselor survivor) in a timely and sensitive manner. Michel (1997) suggested this postvention should include tiered plans specific to staff levels (e.g., therapists, supervisors, administration) that take into consideration confidentiality and the professional closeness of the employee to the client. Thus, responses to those who work closely with the client (e.g., counselor survivors) may be different than to those who are more removed from the client (e.g., administration).

Beyond simply having an action plan, based on our findings and our literature review (e.g., Dransart et al., 2017), we believe that agencies should specifically focus on trainings conducted as preventative measures. Some trainings should include information on how to recognize factors that increase suicide risk among clients. Additional needed trainings may address how to respond to high-risk clients and clients who report suicidal ideations or intent.

Limitations and Future Research

Our study was a cross-sectional survey study; as such, we were only able to examine one point in time. We asked participants to reflect on their experiences of client suicide and how it impacted them at the time, as well as how they currently experienced the impact. The passage of time likely influenced participants' memories of their traumatic experience and might have impacted our results. Because of these limitations, future longitudinal examination of the experience of client suicide may be warranted. Our low response rate, though acceptable based on the niche population (Dillman et al., 2014), and our use of convenience sampling inherently reduces the generalizability of our findings. We cannot claim that the counselors we found through this method are representative of all counselor survivors. As such, future research that can reach a more representative sample of counselors who have experienced a client suicide could be valuable in reproducing our findings.

There also may be some limitations with our scales. The IES-R scale was originally created to account for the impact of events as perceived within the last 7 days (Weiss & Marmar, 1997) and our use of the IES for recalling past experiences has limited supporting evidence. In addition, the SPOS scale may have been focused more on the organizational structure as opposed to the immediate working environment the counselor survivors faced. Although our findings are generally consistent with previous researchers (e.g., Ellis & Patel, 2012; Michel, 1997), they should be considered in light of these limitations.

Summary and Implications for Counseling

Our findings highlight client suicide as a traumatic event for counselor survivors and their subsequent desire for emotional support in the aftermath. Our results inform counselors and mental health agencies of ways they can provide an active and emotionally aware response that recognizes the impact of the event and the myriad of emotions the counselor survivor might be experiencing. Our findings especially indicate the need for counselors to receive supportive supervision (e.g., that supervisors are

approachable, respectful, non-judgmental, and collaborative; Cliffe et al., 2016), as this seems to impact counselor survivors' experience of client suicide. Our findings support the need for counselors to continue to take care of themselves, find support from others, and pursue their own counseling.

For community agencies, administrators, and supervisors, having an action plan detailing how the agency will respond to crises such as client suicide may increase the thoroughness of agency responses to affected individuals including the counselor survivor. The development of a crisis plan increases sensitivity and awareness, and contributes to the development of an institutional culture in which postvention after a client suicide is common practice. Considering the potential benefits of having an action plan, the number of respondents who suggested the agency where they are employed has no protocol or plan in place in the event of a client suicide is concerning. Recommended agency policies may include encouraging the counselor survivor to engage in personal counseling or take time off, or facilitating empathic debriefings and future suicide prevention trainings.

References

Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., Lynch, F., Owen-Smith, A., Hunkeler, E. M., Whiteside, U., Operskalski, B. H., Coffey, M. J., & Solberg, L. I. (2014). Health care contacts in the year before suicide death. *Journal of General Internal Medicine*, *29*(6), 870–877. https://doi.org/10.1007/s11606-014-2767-3

Balkin, R. S., & Sheperis, C. J. (2011). Evaluating and reporting statistical power in counseling research. *Journal of Counseling & Development*, *89*(3), 268–272. https://doi.org/10.1002/j.1556-6678.2011.tb00088.x

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Prentice Hall.

Broadbent, J. R. (2013). 'The bereaved therapist speaks.' An interpretative phenomenological analysis of humanistic therapists' experiences of a significant personal bereavement and its impact upon their therapeutic practice: An exploratory study. *Counselling and Psychotherapy Research*, *13*(4), 263–271. https://doi.org/10.1080/14733145.2013.768285

Brown, J. D. (2009). Open-response items in questionnaires. In J. Heigham & R. A. Croker (Eds.), *Qualitative research in applied linguistics: A practical introduction* (pp. 200–219). Palgrave MacMillan.

Christianson, C. L., & Everall, R. D. (2009). Breaking the silence: School counsellors' experiences of client suicide. *British Journal of Guidance & Counselling*, *37*(2), 157–168. https://doi.org/10.1080/03069880902728580

Cliffe, T., Beinart, H., & Cooper, M. (2016). Development and validation of a short version of the Supervisory Relationship Questionnaire. *Clinical Psychology & Psychotherapy*, *23*(1), 77–86. https://doi.org/10.1002/cpp.1935

Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP standards*. http://www.cacrep.org/wp-content/uploads/2017/08/2016-Standards-with-citations.pdf

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE.

Darden, A. J., & Rutter, P. A. (2011). Psychologists' experiences of grief after client suicide: A qualitative study. *Omega: Journal of Death and Dying*, *63*(4), 317–342. https://doi.org/10.2190/OM.63.4.b

Dillman, D. A., Smyth, J. D., & Christian, L. M. (2014). *Internet, phone, mail, and mixed-mode surveys: The tailored design method* (4th ed.). Wiley.

Dransart, D. A. C., Treven, M., Grad, O. T., & Adriessen, K. (2017). Impact of client suicide on health and mental health professionals. In K. Andriessen, K. Krysinska, & O. T. Grad (Eds.), *Postvention in action: The international handbook of suicide bereavement support* (pp. 245–254). Hogrefe.

Draper, B., Kõlves, K., De Leo, D., & Snowdon, J. (2014). The impact of patient suicide and sudden death on health care professionals. *General Hospital Psychiatry*, *36*(6), 721–725. https://doi.org/10.1016/j.genhosppsych.2014.09.011

Eisenberger, R., Huntington, R., Hutchison, S., & Sowa, D. (1986). Perceived organizational support. *Journal of Applied Psychology*, *71*(3), 500–507. https://doi.org/10.1037/0021-9010.71.3.500

Ellis, T. E., & Patel, A. B. (2012). Client suicide: What now? *Cognitive and Behavioral Practice*, *19*(2), 277–287. https://doi.org/10.1016/j.cbpra.2010.12.004

Fairman, N., Thomas, L. P. M., Whitmore, S., Meier, E. A., & Irwin, S. A. (2014). What did I miss? A qualitative assessment of the impact of patient suicide on hospice clinical staff. *Journal of Palliative Medicine*, *17*(7), 832–836. https://doi.org/10.1089/jpm.2013.0391

Gill, I. J. (2012). An identity theory perspective on how trainee clinical psychologists experience the death of a client by suicide. *Training and Education in Professional Psychology*, *6*(3), 151–159. https://doi.org/10.1037/a0029666

Grad, O. T., & Michel, K. (2004). Therapists as client suicide survivors. *Women & Therapy*, *28*(1), 71–81. https://doi.org/10.1300/J015v28n01_06

Hendin, H., Lipschitz, A., Maltsberger, J. T., Haas, A. P., & Wynecoop, S. (2000). Therapists' reactions to patients' suicides. *The American Journal of Psychiatry*, *157*(12), 2022–2027. https://doi.org/10.1176/appi.ajp.157.12.2022

Higher Education Mental Health Alliance. (2018). *Postvention: A guide for response to suicide on college campuses.* http://hemha.org/wp-content/uploads/2018/06/jed-hemha-postvention-guide.pdf

Kleespies, P. M., & Dettmer, E. L. (2000). An evidence-based approach to evaluating and managing suicidal emergencies. *Journal of Clinical Psychology*, *56*(9), 1109–1130.

Knox, S., Burkard, A. W., Jackson, J. A., Schaack, A. M., & Hess, S. A. (2006). Therapists-in-training who experience a client suicide: Implications for supervision. *Professional Psychology: Research & Practice*, *37*(5), 547–557. https://doi.org/10.1037/0735-7028.37.5.547

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry*, *159*(6), 909–916. https://doi.org/10.1176/appi.ajp.159.6.909

McAdams, C. R., III, & Foster, V. A. (2000). Client suicide: Its frequency and impact on counselors. *Journal of Mental Health Counseling*, *22*(2), 107–121.

McAdams, C. R., III, & Foster, V. A. (2002). An assessment of resources for counselor coping and recovery in the aftermath of client suicide. *The Journal of Humanistic Counseling, Education and Development*, *41*(2), 232–241. https://doi.org/10.1002/j.2164-490X.2002.tb00145.x

McIntosh, J. L., & Drapeau, C. W. (2020). *U.S.A. suicide 2018: Official final data*. American Association of Suicidology. https://suicidology.org/wp-content/uploads/2020/02/2018datapgsv2_Final.pdf

Michel, K. (1997). After suicide: Who counsels the therapist? *Crisis*, *18*(3), 128–130. https://doi.org/10.1027/0227-5910.18.3.128

Nock, M. K., Hwang, I., Sampson, N. A., & Kessler, R. C. (2010). Mental disorders, comorbidity and suicidal behavior: Results from the National Comorbidity Survey Replication. *Molecular Psychiatry*, *15*(8), 868–876. https://doi.org/10.1038/mp.2009.29

Rogers, J. R., Gueulette, C. M., Abbey-Hines, J., Carney, J. V., & Werth, J. L. (2001). Rational suicide: An empirical investigation of counselor attitudes. *Journal of Counseling & Development*, *79*(3), 365–372. https://doi.org/10.1002/j.1556-6676.2001.tb01982.x

Sanders, S., Jacobson, J., & Ting, L. (2005). Reactions of mental health social workers following a client suicide completion: A qualitative investigation. *Omega: Journal of Death and Dying*, *51*(3), 197–216. https://doi.org/10.2190/D3KH-EBX6-Y70P-TUGN

Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics* (5th ed.). Allyn & Bacon.

Ting, L., Sanders, S., Jacobson, J. M., & Power, J. R. (2006). Dealing with the aftermath: A qualitative analysis of mental health social workers' reactions after a client suicide. *Social Work*, *51*(4), 329–341. https://doi.org/10.1093/sw/51.4.329

Weiss, D. S., & Marmar, C. R. (1997). The Impact of Event Scale—Revised. In J. P. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399–411). Guilford.

nbcc.

Toward Culturally Competent School Counseling Environments: Hip-Hop Studio Construction

Ian P. Levy, Edmund S. Adjapong

Literature on the physical design of counseling spaces suggests that calm and comfortable school counseling offices support students' emotional disclosure. However, many counseling environment design studies fail to consider the perspectives of clients. Scholars have called for school counselors to invite youth to co-create interventions as a means to promote cultural responsiveness and honor students' cultural knowledge. The goal of the current exploratory action research was to bring visibility to the experiences of students who participated in a classroom-based school counseling intervention in which they co-created a hip-hop studio as a social and emotional support space. Specifically, focus groups on the value of the co-creation of a hip-hop studio for urban youth were employed. Results suggested students experienced the studio as a shared space for inclusivity, comfort, and belonging; a place to make their own design choices; and a practice space to garner peer support, engage in personal self-development, and support others.

Keywords: counseling environment, urban youth, classroom-based, hip-hop, cultural responsiveness

The physical design of counseling spaces by counseling professionals has been well explored in counseling literature (Devlin et al., 2013; Liddicoat, 2010; Miwa & Hanyu, 2006; Pressly & Heesacker, 2001). Counselor office design has primarily focused on the counselor's preference for office design and has failed to take into consideration the psychological state of clients who are in pursuit of counseling services (Sanders & Lehmann, 2019). Historically, researchers explored how counselors' control over their office design mitigated stress and increased job satisfaction (Pressly & Heesacker, 2001). Pressly and Heesacker (2001) found that counselors who were unhappy with their office may communicate that frustration to their clients. Further, pleasant environments were found to foster creativity, a sense of well-being, and job satisfaction for practicing counselors (Ceylan et al., 2008).

More recently, school counselors reported that their creation of calm and comfortable counseling offices supported students' emotional disclosure (Cook & Malloy, 2014). Counseling office design elements that have been found to be important for the satisfaction of counselors and clients include overall aesthetics and layout, particularly dim lighting (Liddicoat, 2015; Miwa & Hanyu, 2006; Phelps et al., 2008), as well as access to daylight and space for privacy (Huffcut, 2010). In addition, the layout of a counseling office is strongly correlated with a client's psychological state, suggesting that environmental structure can allow clients to evoke emotions and confront discrepancies in their self-concept (Liddicoat, 2015). Goelitz and Stewart-Kahn (2008) expressed a need for counselors to consider the experiences of their clients when designing a counseling environment. Although research shows that aesthetic changes to a counseling environment can support a variety of client outcomes, a specific process for the creation of counseling offices is missing within the literature (Pearson & Wilson, 2012).

Additionally, given the current body of research, scholars note the importance of creating counseling environments that align with client preferences. A recent qualitative study conducted by Sanders and

Ian P. Levy, EdD, is an assistant professor at Manhattan College. Edmund S. Adjapong, PhD, is an assistant professor at Seton Hall University. Correspondence may be addressed to Ian Levy, 4513 Manhattan College Pkwy, The Bronx, NY 10471, ilevy01@manhattan.edu.

Lehmann (2019) indicated clients reported a sense of comfort when a counseling office felt more like a home or a lounge than like a traditional office space. Research has also emphasized the importance of school counselors developing an in-depth understanding of a client's social context as well as their cultural values and differences (McMahon et al., 2014; Ratts et al., 2016), further stressing a need to understand clients' preferences when designing emotionally supportive environments.

Client-Centered Office Design

Considering office design, Benton and Overtree (2012) posited that an understanding of clients' cultural differences was imperative for making design choices. Similarly, Devlin et al. (2013) found that counselors who displayed artwork from different cultures in their office were perceived by clients as being more culturally competent. Decisions to hang artwork might be based on Ponterotto and Austin's (2005) multicultural competence checklist, which suggested that "the physical surroundings of the program area reflect an appreciation of cultural diversity (e.g., artwork, posters, paintings, languages heard)" (p. 31). Beyond this checklist, however, Benton and Overtree (2012) suggested "no research or detailed guidelines on the critical physical elements to consider in designing a multiculturally friendly office" were available (p. 266). Although not in office design research explicitly, L. Smith and Chambers (2015) recommended school counselors invite youth to co-create counseling interventions as a means to promote cultural responsiveness and honor the cultural knowledge youth bring into counseling sessions. School counselors are also responsible for understanding students in the context of their own environments, in an effort to deploy culturally sensitive interventions (Hansen et al., 2014).

School Counselor Collaboration

When determining how school counselors might best employ culturally sensitive interventions, collaborative efforts are of particular value. The American School Counselor Association (ASCA; 2015) released a position statement suggesting that "school counselors demonstrate cultural responsiveness by collaborating with stakeholders to create a school and community climate that embraces cultural diversity and helps to promote the academic, career and social/emotional success for all students" (p. 24). Ratts and Greenleaf (2018) argued for school counselors to use multicultural and social justice approaches to combat threats to their students' academic, career, and personal/social development. Using these approaches requires that school counselors create school–family–community partnerships to collaborate with all stakeholders in support of equitable and socially just school counseling interventions (Bryan et al., 2019). However, an ASCA (2019a) national dataset suggested student-to-counselor ratios in the United States are 455 students to one school counselor, far higher than the recommended 250-to-1 ratio. These results are not surprising given prior research demonstrating that school counselors are often inundated with large caseloads and non–school counseling duties, which hinders their ability to engage in direct academic, career, and personal/social development services (Kim & Lambie, 2018; Mau et al., 2016).

In response to caseload issues, school counselors are encouraged to collaborate with teachers to provide indirect services to all students (Cholewa et al., 2016). Researchers noted the success of social skills–based classroom counseling to support students' social, personal, and academic concerns (Bostick & Anderson, 2009). A study on classroom emotional climate suggested that classroom environments that promote students' autonomy and expression of ideas are predictive of increased academic achievement (Reyes et al., 2012). School counselors are also urged to act as consultants, supporting teachers in developing interventions within their classrooms to address identified social and emotional needs (ASCA, 2019b). Researchers have recommended that school counselors collaborate with principals on school-wide initiatives that support all stakeholders in delivering the counseling curriculum, noting principal–counselor collaboration as significantly correlated with positive school climate (Rock et al., 2017).

In the implementation of a comprehensive school counseling program, school counselors are urged to use interventions like advisory councils (composed of representatives from all stakeholders, including students) to support student outcomes (ASCA, 2019b). However, the implementation of school-wide school counselor–led interventions lacks a specific focus on cultural responsiveness (Betters-Bubon et al., 2016). Therefore, in order to adequately support the academic, career, and personal/social development of all students within a school, school counselors are encouraged to collaborate with ancillary staff who can carry out interventions that meet these developmental outcomes (ASCA, 2019b). In fact, in the current study, a collaboration is explored to support a school counselor—who had a 700-to-1 caseload—with the indirect implementation of a classroom-based school counseling intervention to aid students' social and emotional development.

Counselor–Advocate–Scholar Model

This study strategically drew upon the counselor–advocate–scholar (CAS) model to engage various school-based stakeholders in the deployment of a culturally sensitive classroom-based school counseling intervention. The CAS model is built on the presumption that counselors who solely use office-bound interventions are unfit to address issues of social injustice (Ratts, 2009). In other words, the issues that Black and Brown youth and other marginalized groups bring into session are not solely internal and are likely symptomatic of larger societal ills that need to be addressed through outside-of-office interventions. Therefore, building upon research that suggests community-based counseling practices are particularly useful in supporting historically marginalized groups (Bailey et al., 2007), Ratts (2009) posited that counselors must hold alternative counseling roles and use interventions outside of the office.

The CAS model indicates counselors should have three roles: 1) the counselor, 2) the advocate, and 3) the scholar. The *counselor* role entails the use of culturally responsive approaches to in-office counseling, which assists clients in analyzing emotional experiences (Ratts & Greenleaf, 2018). Ratts and Pedersen (2014) defined the role of an *advocate* as leaving the four walls of the counseling office to advocate for interventions that transcend talk therapy and address larger systemic concerns. They described the *scholar* role as the ability to research and evaluate one's own interventions to inform the development of best practices that support clients and their own advocacy efforts. Together these three roles form *multicultural–social justice praxis*, a reminder that counselors must transition between these roles to support clients in navigating internal and external forms of oppression (Ratts & Pedersen, 2014).

Hip-Hop Culture

In pursuit of using multicultural practice in schools, recent researchers have demonstrated that urban inner-city youth identify as part of hip-hop culture and have explored the use of hip-hop pedagogy (Adjapong, 2017; Adjapong & Emdin, 2015). Given the importance of school counselors honoring their students' cultural knowledge (Hannon & Vereen, 2016), a hip-hop–based school counseling framework can be intentionally used to guide the implementation of the CAS model. Hip-hop culture is rooted in the corralling of a community to combat social inequities (Chang, 2005). The emergence of hip-hop culture was in direct response to the systemic and structural changes in the 1970s South Bronx (Caro, 1975; Chang, 2005). In the midst of an economic crisis, hip-hop culture was conceived by youth who critiqued and commented on social issues facing inner-city communities (Forman, 2002). To support the practice of hip-hop culture, hip-hop often exists within physical spaces, such as block parties, concerts, or recording studios (Harkness, 2014).

Hip-Hop and Spoken Word Therapy

Because of the growing influence of hip-hop culture, many scholars and practitioners have explored the power and potential of hip-hop lyric writing, analysis, and discussion as culturally responsive

interventions in the counseling process (Kobin & Tyson, 2006; Travis & Deepak, 2011; Tyson, 2002; Washington, 2018). This research engendered hip-hop and spoken word therapy (HHSWT), a culturally responsive counseling process whereby students engage in previously validated counseling interventions through the process of writing, recording, and performing hip-hop music (Levy, 2012; Levy & Keum, 2014). The development of HHSWT over time has thoroughly examined varying hip-hop cultural processes and how those might be used inside counseling offices. For instance, HHSWT offers clinicians a set of hip-hop–centered tools that they can use in the counseling process to support youth in exploring difficult thoughts and feelings. These tools include the hip-hop cypher to support group process and sharing (Levy, Emdin, & Adjapong, 2018), creating emotionally themed mixtapes (Levy, Cook, & Emdin, 2018), lyric writing as emotive journaling, and dyadic song collaboration as role-play (Levy, 2019). Each of these HHSWT techniques offers a culturally salient process in which youth of color can disclose and process difficult thoughts and feelings with their counselor. Levy (2019) found a school counselors' use of HHSWT in group counseling inside of a school hip-hop recording studio positively supported students' social and emotional development.

The Hip-Hop Recording Studio

When aiming to design culturally responsive counseling environments, it is important to note that the hip-hop recording studio also has held an important place in hip-hop culture and is largely unexplored in counseling literature. Harkness (2014) defined *the hip-hop recording studio* as a symbolic space or "a zone in which identity and meaning are shaped by social exchanges that occur within a culturally specific location" (p. 85). Harkness locates these studios as "sites for legitimization and personal transformation" where artists convene to collaborate on music as a "means of identity construction and development" (p. 85). Home-studios mark a shift of power into the hands of youth, who have easy access to technology and online media to create and release their own content and shape hip-hop music and culture (Harkness, 2014). Harkness conducted a content analysis of interviews with rappers and producers wherein they describe the value of studios as adapted home environments and places for self-discovery and authenticity. His findings offer insight into how hip-hop practices might be used in the design of culturally responsive environments for urban youth.

Harkness (2014) illuminated that studios are often built wherever they can fit, like inside of a rapper's room, basement, living room, or bathroom. Rappers described the need to have studios be aesthetically pleasing, with foam padding on the walls and dim lighting. For many artists, entering a recording booth to rhyme legitimized their thoughts and feelings and generated "an identity shift where they began to define themselves" (Harkness, 2014, p. 91). Although participants in the Harkness study certainly enjoyed being in recording studios, they were adamant about labeling studios as places where serious work and emotional labor occurred. Inside studios, artists felt required to display authentic reflections of their lived experiences in their music and their environment. Overall, the creation of studio spaces is not about how prestigious they look, but more about whether or not the aesthetics of the environment enable artists to carry out the hard work and emotional labor necessary for the discovery of one's true self.

Purpose of the Present Study

Given that (a) a limited number of studies have explored clients' opinions and perspectives on changes made by school counselors to a school counseling space, (b) most studies focus on designing counseling environments outside of schools, and (c) the school counseling profession lacks research on multicultural office design, there is a need for research exploring the processes by which students themselves engage in the construction of culturally salient school counseling spaces. Consequently, the purpose of this exploratory action research was to illuminate the experiences of urban youth of color who were part of a classroom-based school counseling intervention in which they co-created a space

for social and emotional reflection in an inner-city urban high school. Specifically, this study drew on HHSWT and the CAS model as a culturally sensitive counseling intervention designed to increase understanding of the value of the co-creation of a hip-hop studio as an environment conducive to social and emotional development. The research question that guided the study was: *What do students report experiencing while co-creating the school studio?* Reponses from student focus group interviews were used to assess answers to this question, with an interpretative phenomenological analysis (IPA) framework guiding interview development, data collection procedures, and data analysis.

Method

Sample

This study was conducted in an inner-city urban high school in a densely populated city in the northeastern United States. The pseudonym for the high school is Liberty High School (LHS). A teacher at LHS consulted with the principal investigator (PI) of this study, given that he is a school counselor educator and a former school counselor with noted experience in the use of HHSWT and the studio creation process. Specifically, the teacher was interested in integrating interventions into a hip-hop lyric writing elective class that could support students' social and emotional development. The teacher felt the lack of school counselors at LHS created a gap in social and emotional supports and saw students in their classroom struggle academically as a result of unprocessed emotional experiences.

After an initial planning meeting, the PI and the teacher agreed to guide students through a collaborative hip-hop studio construction process as a space to supplement social and emotional support. To garner additional support for this classroom-based intervention, the PI and the teacher attempted to collaborate with LHS' only school counselor, who declined to participate given their large caseload and being understandably inundated. The school counselor's inability to participate further justified the need for the PI to support the teacher and their students. In this sense, a collaborative and indirect approach was explored in which the PI/counselor educator supported a classroom teacher in the implementation of a classroom-based school counseling intervention.

Participants were recruited from a hip-hop lyric writing class where they worked with their course instructor on the co-creation of a school studio following approval from the school district's Institutional Review Board. Students had selected this course from a range of options to fulfill an elective music course credit, a graduation requirement in the northeastern state where this study took place. There were 15 high school students ranging between 14–18 years of age who participated in this study. Neither the course instructor nor the PI had any influence on student enrollment in the class. Prior to their enrollment in this course, the teacher collected all informed consent and/or assent forms from students and parents/guardians. All 15 students agreed to participate in a post-course focus group regarding their experiences co-creating the school studio.

The racial demographic of students at LHS is: 66% Hispanic, 32% Black, 1% Asian, 1% White, and 1% Other. Like many urban high schools in this particular school district, LHS is one of three schools within a larger school's campus. This setup inherently limits the amount of physical space and resources available to students in each school and in many instances forces them to share. LHS is a Title 1 school, and all students qualify for free or reduced lunch. LHS has 700 students and one school counselor.

Measures

Data collection measures in the present study consisted of two post-intervention focus groups, with seven to eight students in each. The PI facilitated each focus group with the aim of exploring participant

experiences during the studio creation as well as assessing how they believed the studio creation process impacted them and might support them moving forward. The PI and the teacher were interested in understanding participants' lived experiences through action research, so an IPA framework was used for interview guide development, data collection procedures, and data analysis. IPA was selected by the PI as an approach to action research that allows researchers to play a role in guiding a process that leads to development of theoretical and practical knowledge (Zuber-Skerritt & Fletcher, 2007).

The difficulty of action research in this regard is for the researchers to limit their subjectivity, which is why the PI chose not to participate in the intervention and instead facilitated the focus groups. Generally, qualitative methods are most appropriate when engaging in phenomenological research with the PI positioned outside of the intervention (Breen, 2007; Zuber-Skerritt & Fletcher, 2007). Therefore, a focus group interview guide was developed by the PI to prompt discussion around participant experiences, including perceptions of what they learned in the process as well as what they identified as important to them. However, consistent with IPA standards (J. A. Smith et al., 2009), the semi-structured interview guides were flexible enough to allow participants the opportunity to lead the discussion. The two focus groups both lasted 30 minutes and took place within the recording studio at LHS.

Design

The studio construction process occurred over a 3-month period (September to December 2018) as a classroom-based intervention during a hip-hop lyric writing course taught by the teacher. The course met twice a week for 90 minutes each time. Because of school holidays, the class met for a total of 10 sessions for studio construction. The PI met with the teacher twice in late August of 2018, prior to the launch of the class, to order necessary equipment. Further, the PI met with the teacher once a month over the course of the 3-month study to provide curricular support. The studio construction process was designed to be entirely student driven. Based on research suggesting the cultural importance of the hip-hop studio (Harkness, 2014), the need for client voice in counseling office design (Pearson & Wilson, 2012), and cultural competence literature requiring the co-designing of interventions (L. Smith & Chambers, 2015), the PI believed it was necessary to provide students with total ownership over the studio creation process.

Implementing the CAS Model

The studio construction process was guided by the CAS model, which targeted the systemic concern of school counselor availability and subsequently sought to support students in designing an ancillary space for social and emotional services. Drawing from the advocate role of the CAS model, the PI and the teacher collaboratively advocated for financial support through a GoFundMe campaign on Facebook. This crowdsourced campaign garnered $900 for school studio equipment. Next, the teacher met with their school principal to advocate for a location where the class could construct a studio. In line with the scholar role, the teacher and the principal were interested in understanding the impact this classroom-based intervention had on their student body. The PI agreed to assist the teacher and the principal in analyzing evaluation data.

The CAS model suggests the importance of culturally sensitive counseling processes. Pulling from HHSWT, a culturally responsive, process-based counseling framework (Levy, 2012), the teacher functioned as a group facilitator who sought to keep the class focused on their group goal of creating the studio. For example, each session began with a group conversation about the plans for that day, asking group members to agree on varying roles they would take during construction. Halfway through each session, the facilitator would bring the group back into a circle to discuss work done, evaluate progress

toward the group goal, and finalize what building would occur for the remainder of the session. Each session would close with a checkout in which the group reflected on how they felt having completed the work, and what changes or additions they wanted to make during the following session. Exploratory activities were also used to allow students to reflect on environments that make them comfortable, spark conversation, and work toward studio completion. As a signature assignment, the teacher pulled from the HHSWT framework and offered students the chance to create a "Where I'm From" song to support students in exploring who they are and what makes them comfortable, to ultimately inform their studio design decisions. Once the studio was developed, students requested assistance in learning how to use studio equipment for recording purposes. Advocating for students' requests, the teacher asked the PI (as a stand-in for the school counselor) to visit and work with students to support their preparation toward recording their lyrics and teach other students how to record their peers.

Data Analysis

The qualitative data collected in the present study were analyzed using the IPA framework, a qualitative research approach designed to facilitate understanding of the participants' worlds and subjective experiences, typically as they relate to a specific event or phenomenon common to all participants being interviewed (Chapman & Smith, 2002). The recorded focus group was transcribed verbatim using InqScribe technology (Inquirium, LLC, 2013). To begin the analysis, the PI read and re-read the focus group interview transcript to build familiarity with the data. Once familiar with the transcript, the PI started with microanalysis, which included making descriptive, linguistic, and conceptual comments in the right margin of the transcripts (J. A. Smith et al., 2009). J. A. Smith et al. (2009) suggested that *descriptive comments* are those that are focused on the content of the communication, and *linguistic comments* are those that consider the tone and use of language throughout the transcript. *Conceptual comments* are interpreted first through a descriptive lens, and linguistic comments are then considered together alongside the interpretation of the transcript by the researcher. Once microanalysis was completed for the entire transcript, the PI reviewed the notations that had been made to identify initial emergent themes throughout the interview, which were noted in the left margin of the document.

The initial emergent themes for each interview were then compared across individual participants to identify the lower-order themes, which were then combined to inform the identification of the higher-order themes (J. A. Smith et al., 2009). In the final stages of data analysis, emergent themes that represented the lived experiences of participants in the group were situated within the extant literature to offer an interpretation of the experiences through existing theoretical frameworks, a hallmark process of IPA research (J. A. Smith et al., 2009). Transcripts were then sent to the second author, who had not been involved in the data collection, to audit identified themes. When discrepancies existed (e.g., different themes were found), researchers engaged in discussion until consensus was reached.

Trustworthiness

To safeguard the trustworthiness of the data, authors engaged in two intentional strategies identified as important for improving the credibility and reliability of the data (Morrow, 2005). First, to ensure the credibility of the data, prior to engaging in data analysis, the PI who conducted the interview engaged in a reflexive process to examine preconceptions about the data in order to bracket those ideas and focus on understanding the lived experiences of the participants. Additionally, to allow for transferability of the research process and results, the authors provided a rich description of the research processes (i.e., methods) as well as the findings that emerged through data analysis (i.e., results).

To improve the dependability of the results, two strategies were employed. First, to improve recall for the participants, they were encouraged to review the video montage of their work building the

studio. Additionally, to minimize the impact of individual bias, the marked transcript was sent to an additional colleague who acted as an outside auditor. Through the aforementioned processes, the researchers believe trustworthiness consistent with standards in qualitative inquiry was achieved (Thomas & Magilvy, 2011).

Results

The findings of this study are organized by higher- and lower-order themes in accordance with IPA (J. A. Smith, 1996). To elaborate on higher- and lower-order themes, exemplary moments from transcripts that reflect students who participated in co-creation of the school studio were identified. The first higher-order theme was *school studio as shared space*. The lower-order themes that constituted this theme included *feeling comfort and belonging* and *wanting inclusivity*. The second higher-order theme was *student design choices*. The lower-order themes contained within this theme included *designing an authentic studio, needing ownership*, and *thinking independently*. The third and final higher-order theme was *studio as practice space/lab*. The lower-order themes that comprised this theme included *peer support, opportunity*, and *supporting others*. Selected student quotes with student pseudonyms are provided below to illustrate each theme.

School Studio as Shared Space

The first higher-order theme, *school studio as shared space*, generally suggested that students experienced the hip-hop studio as a place within the school that they wanted to share with others. An example of a quote that fell within this category is: "So you get to be surrounded by rappers and a community that knows what you're doing, and you get to be upheld by everybody else and you get to share this space with everyone." This higher-order theme, *school studio as shared space*, contained two lower-order themes, which indicated that students experienced (a) *feeling comfort and belonging* and (b) *wanting inclusivity*.

Feeling Comfort and Belonging

The emergence of the first lower-order theme, *feeling comfort and belonging*, indicated that students felt heard and connected to others while creating the school studio. For example, when students were asked to discuss what it was like to co-create the school studio, a student named Jayda responded, "We're just like a little group. A little family. A little rap family." In this example, the student compares their level of connection with her peers to that of a family. When students were asked what it meant to have a studio in their school, Jordan shared, "In my personal opinion, I feel like what it means to me is being able to communicate with others and letting other people hear your voice." Here the student highlights the school studio as an environment where they have the chance to share their "voice" and message.

Wanting Inclusivity

The emergence of the second lower-order theme, *wanting inclusivity*, indicated that students saw the need to create a space that was inclusive of others and that did not revolve solely around their needs and wants. Carlos shared:

> I'm still overthinking about what should we do because I feel like different people have certain styles. I don't want to make it all about me. I don't want to make it all about other people. I want to make it about the whole school and what they think about. Because we're not gonna be the only ones in this rap studio. I want to know what they think about and I want to know their perspectives and how they want to do it.

This student recognized that other students from LHS might also want to access the school studio; therefore, they wanted to gain the perspectives of others, beyond their peers who were co-constructing the studio, regarding what should be included. In this sense, students discouraged individual choices because that approach would not create an inclusive space. Another student, Tasha, stated that "for the wall, it was hard to know what everybody likes and the whole school and put it into just one small wall." Again, students who had the opportunity to co-construct a school studio were thinking about ways to create a space that reflected, represented, and was inclusive of the entire school.

Student Design Choices

The second higher-order theme, *student design choices*, suggested that students experienced being able to make their own design choices during the co-construction process. For example, a particular student quote read:

> We just came in here and it was like, everything messed around so we came in with an idea of like, where we think stuff should go, and that's how we came up with that. Put it on the corner where the studio gonna be.

The student design choices theme contained three lower-order themes which indicated that students experienced (a) *designing an authentic studio*, (b) *needing ownership*, and (c) *thinking independently*.

Designing an Authentic Studio

Within the second higher-order theme, the first lower-order theme of *designing an authentic studio* illuminated that students made design choices in alignment with what they defined to be a professional or culturally appropriate studio environment. One example of a student quote that demonstrates this theme came while a student detailed the process of co-constructing the school studio. Specifically, Jay commented that "it makes it feel like a real studio. When you see rappers in a studio, you see all these lights and it looks professional and stuff, so I think it would make it look like the mood of that." The installation of colorful LED lights within the school studio supported the students' feeling that the studio was real or professional. The professional aesthetic that students established with the studio enabled the creation of a particular "mood" that also made the school studio space and experience feel culturally authentic.

Students also chose to infuse their school colors into the design of the studio, reporting that design element as an authentic representation of their school. When discussing the design process, Devante shared: "Yeah, and then like, [the foam pads] matched with our school colors like the purple and the green in the middle represents our school." Finally, when sharing about the process, Alexandra detailed her most and least favorite moments: "My favorite moment: actually being able to build the studio, the checkered over there, the foam. The most challenging part: missing one day then being lost." For Alexandra, the foam also functioned as an indicator of an authentic studio space. She also added that missing school made her feel lost or disconnected from the studio construction process, and that was particularly challenging.

Needing Ownership

The second lower-order theme, *needing ownership*, highlighted that students experienced needing ownership of the studio space. When discussing their design process, Gabriel said, "yeah, basically I said like, you put the 'L' so whoever comes in here know that Liberty was here first. We created this place. And that was our main point of putting that big 'L' right there." In this quote, Gabriel spoke to the importance of design choices in letting the surrounding community know who was responsible

for the studio's creation. This statement and the theme of needing ownership more broadly suggests that students wanted to feel properly valued and credited for their work and that they also had ownership over their choices and felt able to make their own decisions. This sentiment is further supported by a quote from Rachael:

> I know it made me feel like the room was built in our hands. Later on, when everything is done, when people come in, whatever they see is what we all thought of together. We could've had this over there, but we decided to put it over here. It just makes us feel . . . well, it makes me feel like, yeah.

Adding support to Gabriel's statement, Rachael appears to be feeling a sense of pride in laying claim to the thoughts, feelings, and physical work that went into the creation of the school studio.

Thinking Independently

The third lower-order theme, *thinking independently*, highlighted that students had opportunities to think amongst themselves and to troubleshoot and find solutions to problems without relying on the direction of an adult. Carlos reported that "without the adults, I feel like we really had to bring our creative ideas straight from our thoughts on how to make the studio." Carlos believed that without adults walking them through the process of creating a school studio, they were able to showcase their "creative ideas" and pull from knowledge and thoughts they already possessed. Additionally, Alexandra shared:

> Well, I'm always used to being told what to do because you would give me an assignment and I'll do it. I can't just think for myself. As you can see, I'm still having difficulty thinking for myself with the wall.

Alexandra highlights that within the traditional classroom lessons, students are always given an assignment that offers directions on how to complete it. When students were given the task of co-constructing a school studio, there were many tasks that could be approached differently, and students were encouraged as experts to think in ways that were independent of adults and pull from within to address their task.

Studio as Practice Space/Lab

The third higher-order theme, *studio as practice space/lab*, suggested that students experienced the hip-hop studio as a place where they could learn to feel more prepared. Student quotes within this higher-order theme included statements like: "If we invite other people from the other school or people in other classes to see us, we're gonna have more . . . prepared. We're gonna be more prepared to do it." This higher-order theme contained four lower-order themes, which indicated that students experienced (a) *peer support*, and (b) *opportunity*, (c) *self-discovery*, and (d) *supporting others*.

Peer Support

The first lower-order theme, *peer support*, suggested that students felt as if the school studio was a location in which they could receive feedback, support, and opportunities for personal preparation from their peers. When responding to a question regarding what students felt they might have learned throughout the co-creation process, Vicki claimed: "This small space is not gonna help me stand up in front of 400 people but bringing little by little people into here while we're rapping or anything, would help me build up more confidence." Although Vicki still felt there was work to do in order to feel ready to share her lyrics with a large number of people, she posited that the studio space

could function as a preparation space for larger group sharing, where peers could help others and boost their confidence. Another student, John, spoke to the experience of individuals who rap within the school studio, reporting that:

> The nice thing, after the person's done with the rap, he makes somebody ask what they heard about that person, about learning about that person, that's gonna put confidence in you. Like, they were actually listening. And that makes you want to rap more so people can actually acknowledge your bars.

In this quote, John spoke to the process of sharing lyrics. Specifically, when people share lyrics, John imagined that others would listen carefully to them and then willingly engage in a discussion about what they heard. John believes the experience of sharing lyrics would make people feel acknowledged and have an increased sense of self-confidence.

Opportunity

The second lower-order theme of *opportunity* evidenced that students experienced the school studio as an environment that could offer opportunities for personal advancement in life. When discussing how this school studio might be used within the school, Devante said:

> It's hard to find a place to rap. That's 1. 2, they cost too much. And 3, you know people say you can buy a microphone and you can do this, that and the third in your own household. Not a lot of people have money, many people they use the money and give it to their parents, and then if you ask your parents, they're gonna tell you the same thing that they tell every other kid when they want to pursue a hobby: "This is not gonna get you anywhere." 'Cause my parents tell me that all the time.

In this statement, Devante appreciates free access to space where he can pursue his hobby. Within the school studio, there is a perceived potential among students to work toward their own dreams without waiting on financial support or support from anyone other than themselves. Statements like this one suggest that access to the school studio provided students with an opportunity to consider their career on their own terms. A second student, Melissa, builds on this notion of opportunity, suggesting:

> So apart from someone finding out their identity with this studio, they could also put their work out there knowing they have a chance to get somewhere. To be very honest, in this decade, everyone has a chance to get somewhere. It doesn't matter if you're good at rapping, bad at rapping, you suck, you great, you can get somewhere. It's all about other people's opinions, it's all about what they like, and if you're liked by the public, then you're gonna get until as far as you can reach.

In this quote, Melissa indicated how a student could use the school studio to garner support from the public to "get somewhere." Within the school studio, students suggested that there is an opportunity for a unique level of access and self-advancement. Further aiding the idea that using the school studio was the desired opportunity for youth, Jay said: "I hate that we only come down here once a week."

Supporting Others

The final lower-order theme, *supporting others*, demonstrated students' intentions and goals of supporting others outside of their class who attended LHS. Jordan shared, "I want to learn how to use all

this equipment. So that in the future other students will be able to be taught how to be using the mixer or putting beats into tracks." Jordan wanted to be able to support other students outside of his class by teaching the skills that he plans on developing, which included "using the mixer" and "putting beats into tracks." This expression demonstrated an understanding of the importance of teaching others how to utilize the school studio, which will contribute to the longevity of the space. Gabriel reported that "You teaching them how to rap, how to use the mic, the laptop and all that, that's just gonna inspire their friends to come. They teach their friends and the cycle just continues like that." Believing in how beneficial the studio was for them, Gabriel mentioned wanting to support his peers by sharing skills that were needed to effectively run the school studio so it could continue to be used. Gabriel also highlights that teaching others to make use of the school studio space will create a cycle that theoretically will allow students to bring their friends to engage as well. Therefore, not only is the school studio intriguing to students, but it will support their development of skills to maintain its use.

Discussion

This study was designed to increase understanding of the experiences of students partaking in a classroom-based school counseling intervention in which they co-constructed a hip-hop studio. Counseling environment data has suggested that counselors often take the lead on the creation of environments for clients (Pearson & Wilson, 2012), whereas we encourage school counselors to partner with youth in the creation of their own counseling spaces (L. Smith & Chambers, 2015). Broadly, results support the co-construction of school studios as culturally relevant environments that promote social and emotional development, addressing a need in the literature for research exploring multicultural counseling office design (Benton & Overtree, 2012). Further, the use of the CAS model enabled a collaboration in which a classroom teacher deployed an indirect and culturally responsive school counseling intervention to support students' personal/social development (ASCA, 2019b; Ratts & Greenleaf, 2018).

Student Experiences

Results of this exploratory action research demonstrated that students experienced a sense of comfort and belonging inside the school studio. Similarly, Sanders and Lehmann (2019) indicated that clients felt a sense of comfort when the counseling office felt like a home or a lounge rather than a traditional office space. Further, data from the current study showed that the studio creation process empowered students to advocate for inclusivity in the use of this space for their entire school campus community. This outcome is ideal given that school counselors are charged with activating the entire school community in the deployment of school-wide interventions that support students' academic, career, and personal/social development (Bryan et al., 2019). In specific comments, youth stated that they would want to locate peers who are in need of help and bring them to the school studio to develop personal/social skills. These statements suggest that after participating in the school counseling intervention, youth voiced that making the studio available to all students would improve the school counseling program at their school. This finding gives credence to the use of advisory councils at schools, with student members, to offer youth a platform to ensure that school counselors and their school counseling programs are serving all students (ASCA, 2019b). Additionally, a bevy of studies emphasized supporting youth in the development of skills as change agents in promoting peace, youth voice, and healing (Allan & Duckworth, 2018; Conner & Cosner, 2016; Levy, Emdin et al., 2018). Overall, the findings are important in that they support the use of studio co-creation as a classroom-based counseling intervention, which research suggests can result in school-wide impact (Bostik & Anderson, 2009).

Another notable finding of this study was students' decisions in creating their authentic and professional school studio. For example, the students' choice to install LED lights provided them with a professional aesthetic and a particular "mood" that also made the school studio space and experience feel authentic. The aesthetics of a counseling environment, particularly interior design choices such as dim lighting, are reported to positively impact clients in session (Miwa & Hanyu, 2006). Similarly, professional hip-hop artists report needing studios to be aesthetically pleasing, pointing to foam padding on walls and dim lighting. For many artists, entering an aesthetically pleasing studio environment was conducive to "an identity shift where they began to define themselves" (Harkness, 2014, p. 91). Student reports regarding the importance of aesthetics in establishing authentic studio spaces are in line with what counseling research suggests is necessary for effective counseling environments both inside and outside of schools (Ceylan et al., 2008; Cook & Malloy, 2014; Huffcut, 2010), as well as what the larger hip-hop community suggests is necessary for personal transformation (Harkness, 2014). Further, scholars have called for school counselors to tailor their interventions to the cultural knowledge and environments of their students (Hansen et al., 2014; L. Smith & Chambers, 2015), particularly when attempting to design multicultural counseling environments (Benton & Overtree, 2012). Evidence from students that the physical space constructed in this study felt like an authentic hip-hop studio suggests that through the use of a classroom-based school counseling intervention, students were able to channel their cultural knowledge and values into the design of a culturally responsive environment that could support their social and emotional development.

An additional finding highlights that youth felt the studio space would allow them to receive peer support that could be generative of improvements in confidence and self-efficacy. Similarly, a systematic review of peer support interventions found that peer educators were particularly effective in facilitating improvements in knowledge, beliefs, and attitudes as well as subsequent behavior change (Ramchand et al., 2017). Findings in the current study aid this supposition, providing evidence of the use of school studios as spaces for peer support.

When reflecting on their engagement in the studio co-construction process, youth reported feeling as if they had been given a valuable opportunity for personal advancement. This finding is particularly important to consider within the context of career counseling work in schools. Lent (2013) encourages counselors to adapt to work in the digital world by preparing individuals for a range of career opportunities. Fostering students' career development is also an expected role of the school counselor and of school counseling interventions (ASCA, 2019b). Students' need for opportunity and career–life preparedness requires counselors to promote students' "alertness to resources and opportunities on which one can capitalize. Most important, preparedness can lead to the use of proactive strategies to manage barriers, build supports, and otherwise advocate for one's own career–life future" (Lent, 2013, p. 7). Further, youth felt an opportunity for personal identity development, aiding Harkness' (2014) argument that studios were spaces for hip-hop–identifying individuals to cultivate a deepening understanding of themselves, and Liddicoat's (2015) position that counseling environments could allow for the positive development of a client's self-concept.

CAS Model to Support School Studio Construction
The findings in this exploratory action research support the implementation of the CAS model as a guide for school counseling interventions. In the current study, with the help of the PI, the course instructor held the counselor role in the use of Levy's (2019) HHSWT framework by facilitating a group process in which students constructed a hip-hop recording studio. Similar to research indicating that school counselors are often inundated with large caseloads and non-counseling duties that strip them of their ability to engage in direct counseling (Kim & Lambie, 2018; Mau et al., 2016),

the school counselor at LHS was unable to support the studio co-construction process. However, to facilitate a comprehensive school counseling program, school counselors are expected to collaborate with teachers to indirectly address students' academic, career, and personal/social needs (Cholewa et al., 2016). Therefore, the current study expands upon the implementation of the CAS model by considering the role of collaboration in the school counselor's work, and the activation of the teacher as a key stakeholder (under the guidance of a counselor educator) in facilitating a classroom-based counseling intervention in which youth co-created a school space to support social and emotional services. The teacher and the PI also held the roles of advocates for the successful deployment of the school counseling intervention (studio co-creation). The teacher met with their principal and contacted a counselor educator (the PI), and together with the PI garnered crowdsourced funding for this project. Finally, the scholar role was also maintained by the teacher, who wished to support students' social and emotional needs by creating a school studio, and thus called on the PI to use qualitative measures to evaluate students' experiences during this process.

Limitations

There are a series of limitations to the current study. The limited availability of the school counselor to participate in this study is a limitation, despite the conscious use of collaboration in the deployment of an indirect classroom-based school counseling intervention. The use of the CAS model without a formal school counselor was difficult, albeit consistent with existing research surrounding the lack of time for school counselors to engage in multi-session group counseling work (Kim & Lambie, 2018). Consequently, the findings of the current study fail to offer support for counselors in the use of a direct school counseling intervention. Further, student reports of their experience in the studio co-construction process are subjective in nature. Had LHS provided an intervention to a larger sample of students and administered quantitative assessments, those findings could potentially have aided this study's qualitative conclusions. The small sample size ($N = 15$) of this study is a limitation, as results lack generalizability. Additionally, LHS is an urban school whose demographic information suggests the majority of youth identified as Black and/or Hispanic. Given that the present study examined a sample of mostly non-White urban youth, it is difficult to generalize findings to suburban and rural schools as well as to youth who do not identify as Black and/or Hispanic. Further, each focus group lasted 30 minutes, which could have limited the ability of the seven or eight participants to offer in-depth data. Lastly, the interactive nature of focus groups could have impacted the authenticity of responses from focus group participants (Smithson, 2000).

Implications

There are a number of implications for both practice and research that can be drawn from the current study. The findings in the current study align with the ASCA National Model and hold promise for engaging teachers and students in school-based interventions that promote social and emotional development and are culturally relevant. The ASCA National Model (2019b) calls for school counselors to use indirect approaches to counseling, often those including collaboration with a teacher, to provide supports to all students across the school. This study exemplifies the importance of activating teachers in the use of indirect classroom-based school counseling interventions, particularly when school counselors themselves are not available. The PI's involvement in supporting the classroom teacher in implementation and evaluation of a classroom-based school counseling intervention serves as a call for school counselors to consider partnering with faculty at local colleges/universities to bolster their comprehensive school counseling programs. If available, school counselors themselves are encouraged to collaborate with teachers in the development, implementation, and evaluation of classroom-based interventions that support students' social and emotional development.

The current study used a culturally responsive classroom-based intervention that honored students' cultural knowledge and trusted youth to guide the studio construction process. Youth reported on the importance of the opportunity to use the hip-hop studio to positively impact their school, their peers, and themselves. Counselors need to design social and emotional development supports within their schools that adhere to the cultural realities of their clients (Ponterotto & Austin, 2005) and are thus encouraged to utilize the studio co-creation approach. Beyond hip-hop, however, the current study suggests that youth-driven construction of an ancillary social and emotional support space should be considered for all students from marginalized populations, including youth identifying as LGBTQ.

Implications for direct school counseling practice exist as well. For example, Levy (2019) demonstrated effectiveness of a series of hip-hop–based cognitive behavioral and person-centered counseling interventions on students' social and emotional development. However, few studies have detailed the cultural importance of the hip-hop studio and how its creation might support the future use of culturally competent interventions. Although this study did not explore the use of lyric writing, recording, or performing to address counseling outcomes, students participating in the studio construction process reported wanting to use the school studio to support their peers and their own personal self-development. These findings suggested it is important for schools to consider co-creating school studios as places for school counselors to deploy hip-hop–based interventions for group and individual counseling with urban youth.

The findings in this study can be expanded upon with future mixed methods research that examines a larger sample of students. Quantitative analysis of students' social and emotional development (examining variables like stress, emotional regulation, and executive functioning) during the studio co-construction process is recommended as a direction for future research. Qualitative researchers should consider case studies of students and counselors who engage in the construction of hip-hop studios and small-group work within counseling studies, using more in-depth interviews (lasting longer than 30 minutes) to ensure rich data is collected. There is also value in exploring the multicultural and social justice competence development of both school counselors and teachers who engage in hip-hop–based school counseling interventions.

Conclusion

The goal of this exploratory action research was to illuminate the experiences of urban youth of color who were part of a classroom-based school counseling intervention in which they co-created their own space for social and emotional support in an inner-city urban high school. As described in this article, a limited number of studies have explored clients' opinions and perspectives on changes made by school counselors to a counseling environment (Pearson & Wilson, 2012). Additionally, most studies focus on designing counseling environments outside of schools, and the school counseling profession lacks research on multicultural office design (Benton & Overtree, 2012). Furthermore, ASCA (2019b) advocates for the use of indirect counseling interventions to support the needs of all students, while others urge school counselors to use multicultural and social justice–oriented interventions to identify and address barriers to student development (Ratts & Greenleaf, 2018). This article highlights the value in using hip-hop studio construction as an innovative approach to a culturally sensitive, indirect, classroom-based school counseling intervention in which students themselves engaged in the construction of an ancillary space to support their social and emotional development.

References

Adjapong, E. S. (2017). Bridging theory and practice in the urban science classroom: A framework for hip-hop pedagogy in STEM. *Critical Education*, *8*(15). https://doi.org/10.14288/ce.v8i15.186248

Adjapong, E. S., & Emdin, C. (2015). Rethinking pedagogy in urban spaces: Implementing hip-hop pedagogy in the urban science classroom. *Journal of Urban Learning, Teaching, and Research, 11*, 66–77.

Allan, D., & Duckworth, V. (2018). Voices of disaffection: Disengaged and disruptive youths or agents of change and self-empowerment? *British Journal of Special Education*, *45*(1), 43–60. https://doi.org/10.1111/1467-8578.12201

American School Counselor Association. (2015). *The school counselor and cultural diversity*. https://www.schoolcounselor.org/asca/media/asca/PositionStatements/PS_CulturalDiversity.pdf

American School Counselor Association. (2019a). *Student-to-school-counselor ratio 2016-2017*. https://www.schoolcounselor.org/asca/media/asca/home/Ratios16-17.pdf

American School Counselor Association. (2019b). *The ASCA national model: A framework for school counseling programs* (4th ed.).

Bailey, D. F., Getch, Y. Q., & Chen-Hayes, S. F. (2007). Achievement advocacy for all students through transformative school counseling programs. In B. T. Erford (Ed.), *Transforming the school counseling profession* (2nd ed., pp. 98–120). Pearson.

Benton, J. M., & Overtree, C. E. (2012). Multicultural office design: A case example. *Professional Psychology: Research and Practice*, *43*(3), 265–269. https://doi.org/10.1037/a0027443

Betters-Bubon, J., Brunner, T., & Kansteiner, A. (2016). Success for all? The role of the school counselor in creating and sustaining culturally responsive positive behavior interventions and supports programs. *The Professional Counselor*, *6*(3), 263–277. https://doi.org/10.15241/jbb.6.3.263

Bostick, D., & Anderson, R. (2009). Evaluating a small-group counseling program—A model for program planning and improvement in the elementary setting. *Professional School Counseling*, *12*(6), 428–433. https://doi.org/10.1177/2156759X0901200602

Breen, L. (2007). The researcher 'in the middle': Negotiating the insider/outsider dichotomy. *The Australian Community Psychologist*, *19*(1), 163–174. http://hdl.handle.net/20.500.11937/22045

Bryan, J., Griffin, D., Kim, J., Griffin, D. M., & Young, A. (2019). School counselor leadership in school-family-community partnerships: An equity-focused partnership process model for moving the field forward. In S. B. Sheldon & T. A. Turner-Vorbeck (Eds.), *The Wiley handbook of family, school, and community relationships in education* (pp. 265–287). Wiley.

Caro, R. A. (1975). *The power broker: Robert Moses and the fall of New York*. Alfred A. Knopf.

Ceylan, C., Dul, J., & Aytac, S. (2008). Can the office environment stimulate a manager's creativity? *Human Factors and Ergonomics in Manufacturing & Service Industries*, *18*(6), 589–602. https://doi.org/10.1002/hfm.20128

Chang, J. (2005). *Can't stop, won't stop: A history of the hip-hop generation*. St. Martin's Press.

Chapman, E., & Smith, J. A. (2002). Interpretative phenomenological analysis and the new genetics. *Journal of Health Psychology*, *7*(2), 125–130. https://doi.org/10.1177/1359105302007002397

Cholewa, B., Goodman-Scott, E., Thomas, A., & Cook, J. (2016). Teachers' perceptions and experiences consulting with school counselors: A qualitative study. *Professional School Counseling*, *20*(1), 77–88. https://doi.org/10.5330/1096-2409-20.1.77

Conner, J. O., & Cosner, K. (2016). Youth change agents: Comparing the sociopolitical identities of youth organizers and youth commissioners. *Democracy and Education*, *24*(1). https://democracyeducationjournal.org/home/vol24/iss1/2

Cook, K., & Malloy, L. (2014). School counseling office design: Creating safe space. *Journal of Creativity in Mental Health*, *9*(3), 436–443. https://doi.org/10.1080/15401383.2014.890557

Devlin, A. S., Borenstein, B., Finch, C., Hassan, M., Iannotti, E., & Koufopoulos, J. (2013). Multicultural art in the therapy office: Community and student perceptions of the therapist. *Professional Psychology: Research and Practice*, *44*(3), 168–176. https://doi.org/10.1037/a0031925

Forman, M. (2002). "Keeping it real"?: African youth identities and hip hop. In R. A. Young (Ed.), *Music, popular culture, identities* (pp. 89–118). Brill.

Goelitz, A., & Stewart-Kahn, A. S. (2008). Therapeutic use of space: One agency's transformation project. *Journal of Creativity in Mental Health*, *2*(4), 31–44. https://doi.org/10.1300/J456v02n04_04

Hannon, M. D., & Vereen, L. G. (2016). Irreducibility of Black male clients: Considerations for culturally competent counseling. *The Journal of Humanistic Counseling*, *55*(3), 234–245. https://doi.org/10.1002/johc.12036

Hansen, J. T., Speciale, M., & Lemberger, M. E. (2014). Humanism: The foundation and future of professional counseling. *The Journal of Humanistic Counseling*, *53*(3), 170–190. https://doi.org/10.1002/j.2161-1939.2014.00055.x

Harkness, G. (2014). Get on the mic: Recording studios as symbolic spaces in rap music. *Journal of Popular Music Studies*, *26*(1), 82–100. https://doi.org/10.1111/jpms.12061

Huffcut, J. C. (2010). Can design promote healing? *Behavioral Healthcare*, *30*(9), 33–35.

Inquirium, LLC (2013). InqScribe [Computer software]. https://www.inqscribe.com

Kim, N., & Lambie, G. W. (2018). Burnout and implications for professional school counselors. *The Professional Counselor*, *8*(3), 277–294. https://doi.org/10.15241/nk.8.3.277

Kobin, C., & Tyson, E. (2006). Thematic analysis of hip-hop music: Can hip-hop in therapy facilitate empathic connections when working with clients in urban settings? *The Arts in Psychotherapy*, *33*(4), 343–356. https://doi.org/10.1016/j.aip.2006.05.001

Lent, R. W. (2013). Career-life preparedness: Revisiting career planning and adjustment in the new workplace. *The Career Development Quarterly*, *61*(1), 2–14. https://doi.org/10.1002/j.2161-0045.2013.00031.x

Levy, I. (2012). Hip hop and spoken word therapy with urban youth. *Journal of Poetry Therapy*, 25, 219–224. https://doi.org/10.1080/08893675.2012.736182

Levy, I. (2019). Hip-hop and spoken word therapy in urban school counseling. *Professional School Counseling*, *22*(1b). https://doi.org/10.1177/2156759X19834436.

Levy, I. P., Cook, A. L., & Emdin, C. (2018). Remixing the school counselor's tool kit: Hip-hop spoken word therapy and YPAR. *Professional School Counseling*, *22*(1). https://doi.org/10.1177/2156759X18800285

Levy, I., Emdin, C., & Adjapong, E. S. (2018). Hip-hop cypher in group work. *Social Work with Groups*, *41*(1–2), 103–110. https://doi.org/10.1080/01609513.2016.1275265

Levy, I., & Keum, B. T. (2014). Hip-hop emotional exploration in men. *Journal of Poetry Therapy*, *27*(4), 217–223. https://doi.org/10.1080/08893675.2014.949528

Liddicoat, S. (2010). Counselling workspace design and therapeutic practice. In J. Zuo, L. Daniel, & V. Soebarto (Eds.), *Fifty years later: Revisiting the role of architectural science in design and practice: 50th International Conference of the Architectural Science Association* (pp. 69–78). The Architectural Science Association and The University of Adelaide. http://anzasca.net/paper/counselling-workspace-design-and-therapeutic-practice

Liddicoat, S. (2015). Exploring relations between body, communication and agency in therapeutic space. In R. H. Crawford, & A. Stephan (Eds.), *Living and Learning: Research for a Better Built Environment: 49th International Conference of the Architectural Science Association* (pp. 123–132). The Architectural Science Association and The University of Melbourne. http://anzasca.net/wp-content/uploads/2015/12/012_Liddicoat_ASA2015.pdf

Mau, W.-C. J., Li, J., & Hoetmer, K. (2016). Transforming high school counseling: Counselors' roles, practices, and expectations for students' success. *Administrative Issues Journal: Connecting Education, Practice, and Research*, *6*(2), 83–95. https://doi.org/10.5929/2016.6.2.5

McMahon, H. G., Mason, E. C. M., Daluga-Guenther, N., & Ruiz, A. (2014). An ecological model of professional school counseling. *Journal of Counseling & Development*, *92*(4), 459–471. https://doi.org/10.1002/j.1556-6676.2014.00172.x

Miwa, Y., & Hanyu, K. (2006). The effects of interior design on communication and impressions of a counselor in a counseling room. *Environment and Behavior*, *38*(4), 484–502. https://doi.org/10.1177/0013916505280084

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, *52*(2), 250–260. https://doi.org/10.1037/0022-0167.52.2.250

Pearson, M., & Wilson, H. (2012). Soothing spaces and healing places: Is there an ideal counselling room design? *Psychotherapy in Australia*, *18*(3), 46–53.

Phelps, C., Horrigan, D., Protheroe, L. K., Hopkin, J., Jones, W., & Murray, A. (2008). "I wouldn't classify myself as a patient": The importance of a "well-being" environment for individuals receiving counseling about familial cancer risk. *Journal of Genetic Counseling*, *17*(4), 394–405. https://doi.org/10.1007/s10897-008-9158-z

Ponterotto, J. G., & Austin, R. (2005). Emerging approaches to training psychologists to be culturally competent. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling* (pp. 19–25). Wiley.

Pressly, P. K., & Heesacker, M. (2001). The physical environment and counseling: A review of theory and research. *Journal of Counseling & Development*, *79*(2), 148–160. https://doi.org/10.1002/j.1556-6676.2001.tb01954.x

Ramchand, R., Ahluwalia, S. C., Xenakis, L., Apaydin, E., Raaen, L., & Grimm, G. (2017). A systematic review of peer-supported interventions for health promotion and disease prevention. *Preventive Medicine*, *101*, 156–170. https://doi.org/10.1016/j.ypmed.2017.06.008

Ratts, M. J. (2009). Social justice counseling: Toward the development of a fifth force among counseling paradigms. *The Journal of Humanistic Counseling, Education and Development*, *48*(2), 160–172. https://doi.org/10.1002/j.2161-1939.2009.tb00076.x

Ratts, M. J., & Greenleaf, A. T. (2018). Counselor–advocate–scholar model: Changing the dominant discourse in counseling. *Journal of Multicultural Counseling and Development*, *46*(2), 78–96. https://doi.org/10.1002/jmcd.12094

Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice: Integration, theory, and application* (4th ed.). American Counseling Association.

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and Social Justice Counseling Competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28–48. https://doi.org/10.1002/jmcd.12035

Reyes, M. R., Brackett, M. A., Rivers, S. E., White, M., & Salovey, P. (2012). Classroom emotional climate, student engagement, and academic achievement. *Journal of Educational Psychology, 104*(3), 700–712. https://doi.org/10.1037/a0027268

Rock, W. D., Remley, T. P., & Range, L. M. (2017). Principal-counselor collaboration and school climate. *NASSP Bulletin*, *101*(1), 23–35. https://doi.org/10.1177/0192636517698037

Sanders, R., & Lehmann, J. (2019). An exploratory study of clients' experiences and preferences for counselling room space and design. *Counselling and Psychotherapy Research*, *19*(1), 57–65. https://doi.org/10.1002/capr.12202

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health*, *11*(2), 261–271. https://doi.org/10.1080/08870449608400256

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE.

Smith, L., & Chambers, C. (2015). Decolonizing psychological practice in the context of poverty. In R. D. Goodman & P. C. Gorski (Eds.), *Decolonizing "multicultural" counseling through social justice* (pp. 73–84). Springer.

Smithson, J. (2000). Using and analyzing focus groups: limitations and possibilities. *International Journal of Social Research Methodology*, *3*(2), 103–119. https://doi.org/10.1080/136455700405172

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for Specialists in Pediatric Nursing*, *16*(2), 151–155. https://doi.org/10.1111/j.1744-6155.2011.00283.x

Travis, R., Jr., & Deepak, A. (2011). Empowerment in context: Lessons from hip-hop culture for social work practice. *Journal of Ethnic & Cultural Diversity in Social Work*, *20*(3), 203–222. https://doi.org/10.1080/15313204.2011.594993

Tyson, E. H. (2002). Hip hop therapy: An exploratory study of a rap music intervention with at-risk and delinquent youth. *Journal of Poetry Therapy*, *15*(3), 131–144. https://doi.org/10.1023/A:1019795911358

Washington, A. R. (2018). Integrating hip-hop culture and rap music into social justice counseling with Black males. *Journal of Counseling & Development*, *96*(1), 97–105. https://doi.org/10.1002/jcad.12181

Zuber-Skerritt, O., & Fletcher, M. (2007). The quality of an action research thesis in the social sciences. *Quality Assurance in Education*, *15*(4), 413–436. https://doi.org/10.1108/09684880710829983

nbcc

Experiences of Black Adolescents With Depression in Rural Communities

TeShaunda Hannor-Walker, Lynn Bohecker, Lacey Ricks, Sarah Kitchens

Literature does little to explore the perceptions of Black adolescents with depression or their perspective of treatment effectiveness. Studies are usually from urban areas and there is a dearth of research with Black adolescents from rural areas. This study explored the unique personal experiences of Black adolescents located in the rural southeastern United States, with the purpose of gaining a clearer understanding when working with this population. An interpretative qualitative method was used to explore 10 participants' interpretation of their experiences to gain insight in how they make meaning of those experiences. Five significant categories were found to capture participant themes: (a) definition of depression, (b) seeking treatment, (c) coping and problem solving strategies, (d) types of emotional support, and (e) contributing factors to depression. Specific recommendations and interventions are suggested for mental health clinicians to become more educated and aware when working with Black adolescents.

Keywords: Black adolescents, depression, treatment effectiveness, rural, contributing factors

Depression is a leading cause of disability worldwide (World Health Organization, 2020). The World Federation for Mental Health (2012) estimated that by 2030, more people will be impacted by depression than any other health problem. In the United States, approximately 13.3% of adolescents, or 3.2 million, had at least one major depressive episode and 9.5% were Black (National Institute of Mental Health [NIMH], 2013). Black people have experienced more severe forms of mental health conditions than individuals of other races because of unmet needs and other barriers (NIMH, 2013). In fact, Black people were reported to be 10% more likely to experience serious mental health problems than the general population (Shushansky, 2017), and Black children have a suicide rate that is almost two times higher than that of their White counterparts (Bridge et al., 2018).

Weaver et al. (2015) noted that although 90% of rural Black people live in the southeastern part of the United States, there are only two studies that specifically examined depression among rural Black people using national data (i.e., Probst et al., 2006; Willis et al., 2003). Most studies of depression that include Black youth are based on data from urban communities (Al-Khattab et al., 2016; Conner & Yeh, 2018; Ofonedu et al., 2013; Robinson et al., 2015). This suggests there is a dearth of research exploring Black adolescent experiences of depression in rural communities, and there is even less research focusing on Black youth who live in the rural southeastern United States (Smokowski et al., 2015: Weaver et al., 2015). The goal of this study was to explore the unique experiences of Black adolescents living in the rural southeastern United States who had been diagnosed with depression.

Contributing Factors to Depression in Black Adolescents

Adolescents who suffer from depression may experience substantial negative health and social consequences in late adolescence and adulthood (Lu, 2019). Black adolescents are particularly vulnerable

TeShaunda Hannor-Walker, PhD, NCC, LPC, CPCS, is an assistant professor at Liberty University. Lynn Bohecker, PhD, LMFT, is an associate professor at Liberty University. Lacey Ricks, PhD, NCC, is an assistant professor at Liberty University. Sarah Kitchens, PhD, NCC, is an assistant professor at Liberty University. Correspondence may be addressed to TeShaunda Hannor-Walker, 1971 University Blvd, Lynchburg, VA 24515, thannorwalker@liberty.edu.

to these consequences because they are more likely to live in low-resource neighborhoods and because they contend with the negative psychological impacts of racial discrimination (Robinson et al., 2015). Choi et al. (2006) found that ethnic minorities have higher scores on social stress and mental distress and lower scores on coping, self-esteem, and family cohesion. The depressive symptoms experienced by Black adolescents are often socially and culturally based (Lu et al., 2017). Therefore, it is essential for counselors, school personnel, and related professionals to remain abreast of the current research on depressive signs and symptoms, beliefs about treatment, and specific needs of Black adolescents.

Choi et al. (2006) discovered that Black, Hispanic, and Asian adolescents in the United States have consistently higher levels of social stress beginning in childhood compared to their White counterparts. Breland-Noble et al. (2010) found that relationship problems, academic problems, bereavement, and stress were primary triggers for depressive symptoms among Black adolescents. Ofonedu et al. (2013) determined in their study of Black adolescents that life events in the home, school, and community contributed to depressive symptoms. These factors included (a) a stressful home life, (b) stressful life circumstances and unique life experiences at school, and (c) the experience of high levels of violent crimes in neighborhoods. Stress is clearly a contributing factor to the depressive symptoms of Black adolescents.

Symptoms of Depression in Black Adolescents
Although understanding national trends and contributing factors can help practitioners identify adolescents suffering from depression, it is also important to understand potential racial and ethnic differences in the expression of adolescent depression (Lu, 2019). The manifestations of depressive symptoms vary in Black youth and affect all dimensions of physical, psychological, interpersonal, and social being (Ofonedu et al., 2013). In the Black community, mental health conditions have often been unacknowledged, misunderstood, and misdiagnosed (Shushansky, 2017; Vontress et al., 2007). According to Vontress et al. (2007), Black people often experience cultural dysthymia and mental health symptoms such as low-grade depression; feelings of sadness, hopelessness, and anger; aggression; and self-destructive behaviors. Vontress et al. (2007) characterized these symptoms as a "psychosocial condition" grounded in external societal experiences of discrimination and oppression that often go unrecognized (p. 131). Additional studies are needed to show how to better identify individuals suffering from depression and thereby increase the effectiveness of treatment for Black adolescents (Ofonedu et al., 2013).

As in adults, unrecognized or undiagnosed dysthymia or symptoms of low-grade depression in adolescents can contribute to poor health and problematic behaviors (Saluja et al., 2004). Researchers discovered that untreated dysthymia elevates the risk of disruptive behaviors, anxiety, substance abuse, unsafe sexual practices, involvement in fights, lower achievement on tests, lower teacher-rated grades, and poorer peer relationships (Saluja et al., 2004). Auger (2005) discovered that the many signs and symptoms of adolescent depression were overlooked not only by parents but also by school systems, administrators, counselors, and teachers who daily were in a very unique position to identify those at risk of depression. Many cases of adolescent depression, particularly among minorities, have gone undiagnosed, misdiagnosed, and untreated (Cook et al., 2017; Shushansky, 2017). A better understanding of the unique experiences of Black adolescents diagnosed with depression would help improve symptom recognition, which may in turn reduce misdiagnosis and increase treatment effectiveness.

An understanding of the cultural implications and influence that oppression, prejudice, and various forms of discrimination have on Black people's mental health in the United States is helpful in contextualizing and normalizing symptoms of depression and reducing instances of misdiagnosis. Hope et al. (2017) posited that discrimination remains a common experience for Black adolescents

that can impact not only the onset of depression but also the quality of and access to mental health services. Furthermore, according to Liang et al. (2016), racial disparities exist, as Black youth are more likely to be misdiagnosed as having psychotic and disruptive behavior problems compared to mood (i.e., depression) and substance abuse disorders.

Lu et al. (2017) echoed these sentiments, stating that depression presents differently for Black adolescents. It is essential for Black adolescents to use their own language when describing their depressive symptoms. Additionally, it is important for clinical and school counseling professionals to be aware of gender differences in Black adolescents' expression of depression, specifically in terms of internalizing and externalizing symptoms. The findings of Breland-Noble et al. (2010) indicated that female Black adolescents seem to internalize behaviors (e.g., becoming withdrawn, exhibiting visible sadness), while male Black adolescents seem to externalize behaviors (e.g., becoming angry or acting out). Lu et al. (2017) further highlighted that "adolescents develop [symptoms] as a means of coping in response to environmental factors" (p. 614). More research is needed to understand how depressed Black adolescents describe their symptoms and assign meaning to their experiences of depression.

Coping Strategies of Black Adolescents

In addition to presenting different symptoms than individuals of other racial groups, Black adolescents have the lowest coping skills scores compared to their peers (Conner & Yeh, 2018). Recent studies suggest that adolescents who live in low-resourced neighborhoods feel like they have limited options in how to respond to stressful and anxiety-provoking situations because of limited or ineffective coping skills (Robinson et al., 2017; Robinson et al., 2015). There are indications that Black adolescents cope with depression in a variety of contexts. Some Black adolescents describe depression as a way of life, noting that everybody becomes depressed one way or another (Ofonedu et al., 2013). Researchers have shown that some Black adolescents conceal their feelings of depression because they are uncertain of how others would perceive them (Al-Khattab et al., 2016; Ofonedu et al., 2013). For instance, some Black adolescents reported trying to manage their depression independently and only going to an adult as a last resort (Breland-Noble et al., 2010). Black adolescents have been shown to manage their depression by strong will and spiritual beliefs (Ofonedu et al., 2013). Conner and Yeh (2018) highlighted how Black adolescents cope with depression in spiritual and creative ways such as listening to music, dancing, and writing.

In 2016, Al-Khattab et al. discovered that Black adolescents controlled their depression through their interactions with other people. Al-Khattab et al. identified five typology interaction models, which include hiding feelings of depression, lashing out verbally or physically toward others, seeking help from others to address emotional feelings, joining with others in social activities, and having others approach them about behavioral and mood changes. Therefore, it is critical for Black adolescents to better understand their experiences with depression and how interactions with others may influence their symptoms.

Treatment of Depression in Black Adolescents

Cook et al. (2017) noted that there are barriers to accessing mental health services and quality of care, which include stigma associated with mental illness, distrust of the health care system, lack of providers from diverse racial/ethnic backgrounds, lack of culturally competent providers, and lack of insurance or underinsurance. Often these barriers cause Black people to be unable or reluctant to seek help (Shushansky, 2017). Although Black adolescents may feel that treatment can be effective, many are reluctant to attend therapy because of the stigma and possible misdiagnosis of their symptoms, much of which has been influenced by their culture (Al-Khattab et al., 2016; Lindsey et al., 2010; Ofonedu et

al., 2013). Positive results have been seen when using family-centered prevention programs to address depressive symptoms in Black adolescents (Brody et al., 2012). Jacob et al. (2013) determined that behavioral activation was effective for decreasing depressive symptoms and impairments for the Black adolescents who participated in their study.

As highlighted by a study of Black adults from a rural faith community, Black people living in rural communities suffering from depression face additional barriers to treatment such as (a) a lack of medical resources, (b) insufficient education about depression, and (c) stigma (Bryant et al., 2013). Sullivan et al. (2017) learned that terminology was crucial when discussing treatment with rural Black adults on a stigmatized topic such as mental illness. Parental concerns about marginalization because of having a child with a mental health diagnosis and some primary care providers' characterization of mental health symptoms as a "phase" have been found to be barriers to treatment for Black children living in rural communities (Murry et al., 2011). Working with Black children who live in poverty, Graves (2017) identified cultural and macro-level barriers that influence the process of seeking treatment.

Treatment of mental health disorders extends from diagnoses. Considering the differences in symptoms and frequency of misdiagnosis, it is not surprising that treatment options for Black adolescents have shown varied outcomes across the literature. Additionally, some researchers suggested that new measures need to be developed for accurately identifying depression in diverse populations, which would then inform modifications in treatment (Ofonedu et al., 2013). Having a better understanding of the unique and complex experiences of Black adolescents may help parents, therapists, schools, and counseling professionals understand and identify those most at risk for depression. Planey et al. (2019) discovered that Black youth viewed seeking mental health treatment as a contextual and relational process rather than an event. What is clear is that more culturally diverse training for therapists, schools, and counseling professionals is needed to prevent, detect, and implement interventions for minorities experiencing depression during the disease's earlier stages. Likewise, research exploring Black adolescents' unique experiences of symptoms, environmental factors, and coping strategies remains necessary in order to inform effective treatment.

Purpose of the Present Study

The review of the literature captured symptoms and coping strategies unique to Black adolescents. Studies highlight that environmental factors contribute to depressive symptoms in this population. Furthermore, disparities exist in mental health care for adolescents, specifically for minorities (Alegria et al., 2010; Brenner, 2019; Lake & Turner, 2017). This clear gap in the literature indicates insufficient knowledge regarding the personal experiences of Black adolescents with depression. Most of the studies in the extant literature took place in urban areas; little is known about rural experiences and even less is known about experiences in the southeastern United States. This qualitative study was designed to help fill that gap. It posed an overarching research question to Black adolescents living in the rural southeastern United States: "What is your experience with depression?" This study was designed to offer human services professionals a clearer understanding of the unique experiences of Black adolescents in this geographical region who had been diagnosed with depression, with the hope of informing clinical practices.

Method

The goal of this study was to explore the unique experiences of Black adolescents living in the rural southeastern United States who had been diagnosed with depression. The research design for

the study was a basic interpretive qualitative method, as described by Merriam (2009). The purpose of this method is to understand the perspectives of the participants involved by uncovering and interpreting their meanings (Everall et al., 2006). This purpose was well-suited to the overall objective of this study, which was to gain a clearer understanding of the unique personal experiences of Black adolescents living with depression in the rural southeastern United States.

According to Merriam (2009), interpretive qualitative research is founded on the idea that people and their interactions with their world, or reality, socially construct meaning. Researchers using this method are interested in how individuals "interpret" their experiences, "construct their worlds," and assign "meanings" to their experiences (Merriam, 2009, p. 38). Moreover, Merriam asserted that interpretive qualitative research has multiple meanings and is a complex phenomenon ideal for attempting to understand and treat Black adolescents with depression. Using Merriam's (2009) model, researchers "strive to understand the meanings individuals construct regarding their world and their experiences" in a natural setting (p. 4). Another characteristic is that the researcher serves as the primary instrument for both collecting and analyzing data. The research process is inductive rather than deductive, which means that the researcher gathers data in an effort to "build concepts, hypotheses, or theories" in the forms of themes and categories (Merriam, 2009, p. 5). A final characteristic of this model is that interpretive qualitative research is richly descriptive and includes details about the context, the participants involved, and quotations and interview excerpts (Merriam, 2009).

Merriam (2009) noted that certain elements of the basic interpretive qualitative design may overlap with other designs, particularly when concepts of cultural values are discussed and explored. Merriam's design does not require researchers to give a full sociocultural interpretation of the data, as is done in ethnography. Indeed, this study does not provide a full sociocultural interpretation. However, the data were analyzed using Patton's (1987) content analysis model because the model provides a rigorous, systemic, and ethical procedure for analyzing data. Merriam's model for collecting data and Patton's model for analyzing data form a rich methodological combination that enhances the trustworthiness of the research study and improves the transferability of its findings.

Participants and Procedure

The university IRB granted approval for this study. Purposive sampling was used to identify 10 Black adolescents living in the rural southeastern United States who were being treated for depression. The southeastern part of the United States was selected because it contains fewer metropolitan areas that have been studied specifically. Each of the participants met the following criteria: (a) self-identified as Black, (b) was between the ages of 13 and 17, (c) was willing to participate, (d) had secured a signed informed consent form from their parents, (e) had signed a participant assent form, and (f) was currently under the care of a counselor either in or out of school for depression. The participants ranged in age from 13 to 17 years old and were in grades seven through 12. Six participants were female and four were male.

Approval was obtained in advance from a public school system located in the rural southeastern United States. The public school system administrator agreed to send the letter of invitation along with the consent and assent forms to the parents and potential participants. In addition, the first author sent a packet of information to a counseling agency; school professionals, including professional school counselors and school psychologists; and social workers. The packet contained an invitation letter requesting that the packet be shared with potential participants and their parents; it also contained consent and assent forms. The informed consent form described the study and the efforts that would be

taken to protect the confidentiality of the participants' information. The informed consent form stated that the risk of participating was the normal discomfort of sharing one's experiences with depression and that if a participant felt uncomfortable, they could withdraw from the study at any time.

Parents and participants signed the consent and assent forms, respectively, and returned them to either the local counseling agency or school professionals, who forwarded the forms to the first author. The first author then contacted the parents, with the participants present, to schedule a 45- to 90-minute, face-to-face interview with the participant. The informed consent form was verbally reviewed, ensuring that the parents and participants understood that a second interview to review and correct the interpretation would be optional. Interviews took place either during the day in a private room at the school or outside of school hours in the first author's office. Because adolescent depression is considered a sensitive topic, participants were instructed to follow up with their counselor if they experienced adverse feelings as a result of participating in the study.

Data Collection and Analysis

The first author met with each of the 10 participants for a single semi-structured interview that lasted between 45 and 90 minutes. In phenomenological research, the researcher follows the essence of participants' responses (van Manen, 1997). The first author spent time establishing rapport with the participants. Once the first author believed a participant was comfortable, she asked the participant the overarching question, "What is your experience with depression?" Follow-up questions specific to each participant were used to probe the participants' responses regarding their experience as Black adolescents living with depression in the rural southeastern United States. Several participants expressed a reluctance to fully disclose or discuss their experiences with depression; however, no participants withdrew from the study, and all participants completed the first interview. At the end of the first interview, the participants were notified that they would be contacted for a second interview to review the transcript of the first interview and verify its accuracy and trustworthiness.

Interviews were recorded and transcribed verbatim by both the first author and a professional transcriber. The transcripts were coded and analyzed for themes related to the research question of this study. The first author utilized Patton's (1987) content analysis model as a process of bringing order to the data by organizing the data into major themes, categories, and case examples. The first author consulted with two experts in qualitative research in the human services field and used three levels of coding: open, axial, and selective. Open coding included reading the transcribed interviews several times and coding phrases, from one word to portions of paragraphs. Based on input from the consultants, the first author enhanced the coding process by entering the data into the NVivo QSR software program, which facilitated organization and analysis. The first author then condensed the data into five categories. Axial coding enabled the first author to organize, link, and cluster codes, while selective coding allowed the first author to analyze the words, sentences, and themes from the interviews. Data analysis via coding was a back and forth process, and staying close to the transcripts was essential. The labeling and coding allowed the first author to interpret and classify the data and themes into five categories that were supported with direct quotations from the participants.

Trustworthiness

Trustworthiness is an important aspect of qualitative research (Hays & Singh, 2012). The generally candid nature of each participant in relating even the most difficult experiences, such as rape, would suggest a high degree of trustworthiness in their responses. Member checking was offered to all participants in the form of a follow-up interview. When contacted by the first author to schedule this interview, however, none of the participants felt that it was necessary. Rather, all of the participants

stated they were satisfied with their responses in the first interview. In addition to offering member checking, the first author used rich data, prolonged engagement, respondent validation, a search for discrepant data, and peer review to ensure trustworthiness. A peer review of the method was conducted by doctoral-level professors in human services who specialized in qualitative research in order to enhance internal validity (Lincoln & Guba, 1985; Merriam, 2009). The first author used an audit trail by engaging in memo-writing to express thoughts, perspectives, observations, and reactions to interviews, transcriptions, and coding. An *audit trail* is a strategy in which a researcher explains as best as possible how they arrived at the results of the study by documenting how the data were collected, how categories were developed, and how findings were interpreted throughout the study (Lincoln & Guba, 1985). An audit trail thus improves the quality of a study. The information and details from this study may be generalizable to other groups and may contribute to the knowledge base of best practices when working with this population in counseling.

Results

Through data analysis, the researcher identified five significant thematic categories: (a) definitions of depression, (b) seeking treatment, (c) coping and problem-solving strategies, (d) types of emotional support, and (e) contributing factors to depression. These five thematic categories were broken down into their constituent contents. Each thematic category was addressed with the invariant constituents that make up that category, including elaboration on any significant constituent patterns (such as high and low frequency of occurrence). Quotations from the participants are included in the text as examples to elucidate the invariant constituents and thematic categories. For reasons of confidentiality, some identifying information was excluded. All participants identified as Black and lived in the rural southeastern United States.

At the time of the study, the participants were living in a southeastern U.S. community in one of the lowest socioeconomic brackets of the country. In the participants' community, the majority of the population was Black and participated in the school's free or reduced-fee lunch program. Because of the homogeneous nature of the community, the participants did not speak of any adverse social or political circumstances, and the researcher avoided broaching the topic in an effort to do no harm. The researcher believed that overlooking the social and political climate of the community increased the trustworthiness of the participants' responses, as the participants were not influenced by the discussion of the climate nor did they voluntarily express its relevance to their experience. As a Black adult, the researcher, who is first author, was aware of how the social and political climate played into their experience. However, because the participants were adolescents experiencing emotional pain, the first researcher attempted to instill hope in them as part of their experiences of this study. To maintain confidentiality, specific details about the contextual factors in the participants' community have been omitted.

Definitions of Depression

Data analysis identified 18 codes that were relevant to the category regarding how participants defined depression. Of these codes, three emerged with significantly higher prevalence than the others: (a) *sadness*; (b) *isolation, social withdrawal, or loneliness*; and (c) *permanent or persistent*. Nine out of the 10 participants (90%) indicated that they experienced the feelings associated with these three codes. For example, in response to how he defined depression, Participant 5 noted that he became "sad, mad, and very frustrated." Participant 1 defined depression in terms of social withdrawal, saying, "Usually I stay in my room and I don't talk to anybody, I just stay in there, and that is about it." Participant 4 provided an example of the theme of permanent or persistent experiences by stating, "I don't think it could just

go away, especially when it's very serious." Participant 3 provided an example that captured the overall essence of this category when he stated:

> I have been sad a whole lot, without reason; and so, I think that is why I was depressed . . . when I am around people for too long, I get sad; but when I am alone, I am happier. I feel safe when I am by myself. When it [depression] comes on, it comes on strong. It is really bad. Because I feel really, really sad, and my thoughts aren't, you know, normal. Sometimes they are violent . . . like I don't have any hope at all. I don't think like I normally would. Sometimes I don't think at all. Sometimes when I get really sad or angry, I think about hurting people. So, I have to withdraw further. I have to push it further down into my mind so that I won't act on it.

It is interesting to note that the next most frequently found codes were *stress-related* and *frustration*, each with a prevalence of 60%, and *more common in young Black girls*, which had a prevalence of 50%. Alternatively, only one participant mentioned each of the following codes with regard to defining depression: *suicidal thoughts or attempts*, *more common in young Black boys*, and *feeling sick*.

Seeking Treatment

The category of seeking treatment contained 10 codes. Participants expressed contradictory feelings about the effectiveness of treatment and the barriers to seeking treatment. For example, 90% of participants expressed that they felt that *therapeutic treatment was effective* in mitigating or curing depression, including Participant 7: "To me, to talk to my therapist was like a relief to me, because he was the only person that I can be able to tell my thoughts, get my thoughts together why I was in there." Simultaneously, 30% of participants noted that they felt that *therapy was not effective* as a treatment. This overlap and apparent incompatibility in the data helped reveal the full breadth of Black adolescents' opinions and feelings about depression and seeking treatment, as participants expressed both positive and negative experiences.

This overlapping trend was seen elsewhere in this thematic category. For example, there were codes of *medication is effective* (50%) and *medication is not effective* (30%). This apparent contradiction was highlighted not only between participants but also within a single participant. Participant 10 directly stated she believed medication to be effective; she then revealed that she had been given medication that sent her into a coma. She reported taking her medication as prescribed but "after that I passed out, and I didn't remember nothing, all I knew I woke up in the hospital." Three codes were identified as directly related to seeking treatment. Significant barriers to therapeutic treatment were *negative connotation of mental illness* (80%), *uncomfortable issues brought up in treatment* (80%), and *lack of trust* (70%). The code *negative connotation of mental illness* was grounded in external perceptions, as many participants indicated that they did not want other people to know that they were in treatment.

For example, Participant 2 stated, "I don't tell them. I don't want them to know," when referring to his friends. Participant 3 provided an example of the code of uncomfortable issues, noting, "I don't like to talk about it much. You know, it is kind of aggravating. It makes me feel weak when I talk to people about my problems." Regarding the code *lack of trust,* Participant 6 noted, "I have very weak trust issues. Sometimes they can be strong but mostly weak."

Three minor codes emerged relating to seeking treatment. Two were *trouble expressing self in therapy* (40%) and *treatment was not necessary* (40%). Participant 3 stated, "I have a lot of trouble expressing myself. You know, when I get into the office, I just forget what to say." Three of the 10

participants openly discussed *lack of Black people's knowledge or education about depression* as a specific barrier to treatment. They shared their perceptions of the lack of education and discussion about depression within their own community, which they felt presented a specific barrier to treatment for them. Participant 6 stated, "I can't overly generalize it, but some people need to know more, 'cause they don't understand, because sometimes you just need that time and people they don't understand that you need it." However, taking these and the other barriers in this thematic category into account, the prevalence of participants who reported that treatment was effective was three times greater than the prevalence of participants who thought that treatment was ineffective.

Coping and Problem-Solving Strategies

The third thematic category contained 29 different codes related to problem-solving strategies and behaviors or activities the participants used to cope with depressive symptoms. The participants described various strategies to cope with depression, but the most prevalent was *suppressing/hiding thoughts/feelings*. There were seven strategies that more than half of the participants reported using as problem-solving strategies and strategies to cope with depression. The positive problem-solving strategies were *listening to music*, *turning to religion/going to church/praying*, and *talking/spending time with family*. The problematic coping strategies reported were *using illegal drugs*, *engaging in self-harm*, *having sex*, and *isolating*. See Table 1 for codes and results.

It is encouraging that 18 out of the 29 codes could be characterized as neutral or positive coping strategies. The other 11 are areas of concern, even if only one participant reported engaging in the behavior. Participant responses overlapped and participants reported coping and problem-solving strategies that might be characterized as both positive and negative. In addition to contrasts in the specific codes and types of behaviors, contrasts in the percentages of participants who reported negative behaviors compared to positive behaviors were noted. For example, participants reporting the negative problem-solving strategy of *engaging in self-harm* as a way to cope often went into detailed narrative descriptions. This strategy was more frequently reported than any of the positive or neutral coping and problem-solving strategies.

Types of Emotional Support

This thematic category addressed the types of emotional support that the participants received during their experiences with depression. Four distinct subthemes of codes were identified: *peers*; *family*; *school* (teachers); and *helping professionals* such as hospitals, managed care facilities, and therapists. Each of the four subthemes contained codes that were sorted as either positive or negative. A lack of support or refusal of support was considered a negative, and similar to other categories, participants shared multiple overlapping experiences. Negative support from peers was the only theme to have 100% prevalence; every participant mentioned that peers had negatively affected them through a lack of emotional support during their experience with depression, including Participant 2: "They didn't believe me at first, but later they just seem like they don't care." Half of the participants expressed that they had also received positive emotional support from their peers during their experience with depression. In the family group, equal percentages of participants (60%) reported receiving positive support from family and experiencing a lack of support from family. The participants were similarly split regarding their perceptions of receiving positive (50%) and negative (50%) emotional support from teachers at school. The greatest proportional difference in negative and positive emotional support was within the category of helping professionals. In this subtheme, four times as many participants (40%) reported that they had had positive emotional support from mental health care providers in a hospital, halfway house, or therapeutic community than participants reporting negative emotional support from mental health care providers (10%).

Table 1

Coping and Problem-Solving Strategies

	Strategy	Percent of Respondents (*N* = 10)
Positive or Neutral Coping Strategies	Listening to music	70%
	Turning to religion / going to church / praying	70%
	Talking / spending time with family	60%
	Attending therapy	40%
	Writing	40%
	Creating art	30%
	Playing video games	30%
	Watching TV	30%
	Crying	30%
	Taking prescription drugs	20%
	Eating food	20%
	Reading	20%
	Talking / spending time with friends	20%
	Distracting self	20%
	Laughing	20%
	Joining clubs	10%
	Working out	10%
	Researching	10%
Problematic Coping Strategies	Suppressing / hiding thoughts / feelings	90%
	Using illegal drugs	70%
	Engaging in self-harm	60%
	Having sex	60%
	Isolating	60%
	Attempting suicide	40%
	Engaging in violence	40%
	Running away	30%
	Yelling / shouting	10%
	Having violent thoughts	10%
	Avoiding responsibilities / rebelling	10%

Contributing Factors to Depression

This theme of contributing factors to depression appeared to be the most salient to the central research question of how Black adolescents living in the rural southeastern United States described their experiences with depression. The previous themes captured definitions of depression, seeking treatment, coping and problem-solving strategies, and types of emotional support. This theme provided a description of the participants' lives in terms of their context and environment, which the participants identified as contributing factors to their experiences of depression. When asked about contributing factors to their depression, the three most noted by the participants were *verbal abuse* (70%), *differences from other people and being bullied* (70%), and *parental or family problems* (70%). Participants also reported *sexual abuse* (40%) and *physical abuse* (30%) as contributing factors. Participant 6 made the following statement, which captures the essence of this theme:

> My depression started really kicking in when I was around 13 . . . it runs in my family.
> My mom has it and when I was little, I was sexually abused . . . and I've been made
> fun of all my life . . . my weight . . . a scalp infection. People make fun of stuff like that.
> And that's been going on since I was little.

The least prevalent factors mentioned by participants were *foster care* (20%), *stress of schoolwork* (20%), and *a scary book* (10%). *Verbal abuse* was reported 30% more frequently than *sexual abuse* and 40% more frequently than *physical abuse*. However, it is interesting to note that Participant 2 considered foster care to be a cause of depression and not a solution. Most participants identified a combination of these factors as contributing to the onset of their depressive symptoms.

Discussion and Implications

This study sought to examine the unique experiences of Black adolescents diagnosed with depression living in a rural community located in the southeastern part of the United States. Five themes emerged when examining the participants' narratives with depression. These themes included definitions of depression, seeking treatment, coping and problem-solving strategies, types of emotional support, and contributing factors to depression. In defining depression, 90% of the participants in this study cited sadness, isolation, and depression's ongoing nature. This is not surprising, as these codes fit within the diagnostic criteria for depression. It was surprising, however, that participants defined depression as stress-related, as stress is not one of the diagnostic criteria. At the same time, the idea of depression as stress-related is supported in other studies (Breland-Noble et al., 2010; Bryant et al., 2013; Choi et al., 2006; Ofonedu et al., 2013; Robinson et al., 2015). The mental health community would do well to acknowledge the differences in how Black adolescents from rural U.S. communities may define depression. When working with Black adolescent clients, practitioners may wish to inquire about stressors and consider their relation to depression in order to inform treatment plans and interventions.

Most participants who sought treatment for depression indicated that treatment was effective; however, 30% of participants expressed that therapy was ineffective. Additionally, only 50% of participants indicated that medication was an effective form of treatment. Participants also identified barriers to seeking treatment, which included negative connotations associated with mental illness and discomfort discussing issues in treatment. Barriers identified included a lack of trust, problems with self-expression, the belief that therapy was not needed, and a lack of knowledge about depression in the Black culture. These results are consistent with prior research (Al-Khattab et al., 2016; Bryant et al., 2013; Lindsey et al., 2010; Ofonedu et al., 2013; Sullivan et al., 2017), indicating that mental health

conditions are often misunderstood, misdiagnosed, or unacknowledged within the Black community (Graves, 2017; Murry et al., 2011; Shushansky, 2017).

Prior research has also highlighted the stigma of mental illness in the Black community (Cook et al., 2017). This stigma helps to explain previous research showing that Black people often seek help as a last resort (Al-Khattab et al., 2016; Breland-Noble et al., 2010; Ofonedu et al., 2013; Vontress et al., 2007). It is essential that counselors acknowledge the stigma associated with mental illness and reluctance to seek treatment within the Black community. More practitioners who are aware of and sensitive to the mental health needs of Black communities are needed. It is imperative that clinicians take it upon themselves to become competent when working with this population. To address the stigma, practitioners might offer training in evidence-based practices related to Black adolescents' mental health at churches, schools, and various community organizations in the Black community. These types of trainings could be particularly effective in rural communities where participants are likely to communicate to others about the trainings, thereby validating the information and possibly reducing the stigma. One of the codes from this study was related to the effectiveness of medication for reducing depressive symptoms. More research is needed to explore factors that may contribute to this experience. Additionally, more research is needed to understand the unique traits of Black adolescents seeking treatment in other regions of the United States.

There were a few positive strategies for coping with depression that the participants identified, including listening to music, engaging in spiritual practices, and spending time with family. These positive coping strategies supported the constructs of spiritual beliefs and relationships with others, which were established in prior studies (Al-Khattab et al., 2016; Conner & Yeh, 2018; Ofonedu et al., 2013). The theme of coping and problem-solving strategies was dominated by the most common strategy: participants hiding their thoughts and feelings as a way of managing their depressive symptoms. This result corroborates the findings of prior studies that show Black adolescents conceal their feelings and symptoms of depression (Al-Khattab et al., 2016; Breland-Noble et al., 2010; Ofonedu et al., 2013; Vontress et al., 2007). As previous studies have suggested, hiding thoughts and feelings may be due to the stigma associated with mental illness and limited options in how to respond to stressful and anxiety-provoking situations (Robinson et al., 2017; Robinson et al., 2015). The finding that the participants hide thoughts and feelings also supports previous research that Black adolescents may be fearful of how others will react to them and isolate themselves as a result (Al-Khattab et al., 2016; Breland-Noble et al., 2010; Ofonedu et al., 2013). Participants also reported engaging in unhealthy coping behaviors such as self-harm, sexual intercourse, and isolation. These harmful strategies may be due to the limited coping skills of Black adolescents that have been identified in prior research studies (Robinson et al., 2017; Robinson et al., 2015). Again, these findings highlight the need for culturally specific training regarding mental health in Black communities.

The theme of emotional support resonated with all participants in this study, suggesting the significance of relationships (Breland-Noble et al., 2010). When examining emotional support, positive and negative experiences emerged. Positive emotional supports were found in family members (60%), teachers (50%), and mental health professionals (40%). Yet all participants indicated being negatively impacted by a lack of support among their peers. Participants reported feeling invalidated or not believed by their peers. They also reported that their peers did not seem to show concern. These experiences may have exacerbated the participants' symptoms. Only half of the participants indicated receiving positive peer support when seeking help for depressive symptoms. These findings are concerning because of the heavy emphasis placed on relationships within Black communities (Breland-Noble et al., 2010).

Relationships were identified as significant to all participants in this study, indicating that healthy relationships may be a protective factor and may increase emotional and mental health. Counseling professionals in private practice and in schools are thus encouraged to inquire about a wide range of relationships when working with their Black adolescent clients. For example, a counseling professional might ask a client to complete a detailed relationship profile for each significant person in their life. This would help to uncover significant relationships that could support the client's current challenges and to identify those individuals who might not be providing support. Counseling professionals might also conceptualize client symptoms as connected to these relationships. Family or systemic interventions may be incorporated into treatment planning to decrease depressive symptoms.

The theme of contributing factors encompassed a surprisingly high number of significant adverse and traumatic experiences. When examining the factors contributing to the development of depression in Black adolescents, most participants in this study cited verbal abuse, differences from others/bullying, and family-related issues as salient factors. Other contributing factors included sexual and physical abuse. Participants reported verbal abuse (70%), sexual abuse (40%), and physical abuse (30%) as contributing factors of depression. However, participants did not identify one single factor but rather described multiple and overlapping factors that contributed to their depressive symptoms. The connection between adverse and traumatic experiences and depressive symptoms specifically within the Black adolescent population appears to be underreported in the literature.

It is important to note the high prevalence of abuse indicated within the study. The lack of existing studies exploring the relationship among Black adolescents, depression, and adverse childhood experiences indicates that additional research is needed. An implication of this study is that when working with Black adolescent clients who are presenting with symptoms of depression, counseling professionals might incorporate an adverse childhood experience screening tool. Assessing clients for adverse childhood experiences as a matter of regular practice may better inform preventative measures and treatment. As this study highlights, it is essential for clinical and school professionals working with Black adolescents to understand that abuse can contribute to depressive symptoms.

Overall, many of the symptoms described by participants could be associated with a diagnosis of dysthymia as a result of oppression, supporting the work of Vontress et al. (2007). However, the participants did not use the word "oppression" and may not have recognized the systemic aspects of their experiences (Vontress et al., 2007). It may be that the participants' adverse experiences of abuse overshadowed any cultural or historical factors that may also have been present. The current study highlighted the overlooked and undertreated experiences of Black adolescents with depression. Counseling professionals may choose to gain a preliminary understanding of Black adolescent depression and dysthymia symptoms "within the context of their legacy of discrimination and oppression" (Vontress et al., 2007, p. 132).

Limitations

Overall, these findings need to be considered in light of some specific limitations. First, the interview questions were semi-structured. This means that the researcher used open-ended questions followed by discussion. As a result, the interviewer may not have covered the exact same content with each participant. Furthermore, because of the nature of the study, some participants may have been more forthcoming about their personal experiences. Thirdly, although the participants were asked about past events, the memories of those events may have been compromised because of

the passage of time or because of received or ongoing treatment. Lastly, given the limited number of participants interviewed, more research is needed to understand the mental health needs and experiences of Black adolescents who are experiencing depression.

Conclusion

In this qualitative study of 10 Black adolescents living in a rural community, the authors provided space for the participants to use their own terms and language to define depression. It is clear through this and other research that contextual factors are often involved in the onset of depression in Black adolescents, and there is not enough active therapeutic and medical treatment for Black adolescents living with depression. There is a stigma associated with mental illness and reluctance to seek treatment within the Black community, particularly in rural areas. As a result, counselors and mental health providers need to become more educated and aware when working with Black adolescents who live in rural communities.

References

Alegria, M., Vallas, M., & Pumariega, A. J. (2010). Racial and ethnic disparities in pediatric mental health. *Child and Adolescent Psychiatric Clinics of North America*, *19*(4), 759–774. https://doi.org/10.1016/j.chc.2010.07.001

Al-Khattab, H., Oruche, U., Perkins, D., & Draucker, C. (2016). How African American adolescents manage depression: Being with others. *Journal of the American Psychiatric Nurses Association*, *22*(5), 387–400. https://doi.org/10.1177/1078390316657391

Auger, R. W. (2005). School-based interventions for students with depressive disorders. *Professional School Counseling*, *8*(4), 344–352.

Breland-Noble, A. M., Burriss, A., & Poole, H. K. (2010). Engaging depressed African American adolescents in treatment: Lessons from the AAKOMA PROJECT. *Journal of Clinical Psychology*, *66*(8), 868–879. https://doi.org/10.1002/jclp.20708

Brenner, E. (2019). The crisis of youth mental health. *Stanford Social Innovation Review*. https://ssir.org/articles/entry/the_crisis_of_youth_mental_health#

Bridge, J. A., Horowitz, L. M., Fontanella, C. A., Sheftall, A. H., Greenhouse, J., Kelleher, K. J., & Campo, J. V. (2018). Age-related racial disparity in suicide rates among US youths from 2001 through 2015. *JAMA Pediatrics*, *172*(7), 697–699. https://doi.org/10.1001/jamapediatrics.2018.0399

Brody, G. H., Chen, Y.-F., Kogan, S. M., Yu, T., Molgaard, V. K., DiClemente, R. J., & Wingood, G. M. (2012). Family-centered program deters substance use, conduct problems, and depressive symptoms in Black adolescents. *Pediatrics*, *129*(1), 108–115. https://doi.org/10.1542/peds.2011-0623

Bryant, K., Greer-Williams, N., Willis, N., & Hartwig, M. (2013). Barriers to diagnosis and treatment of depression: Voices from a rural African-American faith community. *Journal of National Black Nurses' Association: JNBNA*, *24*(1), 31–38.

Choi, H., Meininger, J. C., & Roberts, R. E. (2006). Ethnic differences in adolescents' mental distress, social stress, and resources. *Adolescence*, *41*(162), 263–283.

Conner, L. C., & Yeh, C. J. (2018). Stress, coping, and depression among Black urban adolescents: Implications for school counseling. *Journal of School Counseling*, *16*(15), 1–31.

Cook, B. L., Trinh, N.-H., Li, Z., Hou, S. S.-Y., & Progovac, A. M. (2017). Trends in racial–ethnic disparities in access to mental health care, 2004–2012. *Psychiatric Services*, *68*(1), 9–16. https://doi.org/10.1176/appi.ps.201500453

Everall, R. D., Altrows, J., & Paulson, B. L. (2006). Creating a future: A study of resilience in suicidal female adolescents. *Journal of Counseling & Development*, *84*(4), 461–471. https://doi.org/10.1002/j.1556-6678.2006.tb00430.x

Graves, L. (2017). Filters of influence: The help-seeking process of African American single mothers living in poverty seeking mental health services for their children. *Child & Youth Services*, *38*(1), 69–90. https://doi.org/10.1080/0145935X.2016.1251836.

Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. Guilford.

Hope, M. O., Assari, S., Cole-Lewis, Y. C., & Caldwell, C. H. (2017). Religious social support, discrimination, and psychiatric disorders among Black adolescents. *Race and Social Problems*, *9*(2), 102–114. https://doi.org/10.1007/s12552-016-9192-7

Jacob, M., Keeley, M. L., Ritschel, L., & Craighead, W. E. (2013). Behavioural activation for the treatment of low-income, African American adolescents with major depressive disorder: A case series. *Clinical Psychology & Psychotherapy*, *20*(1), 87–96. https://doi.org/10.1002/cpp.774

Lake, J., & Turner, M. S. (2017). Urgent need for improved mental health care and a more collaborative model of care. *Permanente Journal*, *21*, 17–24. https://doi.org/10.7812/TPP/17-024

Liang, J., Matheson, B. E., & Douglas, J. M. (2016). Mental health diagnostic considerations in racial/ethnic minority youth. *Journal of Child and Family Studies*, *25*(6), 1926–1940. https://doi.org/10.1007/s10826-015-0351-z

Lindsey, M. A., Joe, S., & Nebbitt, V. (2010). Family matters: The role of mental health stigma and social support on depressive symptoms and subsequent help seeking among African American boys. *Journal of Black Psychology*, *36*(4), 458–482. https://doi.org/10.1177/0095798409355796

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* SAGE.

Lu, W. (2019). Adolescent depression: National trends, risk factors, and healthcare disparities. *American Journal of Health Behavior*, *43*(1), 181–194. https://doi.org/10.5993/AJHB.43.1.15

Lu, W., Lindsey, M. A., Irsheid, S., & Nebbitt, V. E. (2017). Psychometric properties of the CES-D among Black adolescents in public housing. *Journal for the Society for Social Work and Research*, *8*(4), 595–619. https://doi.org/10.1086/694791

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation* (3rd ed.). Jossey-Bass.

Murry, V. M., Heflinger, C. A., Suiter, S. V., & Brody, G. H. (2011). Examining perceptions about mental health care and help-seeking among rural African American families of adolescents. *Journal of Youth and Adolescence*, *40*(9), 1118–1131. https://doi.org/ 10.1007/s10964-010-9627-1

National Institute of Mental Health. (2013). *Major depression.* https://www.nimh.nih.gov/health/statistics/major-depression.shtml

Ofonedu, M. E., Percy, W. H., Harris-Britt, A., & Belcher, H. M. E. (2013). Depression in inner city African American youth: A phenomenological study. *Journal of Child and Family Studies*, *22*(1), 96–106. https://doi.org/10.1007/s10826-012-9583-3

Patton, M. Q. (1987). *How to use qualitative methods in evaluation* (2nd ed.). SAGE.

Planey, A. M., Smith, S. M., Moore, S., & Walker, T. D. (2019). Barriers and facilitators to mental health help-seeking among African American youth and their families: A systematic review study. *Children and Youth Services Review*, *101*, 190–200. https://doi.org/10.1016/j.childyouth.2019.04.001

Probst, J. C., Laditka, S. B., Moore, C. G., Harun, N., Powell, M. P., & Baxley, E. G. (2006). Rural-urban differences in depression prevalence: implications for family medicine. *Family Medicine Kansas City*, *38*(9), 653–660.

Robinson, W. L., Brown, M., Beasley, C. R., & Jason, L. A. (2017). Advancing prevention intervention from theory to application: Challenges and contributions of community psychology. In M. A. Bond, I. Serrano-García, C. B. Keys, & M. Shinn (Eds.), *APA handbook in psychology. APA handbook of community psychology: Methods for community research and action for diverse groups and issues* (pp. 193–213). American Psychological Association.

Robinson, W. L., Droege, J. R., Case, M. H., & Jason, L. A. (2015). Reducing stress and preventing anxiety in African American adolescents: A culturally-grounded approach. *Global Journal of Community Psychology Practice*, *6*(2). https://doi.org/10.7728/0602201503

Saluja, G., Iachan, R., Scheidt, P. C., Overpeck, M. D., Sun, W., & Giedd, J. N. (2004). Prevalence of and risk factors for depressive symptoms among young adolescents. *Archives of Pediatrics and Adolescent Medicine*, *158*(8), 760–765. https://doi.org/10.1001/archpedi.158.8.760

Shushansky, L. (2017, July 31). *Disparities within minority mental health care* [Blog post]. National Alliance on Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/July-2017/Disparities-Within-Minority-Mental-Health-Care

Smokowski, P. R., Bacallao, M. L., Cotter, K. L., & Evans, C. B. R. (2015). The effects of positive and negative parenting practices on adolescent mental health outcomes in a multicultural sample of rural youth. *Child Psychiatry & Human Development*, *46*(3), 333–345. https://doi.org/10.1007/s10578-014-0474-2

Sullivan, G., Cheney, A., Olson, M., Haynes, T., Bryant, K., Cottoms, N., Reaves, C., & Curran, G. (2017). Rural African Americans' perspectives on mental health: Comparing focus groups and deliberative democracy forums. *Journal of Health Care for the Poor and Underserved*, *28*(1), 548–565. https://doi.org/10.1353/hpu.2017.0039

van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy*. (2nd ed.). Althouse.

Vontress, C. E., Woodland, C. E., & Epp, L. (2007). Cultural dysthymia: An unrecognized disorder among African Americans? *Journal of Multicultural Counseling and Development*, *35*(3), 130–141. https://doi.org/10.1002/j.2161-1912.2007.tb00055.x

Weaver, A., Himle, J. A., Taylor, R. J., Matusko, N. N., & Abelson, J. M. (2015). Urban vs. rural residence and the prevalence of depression and mood disorder among African American women and non-Hispanic white women. *JAMA Psychiatry*, *72*(6), 576–583. https://doi.org/10.1001/jamapsychiatry.2015.10

Willis, L. A., Coombs, D. W., Drentea, P., & Cockerham, W. C. (2003). Uncovering the mystery: Factors of African American suicide. *Suicide and Life-Threatening Behavior*, *33*(4), 412–429. https://doi.org/10.1521/suli.33.4.412.25230

World Federation for Mental Health. (2012). *Depression: A global crisis.* https://www.who.int/mental_health/management/depression/wfmh_paper_depression_wmhd_2012.pdf

World Health Organization. (2020). *Depression.* https://www.who.int/news-room/fact-sheets/detail/depression

nbcc

TPC

The Professional Counselor™

NATIONAL BOARD FOR
CERTIFIED COUNSELORS®

10 Years
of
PUBLISHING
EXCELLENCE