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Lifetime Achievement in Counseling Series
An Interview With Mona Robinson

Joshua D. Smith, Neal D. Gray

Each year TPC *presents an interview with a seminal figure in counseling as part of its Lifetime Achievement in Counseling series. This year I am honored to introduce Dr. Mona Robinson. She identifies as a counselor with expertise in rehabilitation counseling, is among the distinguished faculty at Ohio University, and is an internationally recognized scholar. I am grateful to Dr. Joshua Smith and Dr. Neal Gray, who continue to bring the contributions and wisdom of leaders in the profession to* TPC *readers. Here they present a view to Dr. Robinson's accomplishments throughout her career, along with her reflections on the CACREP and CORE merger and the evolution of the profession. —Amie A. Manis, Editor*

Mona Robinson, PhD, LPCC-S, LSW, CRC, is a professor at Ohio University and Program Coordinator for both their Counselor Education Program and their Human Services Program. She is the Immediate Past Chair of the Department of Counseling and Higher Education. She holds a BS in psychology, an MA in rehabilitation counseling, and a PhD in rehabilitation services (Rehabilitation Counselor Education) from The Ohio State University. Dr. Robinson is a certified rehabilitation counselor, a licensed professional clinical counselor supervisor, and a licensed social worker.

Prior to her employment at Ohio University, Dr. Robinson served as a counselor and administrator of vocational rehabilitation counseling and employment services to clients with severe mental illness and other barriers to employment. Additionally, she served as a consultant and adjunct professor at Wilberforce University. Her areas of expertise include psychiatric rehabilitation, disability advocacy, multicultural counseling, ethics, and dual diagnosis.

Dr. Robinson serves as the institute director for study abroad programs held in Italy and Botswana. She is currently 1st Vice President for the National Council on Rehabilitation Education, Accessibility Coordinator for the Association for Multicultural Counseling and Development 2019 Summit, and a member of their 2019 Day of Service Committee. She has served as Past President of the National Association of Multicultural Rehabilitation Concerns, Ohio Rehabilitation Association, and Ohio Rehabilitation Counseling Association. She is a past board member of the National Rehabilitation Association and the Ohio Counseling Association Executive Council, and a Past President and Past Secretary of the Central Ohio Counseling Association.

In addition to her extensive professional service, she is also a current member of numerous professional organizations, including but not limited to the American Counseling Association, American Rehabilitation Counseling Association, Association for Multicultural Counseling and Development, National Rehabilitation Counseling Association, Ohio Rehabilitation Association, and Ohio Rehabilitation Counseling Association. She is on the editorial boards of the *Journal of Applied Rehabilitation Counseling* and the *International Journal of Applied Guidance and Counseling*, a Vocational Expert for the Social Security Administration Office of Hearing Operations, and a Site Team Chair for the Council for Accreditation of Counseling and Related Educational Programs (CACREP).

Dr. Robinson's awards and honors include the 2008 and 2014 Ohio University College of Education Distinguished Faculty Graduate Teaching Award; the 2009 Sylvia Walker Multicultural Education Award; and the 2010 Visiting Scholar to South Korea Award, through which she taught global communication at the Kyungpook National University. She was a presenter at the 2012 International Conference on Education in Honolulu, Hawaii, and a speaker at the 2017 4th Biennial Bhutan International Counseling Conference held in Thimphu, Bhutan. Dr. Robinson has been the recipient of the 2014 Ohio University College of Education Distinguished Faculty Outstanding Outreach Award, the 2016 and 2017 Ohio University Faculty Newsmakers Award, the 2017 Virgie Winston-Smith Lifetime Achievement Award, and a 2018 National Association of Multicultural Rehabilitation Concerns Fellow Award. Dr. Robinson was an invited speaker at the University of Botswana in 2017 and 2019 for the Ultimate Motivational Speaker Competition. Lastly, she was the keynote speaker for the Seminar on Guidance and Counseling Conference held in Yogyakarta, Indonesia, in October 2019.

In this interview, Dr. Robinson shares insights on growth and change within the counseling profession, her experience as a woman of color in counselor education, and her outlook on the future development of the profession.

1. **As a rehabilitation counselor educator, how has the merger between the Council on Rehabilitation Education (CORE) and CACREP impacted your role and the counseling profession?**

For me personally, I am pleased to see the merger finally come to fruition. In the past, I worked as a vocational rehabilitation counselor and a licensed professional clinical counselor, so I certainly see the value of both specialty areas. I view myself as a counselor with a specialty area in clinical rehabilitation counseling. I am fortunate to work in a program that has historically integrated clinical mental health counseling, rehabilitation counseling, and school counseling at the master's level. Holding accreditation with both CORE and CACREP meant we had to go through the accreditation process twice. However, since the merger occurred, we now have one accreditation cycle and our students can obtain credentialing under CACREP for both clinical mental health and rehabilitation counseling.

With respect to the counseling profession, I continue to be involved in discussions regarding the merger, including the revisions to the 2023 CACREP standards, particularly as they relate to clinical rehabilitation counseling. For the purpose of clarification, I think it is noteworthy to mention that rehabilitation counselors receive the same general training as clinical mental health counselors with the exception of diagnosis and treatment of mental and emotional disorders. Traditional rehabilitation counselor training focuses on vocational rehabilitation, specifically as it relates to assisting people with physical and mental disabilities in obtaining meaningful employment and/or independent living opportunities that improve their quality of life. Clinical rehabilitation counselor training would continue to focus on vocational rehabilitation with the inclusion of a clinical mental health counselor curriculum that focuses on treating mental and emotional disorders that lead to licensure as a professional clinical counselor as well as certification as a certified rehabilitation counselor.

Over the years, I presented at national conferences regarding the advantages and disadvantages of the merger. One of the main points of contention in the field of rehabilitation counseling centers around the lack of coursework necessary to treat and diagnose mental and emotional disabilities, including completing an internship in a setting that treats and diagnoses mental and emotional conditions. I firmly believe that the counseling profession as a whole will benefit from the merger with the infusion of clinical rehabilitation standards. This is a first step toward standardization so that all counseling

programs can offer the same educational requirements that lead to licensure. Having a standardized counseling program will aid licensure portability as well as serve as a precursor to a national license for counselors. Counseling students reap the benefits of being taught by counselor educators with multiple specialty areas. Rehabilitation counselor educators play a pivotal role in teaching students knowledge from their specialty areas in addition to the clinical mental health competencies.

2. What are the benefits and challenges associated with that merger, and where do you see rehabilitation counseling going in the future?

Students in rehabilitation counseling programs will benefit from a more well-rounded education that gives them an opportunity to work with people with physical, mental, and emotional disabilities. Having this additional knowledge will prepare students to work in integrated medical and behavioral settings. Counselor educators who teach from a holistic approach allow students an opportunity to gain skills that will assist them in achieving better outcomes for their clients. In addition to the obvious time considerations, one accreditation cycle for all programs instead of two has positive financial implications for students and institutions alike. Some of the challenges associated with the merger include concerns that rehabilitation counselor educators may need to take additional counseling coursework to become eligible for licensure as a professional clinical counselor. Currently, rehabilitation counseling professionals who teach in rehabilitation counselor programs come from varying backgrounds, including vocational rehabilitation counselors (public and private sector), rehabilitation specialists, physical therapists, and occupational therapists; while beneficial to rehabilitation counseling, they may not be eligible to become licensed as professional clinical counselors without taking additional courses or obtaining another degree. Additionally, there are concerns about rehabilitation counselors losing their professional identity. Therefore, adopting a curriculum that focuses on vocational rehabilitation learning outcomes while infusing clinical mental health learning outcomes will aid in alleviating these fears. Long term, a reunification of the rehabilitation counseling professions (i.e., rehabilitation counselor educators, vocational rehabilitation counselors, rehabilitation specialists, physical therapists, and occupational therapists) will need to happen, as splintering of the profession occurred well before the CORE and CACREP merger process began. It is my hope that the merger will bring about changes in counseling that are beneficial for all counseling professionals.

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

Increasing faculty diversity as well as student diversity has been a cornerstone of my contribution to the development of the counseling profession. I have been intentional about recruiting AND retaining diverse students and faculty worldwide. The counseling profession has historically been predominantly White. However, the clients that present for counseling continue to come from increasingly diverse backgrounds. Hence, recruitment and retention of African American students and faculty are essential in the 21st century to meet the needs of diverse client populations. Therefore, I will continue to present and publish on the topic of diversity and the need to be responsive to all aspects of diversity. Undertaking my mission to speak about the necessity to respect diversity not only in conversation but also through action is an endeavor that I will continue to pursue.

Another contribution of mine is mentorship. When working in academia, one of the most valuable resources faculty members can acquire is a mentor. Personal relationships and support systems are important factors for a successful career. I believe that participation in formal and informal networks

and mentoring relationships is critical in the persistence of African American female faculty in the academy. Mentors provide support, guidance, information, and advice to their mentees who may be struggling with career advancement. A mentor can serve as a support system for a faculty member by providing protection, coaching, and even validation for them through acceptance, friendship, and role modeling.

I believe in the importance of mentoring counselors, students, and faculty. While recruitment is important, retention efforts are even more crucial. I have spent countless hours focusing on the recruitment and retention of African American students and faculty. Additionally, I enjoy speaking locally, nationally, and internationally about issues that affect people of color, including those with varying disabilities. While licensed professional clinical counselors are trained to work with people with mental and emotional conditions, they often lack knowledge to effectively assist people with physical disabilities. I have been fortunate to fill the gap by providing trainings in this area.

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

Despite the fact that counseling has been a helping profession for decades, it still lags behind social work and psychology in terms of recognition as a profession. If the counseling profession aspires to obtain the same status as other helping professions such as social work and psychology, we must utilize our specialty areas as one cohesive profession. Social workers have done this successfully for decades through being known by the profession first, and then by their specialty areas. For example, someone may seek out a medical social worker that works in a hospital setting. In essence, the setting determines the specialty area of the social worker; counseling should consider adopting the same process. Counselor training is frequently viewed as not being on par with psychology. Therefore, adopting a standardized curriculum for training counselors will aid in eradicating this myth.

Another challenge is the lack of access to billing for Medicare on the part of counselors. Part of the reason for this disparity is that counselors are not viewed as having the appropriate training to serve as professional helpers similar to social workers and psychologists. While the need for trained professionals continues to increase, counseling has not been embraced by the mainstream. Efforts are underway to achieve parity that will allow counselors to bill Medicare—to date, this has not happened. Again, adopting a standardized curriculum will increase the likelihood of counselors serving as vendors for Medicare.

A third area of concern is the looming financial crisis that many institutions of higher learning face. Declining enrollments and increasing tuition costs make recruiting and retaining quality students and faculty a challenge. More attention should be given to offering alternatives to traditional classroom settings as a way to reach more students. Developing and implementing a curriculum that appeals to a broader audience is one way to attract diverse faculty and students. Institutions that offer welcoming environments and appreciate differences will be at the forefront of any future growth.

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

I think it will be important for the counseling profession to take the time to respect diversity in all forms, not only in language but also in action. More unification is necessary between disciplines. Embracing an approach that demonstrates that we are ALL counselors first will be an important first step toward unification of the profession. Professional conferences should be inclusive of all specialty

areas when offering sessions. Counselors should take the time to learn about other specialties. We show ourselves as a much stronger profession if we train counselors who can provide services to a diverse population, and that includes meeting the needs of people with disabilities.

With respect to billing parity, counselors should band together to advocate for Medicare. Standing as one unified profession will allow our voices to be heard on a broader scale. Finally, offering a diverse curriculum that meets the needs of underrepresented and underserved populations will aid in increasing enrollment in institutions of higher learning.

6. As a woman of color, what has been your experience in counselor education? What advice would you give to others from your experience?

I am thankful for my position and experiences as a counselor educator. I have had many experiences that most counselors do not get to have, and for that I am eternally grateful. I have had the opportunity to travel all over the country and abroad. My entire career as a counselor educator has consisted of working at a predominately White institution (PWI). I believe my training at a Research I PWI contributed to my gaining access to my position. I was fortunate to have mentors who advocated on my behalf and helped open doors that probably would not have been opened otherwise. I worked my way up from an assistant professor to a professor over a 10-year period. I served as the first African American department chair in the College of Education. Throughout my tenure, I actively recruited diverse students and faculty to the university. I had to work harder to prove I was as qualified as the dominant culture. I've had decisions challenged as well as faced harassment simply because of the color of my skin. At the end of the day, I've learned to do my best and not worry about it. The advice I would give to others based upon my experiences is to be the best you can be and do not let anyone make you feel that you are less—know your self-worth. I always share these words with my mentees: "We have to be better." Last but not least, self-care!

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

Unity makes strength. If we stand together as a profession, we will remain relevant. Advocate for the profession as a whole. Be knowledgeable about Medicare and other issues that affect our profession. Be a part of advocacy efforts that benefit all counselors. Be open-minded to being a counselor first with varying specialty areas. Listen to the concerns of the members of our professional counseling organizations, and finally, recruit students—they are our future!

This concludes the fifth interview for the annual Lifetime Achievement in Counseling Series. TPC is grateful to Joshua D. Smith, PhD, NCC, and Neal D. Gray, PhD, for providing this interview. Joshua D. Smith is a counselor at the Center for Emotional Health in Concord, North Carolina. Neal D. Gray is a professor and Chair of the School of Counseling and Human Services at Lenoir-Rhyne University. Correspondence can be emailed to Joshua Smith at jsmit643@uncc.edu.

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Strengthening the Behavioral Health Workforce: Spotlight on PITCH

Jessica Lloyd-Hazlett, Cory Knight, Stacy Ogbeide,
Heather Trepal, Noel Blessing

The coordination of primary and behavioral health care that holistically targets clients' physical and mental needs is known as *integrated care*. Primary care is increasingly becoming a de facto mental health system because of behavioral health care shortages and patient preferences. Primary care behavioral health (PCBH) is a gold standard model used to assist in the integration process. Although counselor training addresses some aspects of integrated care, best practices for counselor education and supervision within the PCBH framework are underdeveloped. This article provides an overview of the Program for the Integrated Training of Counselors in Behavioral Health (PITCH). The authors discuss challenges in implementation; solutions; and implications for counselor training, clinical practice, and behavioral health workforce development.

Keywords: integrated care, primary care, counselor training, PITCH, behavioral health workforce development

In 2016, 18.3% of adults were diagnosed with a mental illness and 4.2% of adults were diagnosed with a *serious* mental illness (SMI; Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). Of those with a mental illness, only 41% received mental health services, leaving more than half unserved (SAMHSA, 2015). Many of these untreated adults turn to their primary care provider (PCP) for help and report preference for behavioral health services within primary care (Ogbeide et al., 2018). In fact, data show that primary care has become the de facto mental health system in the United States (Robinson & Reiter, 2016).

Although PCPs attempt to provide pharmacological interventions and appropriate behavioral health referrals, patients often return still experiencing distress because they are unable to follow through on referrals (Cunningham, 2009; Robinson & Reiter, 2016). On average, this circular process results in substantially longer medical visits (e.g., 20 minutes versus 8 minutes) and fewer billable services (e.g., one versus five or more; Meadows et al., 2011). This also results in a significant increase in health care spending, with patients incurring 30%–40% higher costs because of the presence of a mental health condition (de Oliveira et al., 2016; Wammes et al., 2018). There is a need for professionals trained in behavioral health care working within the primary care setting (Serrano et al., 2018).

Counselor training addresses some aspects of the role of behavioral health professionals in primary care. The most recent version of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) entry-level program standards mandates that all accredited programs, regardless of specialty, orient counseling students to "the multiple professional roles and functions of counselors across specialty areas, and their relationships with human service and integrated behavioral health care systems, including interagency and interorganizational collaboration and consultation" (CACREP, 2016,

Jessica Lloyd-Hazlett, PhD, NCC, LPC, is an associate professor at the University of Texas at San Antonio. Cory Knight, MS, is a master's student at the University of Texas at San Antonio. Stacy Ogbeide, PsyD, ABPP, is a behavioral health consultant, licensed psychologist, and associate professor at the University of Texas Health Sciences Center San Antonio. Heather Trepal, PhD, LPC-S, is a professor and coordinator of the Clinical Mental Health Counseling Program at the University of Texas at San Antonio. Noel Blessing, MS, is a doctoral student at the University of Texas at San Antonio. Correspondence may be addressed to Jessica Lloyd-Hazlett, 501 W. Cesar E. Chavez Blvd., DB 4.132, San Antonio, TX 78207, Jessica.lloyd-hazlett@utsa.edu.

Standard F.1.b.). As patients' needs and training mandates increase, there is a demand for counselor training programs to respond with models and practices for counselor training in behavioral health in primary care settings.

The Program for the Integrated Training of Counselors in Behavioral Health (PITCH) is a 4-year project sponsored by a Health Resources and Services Administration (HRSA) Behavioral Health Workforce Education and Training (BHWET) grant received by the Department of Counseling at the University of Texas at San Antonio. The purpose of this article is to describe this innovative program. Toward this end, we briefly outline the Primary Care Behavioral Health (PCBH) consultation model undergirding PITCH. Next, we describe the need for behavioral health integration in primary care settings. Then, we delineate our implementation of PITCH to date, including specialized field placements, training curriculum, and program evaluation methodologies. Following, we discuss challenges and resolutions gleaned from the first 1.5 years of implementation. Finally, we explore implications for counselor education to further enhance counselor preparation and engagement in behavioral health care delivery in primary care settings.

Primary Care Behavioral Health

The coordination of primary and behavioral health care that holistically targets clients' physical and mental needs is known as *integrated care* (SAMHSA, 2015). One model used to assist in the integration process is the PCBH consultation model—a team-based and psychologically informed population health approach used to address physical and behavioral health concerns that arise in the primary care setting (Reiter et al., 2018). A hallmark of the PCBH model is integration of behavioral health consultants (BHCs), who dually function as generalist clinicians and as consultants to the primary care team (Serrano et al., 2018).

A BHC is different than a traditional counselor. In fulfilling their roles and functions, a BHC:

> Assists in the care of patients of any age and with any health condition (Generalist); strives to intervene with all patients on the day they are referred (Accessible); shares clinic space and resources and assists the team in various ways (Team-based); engages with a large percentage of the clinic population (High volume); helps improve the team's biopsychosocial assessment and interventions skills and processes (Educator); and is a routine part of psychosocial care (Routine). (Reiter et al., 2018, p. 112)

BHCs conduct brief functional assessments, collaborate with patients on treatment goals, implement evidence-based treatment interventions, and provide PCPs with feedback and recommendations for future patient care and support (Hunter et al., 2018). In addition, BHCs see patients for approximately 15–30-minute visits, with an average range between two and six visits per episode of care (Ray-Sannerud et al., 2012). In many ways, the BHC role involves a new professional identity for mental health professionals (Serrano et al., 2018). To date, BHC training and employment has typically involved social workers and psychologists. However, the counseling profession is increasingly recognized and engaged in integrated PCBH (HRSA, 2017).

Need for Integrated Services

Primary care settings must begin to consider behavioral health integration in order to increase the quality of life of their patients. Over recent years, there has been a significant increase in patients who receive psychotropic medication for mental health complaints in the primary care setting (Olfson et al., 2014). PCPs are managing increasingly complex diagnoses beyond anxiety and depression. These

include bipolar, disruptive, and other comorbid disorders (Olfson et al., 2014). Individuals diagnosed with an SMI such as these also show a high prevalence of chronic health conditions, including diabetes and cardiovascular disease. Untreated psychological symptoms can often present themselves in somatic forms and can have a strong impact on chronic health conditions (McGough et al., 2016). People with SMIs prefer behavioral health services from their PCP; however, treatment outcomes for those with SMIs that seek services from their PCP are generally of lesser quality (Viron & Stern, 2010). Patient, provider, and systemic-level factors influence this phenomenon. Relevant factors may include impacts of patients' mental health diagnoses on treatment adherence, misdiagnosis from PCPs, and minimal collaboration between medical and behavioral health providers (Viron & Stern, 2010).

The PITCH program addresses several critical needs of individuals seeking behavioral health services in the local community, where conditions that necessitate behavioral health services, including mental illness and substance use disorders, are common. In a focus group run in 2011 with members of the community, the group identified mental health as a key concern (Health Collaborative, 2013). Although mental health services were offered in a psychiatric facility for children, adolescents, and adults, members of the focus group reported that the demand for mental health providers and psychiatric beds exceeded the supply. The stigma associated with mental health also was seen as a barrier to care. As a result, many people go undiagnosed and untreated (SAMHSA, 2015).

PITCH also addresses the need for interdisciplinary approaches to behavioral health workforce development. The expansion of PCBH consultation services amplified this need (Robinson & Reiter, 2016). Unlike other models of integrated care (i.e., Collaborative Care Model, Chronic Care Model), the PCBH model makes available primary care–focused behavioral health services across an entire clinic population and across all possible patient presentations. This model also requires a skilled mental health professional adept at a variety of patient presentations and able to manage processes like clinic flow and a new role as consultant—skills and roles not commonly present in training for specialty mental health services (Robinson & Reiter, 2016).

PITCH: An Overview

PITCH is housed within a CACREP-accredited master's-level clinical mental health counseling (CMHC) program enrolling more than 100 students each year. The principal investigator (PI) of PITCH is a professor specializing in clinical supervision, bilingual counselor education, and professional advocacy. Other PITCH team members include an assistant professor (Co-PI, university liaison) specializing in family counseling, program evaluation, and ethics; an assistant professor and board-certified clinical health psychologist (consultant); and an external project evaluator.

The primary purpose of PITCH is to develop a highly trained workforce of professional counselors to provide integrated behavioral health care (IBH) to rural, vulnerable, and underserved communities in primary care. Sub-goals of the PITCH program include establishing meaningful, longitudinal interdisciplinary partnerships as well as a graduate-level certificate in IBH to support sustainability. Toward this, 12 advanced counseling students enrolled in the aforementioned CMHC program are selected to participate each year from a competitive application pool. Selected trainees are required to complete two specialized IBH courses and two 300-hour clinical rotations in designated primary care settings. In exchange, trainees receive a $5,000 stipend upon completion of each semester rotation. Additionally, PITCH staff coordinate quarterly interprofessional trainings, including workshops focused on primary care, behavioral health, supervision, funding, and policy.

Specialized Field Placements

A unique feature of the PITCH program is the development of specialized field placement sites. Other behavioral health integration projects have relied on existing clinical placement sites (Sampson, 2017). Often these sites have low levels of existing integration, as well as underdeveloped infrastructure to support behavioral health delivery in primary care. When existing clinical site placements do have some integrated services, they are most often co-located services (Peek & the National Integration Academy Council, 2013). Instead of field site development, previous efforts have emphasized student training through workshops (Canada et al., 2018). These workshops are often open to community members. Individuals are then charged to bring knowledge back to extant clinical sites. Although this offers some positive benefits, it may not be as impactful. Further, this approach may fall short of establishing infrastructure to support longitudinal changes (Serrano et al., 2018).

To start development of specialized field placements, we identified potential sites interested in IBH delivery. We then set up initial meetings with sites to discuss the PITCH project and to determine the feasibility of placing a BHC trainee. If sites were amenable, we scheduled a series of follow-up visits to provide orientation to clinic staff on IBH, the PCBH model, and the role and scope of BHCs. During these visits, we also provided consultation on infrastructure components, such as electronic medical record documentation procedures, suggestions for clinic flow, and room spacing (Robinson & Reiter, 2016). Throughout the field placement, we remained active in checking with sites to make workflow adjustments as needed. Trainees complete certificate-based coursework prior to beginning field placements as well as during the clinical rotations.

Trainee Curriculum

Selected trainees are required to complete two specialized courses in IBH, as well as two 300-hour clinical rotations at one of the specialized field placement sites discussed above. The PCBH model scaffolds all aspects of the PITCH training and delivery. We utilize this model to support conceptualization of the BHC role in primary care settings, interventions, and supervision.

As part of the PITCH program, two didactic courses were created to provide training in IBH and PCBH. The courses were developed and instructed by the PITCH IBH consultant. The first course, IBH-I, introduces students to the primary care setting (e.g., family medicine, pediatrics, geriatrics), the PCBH model of care, behavioral health consultation, health behavior change, and common mental and chronic health conditions encountered in primary care, and offers a basic understanding of brief, cognitive-behavioral–based and solution-focused interventions used in primary care (Reiter et al., 2018; Robinson & Reiter, 2016).

Students must complete the following assignments in the course: two exams, an IBH journal article review, a primary care clinic tour, an interview with a PCP, a presentation on one commonly seen problem in primary care (e.g., insomnia, chronic pain, depression), and a term paper highlighting treatment on a common problem in primary care using the 5A's model (Hunter & Goodie, 2010). The 5A's is a behavioral change model that includes assessing, advising, agreeing, assisting, and arranging. Upon demonstrating satisfactory performance, students may enroll in IBH-II.

The primary purpose of the second course is to begin applying foundational knowledge of PCBH as well as practice functional and contextual assessment and cognitive-behavioral intervention skills in the primary care setting. Trainees demonstrate their skills through a series of in-class role-plays, leading up to a final evaluation of their performance in a 30-minute initial consultation visit with a standardized

patient. Trainees must complete both courses to maintain their status in PITCH. Both courses are open as electives to students enrolled in the counseling program or a related discipline (e.g., social work).

PITCH trainees also complete two semester-long clinical rotations in primary care. Trainees are assigned to one of the specialized field placement sites based on availability, interest, and anticipated fit. Trainees are required to clock 300 hours each semester, 120 of which must represent direct clinical engagement. Direct clinical engagement time includes patient visits, consultation with the primary care team, and facilitating psychoeducational groups tailored to unique clinical populations. Trainees are required to participate in at least 1 hour of clinical supervision with an on-site supervisor each week. Additionally, trainees attend a bi-weekly group supervision course on campus instructed by a CMHC faculty member. After successful completion of didactic and clinical courses of the PITCH program, trainees are eligible to earn a graduate certificate in IBH. Adjustments to specialized field placement sites and the trainee curriculum are made as needed based on ongoing informal and formal evaluation of the program.

Program Evaluation

The HRSA BHWET grant supporting PITCH prioritizes evaluation activities related to workforce training and development effectiveness (HRSA, 2017). In partnership with our external evaluator, we are conducting program evaluation across several domains of PITCH, including evaluations focused on trainees and clinical sites (e.g., level of integration).

Trainee-Focused Metrics

We have several evaluation metrics that are focused on trainees. Trainees complete the Behavioral Health Consultant Core Competency Tool (BHC CC Tool; Robinson & Reiter, 2016) and the Primary Care Brief Intervention Competency Assessment Tool (BI-CAT; Robinson, 2015) at the beginning, midpoint, and conclusion of clinical rotations. The BHC CC Tool measures and tracks skill development across four domains of BHC practice: clinical practice, practice management, consultation, and documentation. The BI-CAT includes domains of practice context, intervention design, intervention delivery, and outcomes-based practice. On-site observations of trainees also are conducted using the PCBH Observation Tool as part of the certificate coursework. These competency tools were developed based on observations of BHC clinical behaviors likely to work effectively in a PCBH model of service delivery. These measures have not yet been formally assessed for psychometric properties or predictive outcomes (Robinson et al., 2018).

In addition to tools that target individual trainee development, program evaluation efforts also attend to the macro experiences of trainees in the program. Specifically, trainees participate in focus groups facilitated by the external evaluator at the end of each semester. Focus groups provide the opportunity to understand pathways and barriers to program development. We also have developed an online database to track trainees' postgraduation employment trajectories and sustained engagement in PCBH.

Site-Focused Metrics

Although this particular HRSA grant is primarily concerned with trainee-focused outcomes (e.g., employment), we also ask identified clinical site liaisons to complete the Integrated Practice Assessment Tool (IPAT; Waxmonsky et al., 2013) at the start and finish of each rotation. Scores on the IPAT provide a snapshot estimation of the level of integration of clinical sites. Levels of integration correspond to those identified by *A Standard Framework for Levels of Integrated Healthcare* (Heath et al., 2013) and range from 1–6. Levels 1 and 2 are indicative of minimal, coordinated collaboration, with behavioral health and PCPs maintaining separate facilities and systems. Levels 3 and 4 reflect shared physical space

and enhanced communication among behavioral health and PCPs; however, practice change toward system-level integration is underdeveloped. Finally, Levels 5 and 6 are indicative of transformed, team-based approaches in which both "providers and patients view the operation as a single health system treating the whole person" (Heath et al., 2013, p. 6). Focus groups also were conducted with members of selected clinical training sites to explore barriers and pathways to PCBH delivery as a function of level of integration. At this time, the IPAT has not yet been formally assessed for psychometric properties.

Rapid Cycle Quality Improvement

Finally, program evaluation efforts include ongoing rapid cycle quality improvement (RCQI), a quality-improvement method that identifies, implements, and measures changes to improve a process or a system (Center for Health Workforce Studies, 2016). RCQI can be targeted at different aspects of the program. To date, RCQI has targeted trainee competencies related to functional assessment interviews, breadth of referrals concerns, and patient visit length. For example, after tracking trends in daily activity logs submitted by trainees, we noted a majority of referrals centered on anxiety and depression. We then provided supplemental training on identifying behavioral health concerns related to chronic health conditions, such as diabetes and asthma. Following this instruction, we reviewed the daily activity logs and noted greater breadth of referral concerns.

Challenges and Solutions

Best practices for PCBH implementation within the context of workforce development are still developing. Further, available guidelines do not speak to counselor training programs specifically. In the section below, we discuss challenges we have encountered in the first 1.5 years of implementation of the PITCH program. We also share solutions we have generated to support optimal training experiences.

Challenge: On-Site Clinical Supervision

A significant challenge we encountered was related to on-site clinical supervision for the PITCH trainees. National accreditation standards require trainees to participate in regular supervision with both an on-site and university supervisor (CACREP, 2016). The on-site supervisor must have at least 2 years of postgraduate experience, as well as hold a master's degree in counseling or a related field (e.g., psychology, social work). Furthermore, best practices for BHC training support a scaffolded supervision approach (Dobmeyer et al., 2003), wherein trainees' initial time is spent completing 360 clinic shadowing visits with an experienced BHC. As trainee skills develop, leadership within patient visits transitions from co-visits to visits. In time, the trainee leads the visits, with an experienced BHC in independent practice shadowing. Additionally, the PCBH model emphasizes preceptor-style supervision, where the supervisor is readily available on-site for patient consultation as needed (Dobmeyer et al., 2003).

Solution: Changes to Specialized Field Placement Sites

During Year 1 of PITCH, almost two thirds of the specialized field placement sites we partnered with did not employ the PCBH model at the time, and thus did not have a BHC available to provide on-site clinical supervision. To meet this need, we provided intensive PCBH and supervision training to four doctoral students enrolled in our counselor education and supervision program. Doctoral student supervisors were asked to spend at least half a day on-site with trainees with this amount tapering off with time and experience.

Although this solution met national accreditation requirements for supervision (CACREP, 2016), we noticed stark differences between the clinical experiences of trainees placed at field sites with an on-site BHC versus doctoral student supervisors. As such, we made the difficult decision in Year 2

to separate from all but two field placement sites that lacked an on-site BHC to provide supervision. The inclusion of a BHC to supervise became a requirement for all the new sites we partnered with in Year 2. Additionally, we made modifications to our grant funding allocations to support graduate assistantships focused on supervision for two of the four doctoral supervisors utilized in Year 1.

Challenge: Knowledge About PCBH and the BHC Role

We encountered internal and external gaps in knowledge about the PCBH model, the BHC role, and the general culture of primary care settings. Internally, members of our faculty less connected to PITCH expressed support but also concern about alignment of PITCH training experiences and the experiences of other counseling students. Specific points of concern related to the brevity of visits, frequency of single encounters with patients, and the underpinning medical model. Additionally, because of patient privacy restrictions, PITCH field placement sites do not permit audio or video recording of clinical work, which is a typical supervision practice for counseling trainees. PITCH trainees also expressed some tension between the professional identity and skills training obtained in the CMHC program to date with the PCBH model and BHC role. Externally, we observed varying degrees of provider knowledge and buy-in about the PCBH approach to integrated practice. Areas of provider disconnect were more prominent at placement sites without existing integrated primary care services.

Solution: Ongoing Education and Advocacy

At the internal level, we provided a brief educational session about the PCBH model at regular faculty meetings. It was important to emphasize PCBH as a different context of practice that, similar to school counseling, requires modes of practice outside of traditional 50-minute sessions. We also sought faculty consultation related to curriculum and structure for our specialized coursework. For example, faculty members expressed concern about missing opportunities for recorded patient visits, so we developed two assignments for the clinical courses that could meet this need. The first was a mock visit with a classmate that was video recorded and transcribed. Students then analyzed micro-skills and reflected. The second assignment consisted of a live observation by the university- or site-based supervisors of the trainee's work on-site with a patient.

We also encountered various levels of provider buy-in at our different sites. We encouraged students to reframe this resistance as an opportunity for learning and advocacy. As students gained knowledge about what we call the *primary care way*, students could better contextualize the questions or concerns of providers. For example, students could understand the premiums placed on time and space. From this position, students could tailor their approach to PCPs to enhance the PCP workflow. Additionally, faculty and supervisors emphasized the importance of ongoing psychoeducation about the PCBH model to their teams. Students are encouraged to be proactive in reviewing daily patient schedules for prospective services (i.e., *scrubbing the schedule*) and educating providers about how BHC services can augment patient care. The use of the BHC competency tools also facilitated this process, which encouraged students to consistently engage in behaviors conducive to BHC practice.

Challenge: Shortage of Spanish-Speaking Service Providers

A final challenge we faced related to a shortage of Spanish-speaking service providers. Some sites offered formal translation services (i.e., in-person medical translator, phone- or tablet-based translators), while others utilized informal resources (i.e., other staff members). When placing students, we prioritized placement of bilingual trainees at locations with the greatest number of Spanish-speaking patients. However, we were not able to accommodate all sites.

Solution: Recruitment and Resources

We have implemented several solutions to address this challenge. Among these, we have moved to weighing Spanish language fluency more heavily in PITCH selection criteria. We also are exploring future partnerships with the bilingual counseling certificate program that is housed in the University of Texas at San Antonio Department of Counseling. Additionally, we provide basic training and support to trainees related to the use of translators (in-person and virtual), and we have employed Spanish-speaking doctoral graduate assistant supervisors where possible for extra support.

Discussion

The implementation of PITCH provides challenges but also solutions to the growing need for counselor education to focus on training in primary care. Patients prefer behavioral health services in primary care (Ogbeide et al., 2018). Thus, equipping the behavioral health workforce to provide services in this setting has proved to be imperative. Although primary care and interprofessional education is relatively new to counselor education, other behaviorally inclined disciplines (e.g., psychology, social work, nursing) have provided a training blueprint for counselor education programs to use and continue developing a place for themselves in primary care (Hooper, 2014; Vogel et al., 2014).

Serrano and colleagues (2018) shared recommendations for PCBH workforce development. These recommendations include: (a) development of an interprofessional certification body; (b) PCBH-specific curricula in graduate studies, including both skills and program development; (c) a national employment clearinghouse; and finally, (d) coalescing knowledge around provision of technical assistance sites. Below we discuss the implications of counselor education programs seeking to advance PCBH workforce development.

Standardized Training Models

An important implication for training future counselors is the use of standardized training models (Tang et al., 2004). Throughout this article, much of the focus has centered on the PCBH consultation model (Reiter et al., 2018). In recent years, training standards have emerged for BHCs in primary care. These standards focus on a psychologically informed, population-based approach to treatment, in which BHCs are trained to create clinical pathways, collaborate with medical providers, conduct a brief functional assessment, and provide a brief behavioral intervention, mostly consisting of skills training and self-management (Reiter et al., 2018)—all of which is done in under 30 minutes. This clinical practice approach has become the de facto model in most BHC preparation programs throughout the United States (Hunter et al., 2018) and is currently endorsed by the Veterans Administration and the Department of Defense for integrated primary care (Funderburk et al., 2013). However, inconsistencies exist in how the PCBH model is taught, and there is a lack of available internship opportunities for master's-prepared behavioral health providers to receive clinical training (Hall et al., 2015). This challenge is especially relevant to future counselors, who lack a standardized model of training for primary care (Hooper, 2014). Our experience suggests that programs such as PITCH accomplish the joint goals of focusing on instruction and supervised practice in PCBH, developing BHC competencies, and meeting accreditation standards of orienting counselors to their role in integrated care settings (CACREP, 2016).

Behavioral Health Integration

One of the largest challenges facing the PCBH model is behavioral health integration (Hunter & Goodie, 2010). Moreover, the PCBH model requires full integration (e.g., Level 5–6 integration) to be

maximally effective. Traditionally, PCPs would refer patients to a local mental health practitioner for issues related to depression or anxiety (Cunningham, 2009). However, these referrals would result in a low rate of success and deter many individuals from seeking out mental health services in the future (Davis et al., 2016). Co-located care (an in-house mental health practitioner conducting traditional psychotherapy or counseling) became the logical next step. This level of integration resulted in quicker referrals but led to poor communication and confidentiality issues between PCPs and mental health providers. This also left out other common, behaviorally influenced conditions in primary care such as diabetes, chronic pain, hypertension, and tobacco cessation (which are not routinely addressed or treated by mental health providers). Full integration (in which PCPs and mental health providers work collaboratively in the same setting) has become the ideal standard for the integration of behavioral health services in primary care (Heath et al., 2013).

Despite the many benefits, full integration might be impractical for clinics just beginning PCBH services. Clinics may not have the staff support, leadership support, and organizational buy-in to be successful because "successful integration is really hard" (deGruy, 2015). Integration, in a sense, causes a necessary disruption in how a clinic functions and serves patients. Although necessary, it is still a disruption and it can take time for a team to normalize their new way of practicing primary care. Clinics may need specific support to help establish pathways for behavioral health referrals (Landis et al., 2013), allow clinic staff more time to adjust to integrated services, and provide a pathway for the development of fully integrated services (Reiter et al., 2018). Investing in technical assistance experts can aid in integration efforts (Serrano et al., 2018). Additionally, clinics that already offer co-located services might benefit from a quality-improvement plan (Wagner et al., 2001) such as a plan-do-study-act model (PDSA; Speroff & O'Connor, 2004) to move to a higher level of integration. A sample PDSA cycle might consist of identifying barriers to improved patient care, creating a team-based plan for addressing barriers, designating a project overseer, tracking outcomes across time, and evaluating project success (Speroff & O'Connor, 2004). Both suggestions are great steps toward full integration and can be performed by counselors and counselor educators with training in PCBH and program evaluation (Newcomer et al., 2015). Funding for counselors in BHC roles would assist in meeting the aforementioned goals.

Funding for Counselors in PCBH

One of the greatest barriers to providing accessible behavioral health services in primary care is funding (Robinson & Reiter, 2016). Insurers are just beginning to reimburse for same-day services (both a PCP and BHC visit; Robinson & Reiter, 2016). However, this recent development has primarily benefited psychologists and social workers in primary care and excludes licensed counselors, who account for 14%–25% of the mental health labor force (U.S. Department of Health and Human Services, 2016). Licensed counselors are a crucial part of the growing behavioral health workforce (Vogel et al., 2014) and bring a strong wellness and systems-based perspective to primary care (Sheperis & Sheperis, 2015). Furthermore, licensed counselors, along with other behavioral health providers, can help in a variety of ways such as reducing patient costs in the medical system (Berwick et al., 2008), reducing patient emergency room visits (Kwan et al., 2015), and implementing continuous quality improvement (Wagner et al., 2001).

Robinson and Reiter (2016) offered several suggestions regarding funding for BHCs unable to conduct same-day billing. The first is for BHCs to understand that PCPs will always be the main source of clinic revenue. Therefore, BHCs can provide support to the primary care team through behavioral consultation; improve screening and clinical pathway procedures; provide support for difficult patients and frequent visitors; and reduce PCP visit time through *warm handoffs*, with the patient witnessing the transfer of their care between PCP and BHC. Second, BHCs can secure bottom-up support from PCPs by providing "curbside" consultation services (consulting face-to-face with PCPs about a patient without directly

treating the patient). It comes as no surprise that PCPs feel more supported when BHCs are an available part of the medical team. Third, BHCs can generate top-down support through billing for group visits such as drop-in group medical appointments and 30-minute follow-up visits (Robinson & Reiter, 2016). Finally, grants represent another potential source of funding for behavioral health implementation (HRSA, 2017, 2018). HRSA and SAMHSA have been a tremendous resource in providing training grants specifically aimed at increasing the BHC workforce (e.g., HRSA, 2017) and addressing the nation's opioid epidemic (e.g., HRSA, 2018). In Texas, the Hogg Foundation has provided training grants for training future BHCs. Finally, the counseling profession must continue advocacy efforts toward establishing licensed counselors as Medicare providers. With this key change, licensed counselors would be more readily employable in medical settings (Dormond & Afayee, 2016).

Conclusion

Primary care has been the de facto mental health system in the United States for decades. Providing comprehensive primary care to patients is imperative, and in order to do this well, our workforce needs to be equipped to meet the growing behavioral health needs where patients show up to receive care. Given clinical measures such as successful patient outcomes and CACREP accreditation standards targeting integrated health care knowledge, it behooves counselor training programs to consider developing models for BHC training. This article presents the key aspects of the PITCH program in the hopes that our model will be useful to other counselor education programs as the profession moves toward integrated practice models in order to meet the ever-changing needs of the health care landscape.

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Training Counselors to Work With the Families of Incarcerated Persons: A National Survey

Jessica Burkholder, David Burkholder, Stephanie Hall, Victoria Porter

The national epidemic of increasing imprisonment rates in the United States, also known as *mass incarceration*, disproportionally impacts communities of color. Additionally, the needs of children of incarcerated parents have been neglected. This study examined whether topics pertinent to mass incarceration and the impact on families are being addressed in counselor education programs. Of the 95 counselor educators who participated in the study, results indicated that the majority did not have training to work with families of the incarcerated and did not include information about working with families of the incarcerated in their courses. In addition to exposing students to discussions of implicit bias and data on mass incarceration, specific treatment modalities and protocols need to be developed and validated.

Keywords: mass incarceration, children, counselor education, communities of color, incarcerated parents

The rise of mass incarceration is dramatically affecting families and communities across the nation, with a disproportional impact on communities of color (Glaze & Maruschak, 2008; Graham & Harris, 2013; A. Lopez & Burt, 2013; C. Lopez & Bhat, 2007; Mignon & Ransford, 2012; Western & Smith, 2018). With the increase of persons involved in the criminal justice and legal systems, their families have been found to be more at risk for facing long-lasting life challenges within both the family system and society (Glaze & Maruschak, 2008; Luther, 2016; Mignon & Ransford, 2012; Phillips & Gates, 2011). Client advocacy is one of the most critical roles of the professional counselor (Hipolito-Delgado et al., 2016). The counseling profession is characterized by working with diverse individuals from heterogeneous communities. Counselors are needed to function as advocates, especially when families and communities are facing a sociocultural crisis (American Counseling Association [ACA], 2014; Hipolito-Delgado et al., 2016).

Both ACA and the Council for Accreditation of Counseling and Related Education Programs (CACREP) have identified advocacy, multicultural competence, and social justice as priorities in training and practice (ACA, 2014; CACREP, 2015). The *ACA Code of Ethics* instructs that "when appropriate, counselors advocate at individual, group, institution, and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients" (ACA, 2014, Section A.7.a., p. 5). It also directs counselors to gain "knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population" (ACA, 2014, Section C.2.a., p. 8).

Counselor educators are directed to "infuse material related to multiculturalism/diversity into all courses and workshops" (ACA, 2014, Section F.7.c., p. 14). When describing professional and ethical practice, the CACREP standards require programs to instruct students on "the advocacy processes

Jessica Burkholder, PhD, NCC, ACS, LPC, is an associate professor at Monmouth University. David Burkholder, PhD, ACS, LPC, is an associate professor and department chair at Monmouth University. Stephanie Hall, PhD, NCC, ACS, LPC, is an associate professor and founding department chair at Emory & Henry College. Victoria Porter is a master's student at Monmouth University. Correspondence may be addressed to Jessica Burkholder, 400 Cedar Ave, West Long Branch, NJ 07764, jburkhol@monmouth.edu.

needed to address institutional and society barriers that impede access, equity, and success for clients" (CACREP, 2015, Standard F.1.e., p. 10). Further, the curriculum guidelines for social and cultural diversity emphasize counselor advocacy when instructing counselor educators to cover "strategies for identifying and eliminating barriers, prejudices and processes of intentional and unintentional oppression and discrimination" (CACREP, 2015, Standard F.2.h., p. 11). Although mass incarceration and its effects are not specifically mentioned in the *ACA Code of Ethics* or CACREP standards, these broad directives provide support for the specific argument that the scope of this crisis and its impact on families require attention in counselor training. Consequently, the purpose of this research study is to describe the current state of how counselor educators are providing training to counselor trainees to support families of the incarcerated.

The Rise of Mass Incarceration

The national epidemic of increasing imprisonment rates, commonly referred to as *mass incarceration*, has been a topic of alarm for nearly five decades (Garland, 2001; Glaze & Maruschak, 2008; Graham & Harris, 2013; A. Lopez & Burt, 2013; C. Lopez & Bhat, 2007; National Research Council [NRC], 2014; Sykes & Pettit, 2014). Although the United States accounts for 4.4% of the world's population, nearly one quarter (22%) of the world's prisoners are in the United States (American Psychological Association [APA], 2014; NRC, 2014). According to The Sentencing Project (2012), the United States continues to have the highest incarceration rate in the world, consistently increasing since the mid-1970s. The most recent statistics indicate that the United States has an incarcerated population of 2.2 million individuals (APA, 2014; Kaeble & Cowhig, 2018; NRC, 2014). This represents a 500% increase over the last 40 years (The Sentencing Project, 2012). More than 20% of those released return to incarceration within one year (Durose et al., 2014; Western & Smith, 2018). Researchers have found a correlation between imprisonment and individuals belonging to underserved (e.g., lower levels of education, low income, psychiatric treatment and substance abuse histories) and minority populations (Alexander, 2012; Cnaan et al., 2008; NRC, 2014).

Despite the race gap narrowing since 2007, Blacks are imprisoned at a rate 6 times that of Whites and at double the rate for Hispanics (Bronson & Carson, 2019). Because incarceration disproportionately affects minority group members, families of the incarcerated are more likely to be concentrated in minority communities (Graham & Harris, 2013). Consequently, even those children in the community whose parents are not facing incarceration are likely to be impacted by mass incarceration (Wakefield & Wildeman, 2011), as their communities may experience lower incomes, lopsided gender ratios, disrupted social integration and roles, high levels of joblessness, and increased crime (Crutchfield & Weeks, 2015).

An Invisible Group

Results from the National Survey of Children's Health (U.S. Department of Health and Human Services, 2018) found that more than 7% or 5 million children in the United States have experienced a parent being incarcerated. Gathering current statistics is difficult for researchers. The majority of data on children of incarcerated parents has measured the number of parents in prison, leaving unknown data about the number of parents spending time in jail (Cramer et al., 2017). Because of this, there is reason to believe that the current number of children of incarcerated parents exceeds previous findings of 2.7 million children.

Children of incarcerated parents have frequently been described as an invisible group (Bernstein, 2005; Bouchet, 2008) that bears the collateral consequences of mass incarceration. There are many reasons for the invisibility. Although the children have not committed any crimes, their parent's

incarceration impacts much of what is important to them—family bonds, housing stability, safety, self-image, and social relationships. The criminal justice system does little to support family relationships and there is frequently poor communication between social service organizations and families that may be beneficial for the children (Bernstein, 2005). Those caring for the children often experience high levels of stress (Poehlmann et al., 2010), and families fear stigmatization and may keep secrets or refrain from disclosing an incarceration (Phillips & Gates, 2011).

When a parent is incarcerated, one of the first losses is physical separation between parent and child. Most parents report no physical contact with their children following incarceration (Bocknek et al., 2009). Visitation with parents has been found to be beneficial to the attachment relationship and the child's overall well-being (Poehlmann et al., 2010) but is often infrequent and not child friendly. Visits can be costly, and relationships may be strained with the child's caregiver. Children frequently have to travel long distances, endure long wait times, and meet with parents in environments that can feel intimidating and stressful. Mignon and Ransford (2012) found that almost half of the mothers they surveyed never had a visit from their children, and visits became less frequent for those with longer sentences. Yet prisons that implemented child-friendly visitation interventions and allowed for physical interaction demonstrated greater visitation benefits to those children (Poehlmann et al., 2010). Some benefits included improved maternal perceptions of the relationship and improved self-esteem in the children.

This loss associated with the physical separation of parent and child has been discussed in the literature and is commonly referred to as *ambiguous loss* because children experience the loss without closure. The ambiguity of their parent's abrupt removal can disrupt children of incarcerated parents from finding meaning in the loss and disrupt the development of coping strategies (Bocknek et al., 2009). Children also experience stigmatization associated with ambiguous loss. In contrast to children who are separated from their caregivers by death, deployment, or divorce, it is often not socially acceptable for children of incarcerated parents to grieve the loss of parents because such parents are viewed as criminals (Phillips & Gates, 2011).

Children of incarcerated parents experience the loss of both fathers and mothers, and there are substantially more fathers in prison than mothers. But since the late 1970s, the growth rate for women in prison is more than double the growth rate for men (Sawyer, 2018). When mothers are incarcerated, the disruptions the child experiences are magnified, as children are more likely to lose their home and their primary support. Children with incarcerated mothers have been found to experience more stress and more risks than those with incarcerated fathers (Poehlmann et al., 2010). Maternal incarceration is often more closely associated with factors such as poverty, substance abuse, and mental health issues (Turney & Goodsell, 2018).

Experiencing the incarceration of a parent has been found to impact the long-term well-being of children (Turney & Goodsell, 2018). Children of incarcerated parents have increased risk for health issues, stigmatization, poverty, negative social interactions, behavior problems, school truancy and failure, and substance abuse (Poehlmann et al., 2010; Turney & Goodsell, 2018). Turney (2018) found that children with incarcerated parents are more than 5 times more likely to face adverse childhood experiences than those without an incarcerated parent. Often these children were already at risk, and the incarceration compounds these inequities. It is important to note that the research on children of incarcerated parents is fraught with selection bias and focus on negative outcomes. Very little research exists that examines protective factors and environments beyond urban, lower-income communities of color. Graham and Harris (2013) cautioned that this narrow research focus can decrease potential positive outcomes. A review of the current literature on children of incarcerated parents revealed that this narrow research trend continues.

Stigmatization and Families of the Incarcerated

Many experts consider stigmatization to be one of the most significant negative consequences of parental incarceration. Families are not stigmatized based on a specific trait they possess, but rather based on being associated with the incarcerated person (Phillips & Gates, 2011). This phenomenon is known as *courtesy stigma* and results in a spoiled identity for family members (Luther, 2016). The stigmatization may come from other family members, peers, teachers, social service agencies, and mental health providers. Children may be seen as "guilty by association" or perceived as being "deviant" like the parent that is incarcerated (Luther, 2016, p. 1265). In order to avoid stigmatization, families often keep the incarceration a secret, but children tend to fare better when they know the truth. Stigmatization can increase feelings of shame and impact the child's willingness to reunite with parents (Harris et al., 2010). Foster and Hagan (2015) found parental incarceration leads to social exclusion for children into their 30s, and as a result can contribute to intergenerational socioeconomic inequality.

Purpose of the Research

The longstanding need for increased support in communities impacted by mass incarceration is clear (Harris et al., 2010). Increased awareness of the United States' imprisonment crisis has prompted research initiatives to better understand community needs. Recent data on adverse childhood experiences suggested that children with incarcerated parents are even more vulnerable than previously thought (Turney, 2018). The developmental needs of families and children of the incarcerated are not being appropriately attended to in the literature (Holmes et al., 2010; Turney, 2018). Although research is clear that children of incarcerated parents and the family system face disequilibrium when parental incarceration occurs (Harris et. al., 2010; Luther, 2016; Phillips & Gates, 2011; Wachter Morris & Barrio Minton, 2012), 58% of new professional counselors reported having either minimal training or no training at all in individual or family-level trauma and crisis preparation (Wachter Morris & Barrio Minton, 2012). Brown and Barrio Minton (2018) found that school counselors wanted more training and resources to work with children of incarcerated parents and their families. This lack of training created barriers and ethical dilemmas in attempting to support children with incarcerated parents. Brown and Barrio Minton recommended counselors learn about families of the incarcerated through reading and participating in professional development opportunities, but the curricular experience of professional counselors working with populations affected by incarceration appears predominantly absent from the literature.

The incongruence between the urgency of mass incarceration affecting communities and the lack of literature exploring how to support families of the incarcerated demands further research. Two key research questions organized our exploration: (1) Are topics pertinent to mass incarceration and its impact on families being addressed in the classroom? (2) If so, how are these topics being included?

Method

Participants

The sample included full-time counseling professors in CACREP-accredited counseling programs in the United States. The researchers compiled an email list of 356 CACREP liaisons from the list of accredited programs on the CACREP website. Upon receiving IRB approval, CACREP liaisons were contacted and asked to forward the email invitation to full-time faculty in their departments. The request for participants was also posted to the Counselor Education and Supervision Network Listserv. The email served as an invitation to participate, contained a synopsis of the purpose of this research, and included an online Survey Monkey link. Informed consent was collected using an electronic consent form. Demographic information was gathered after consent had been obtained.

Ninety-five counselor educators began and completed the survey. Sixty-nine female and 26 male individuals participated, ranging in age from 29 to 78 years. A majority of the participants identified as White or of European descent (*n* = 61, 64%); 18 (19%) identified as African American/Afro-Caribbean or of African descent; five (5%) identified as Hispanic/Latinx, five (5%) identified as Asian/Polynesian or of Pacific Island descent, and five (5%) identified as multiracial. One person (1%) did not identify a race or ethnicity.

Of the participants, 20 (21%) were full professors, 22 (23%) were associate professors, 43 (45%) were assistant professors, nine (10%) were non–tenure track full-time instructors, and one (1%) was a clinical coordinator. Sixty-five (68%) came from master's-only programs, and 30 (32%) came from combined master's and doctoral programs. All CACREP regions were represented with 33 (35%) from the Southern region, 27 (28%) from the North Atlantic region, 21 (22%) from the North Central region, nine (10%) from the Western region, and five (5%) from the Rocky Mountain region.

Survey

The researchers created a brief survey that could lead to a description of the current state of counselor training on issues of mass incarceration and families of the incarcerated. Using broad survey research was necessary because there is currently nothing on this topic in the counseling literature. Eight questions were included in the survey: 1) Do you include the topic of mass incarceration in any of your courses? 2) If yes, what courses? 3) If yes, how do you cover this topic? 4) Do you include working with families of incarcerated persons in any of your courses? 5) If yes, what courses? 6) If yes, how do you cover this topic? 7) Have you received any training on these topics? and 8) If yes, describe.

Results

When asked whether they included the topic of mass incarceration in their courses, only 35 (36.8%) of the counselor educators surveyed answered *yes*. The most frequently noted course was Multicultural Counseling, under many different titles such as "Social and Cultural Diversity Issues in Counseling" or "Cultural Diversity." Other courses noted were Foundations of Clinical Mental Health, Career Counseling, Addictions, Diagnosis, Trauma, Practicum, and Internship. Only one participant responded, "every class I teach." When surveyed whether they included working with families of the incarcerated in their courses, 27 (28.4%) of the counselor educators answered *yes*. This too was most frequently covered in a multicultural counseling course but also was included in school counseling, child and adolescent counseling, and crisis counseling courses.

Using an open-ended question, participants were asked to describe how they covered the topics. The vast majority of the responses were "discussion." These discussions were prompted by topics or readings on issues such as "systematic oppression," "the intersection of race and social class," "mandated clients," and "vicarious trauma." Two participants described developing a special topics course on incarceration and one participant invited a guest speaker related to families of the incarcerated.

When counselor educators were asked whether they had received training on these topics, only 30 (31.58%) reported that they had. But, when the participants described the training that they had received, it is notable that 19 (63.3%) of those reporting training described experiences with incarcerated persons, not specifically the families. Seven (23.3%) of those who responded had attended conference presentations on the topics of incarceration and families of the incarcerated. Two participants (6.7%) had completed research on incarcerated persons. Only one counselor educator (3.3%) described an extended

training experience specific to families of the incarcerated. Finally, one (3.3%) participant described the topics being integrated into their doctoral program that was combined with rehabilitation counseling.

Discussion

The purpose of this research was for counselor educators to articulate whether topics relevant to mass incarceration and the effect on families were addressed in their classrooms, and if so, how they were addressed. Because no similar research has been reported, this study was singular in seeking to investigate how or if counseling faculty prepare their students to work with families affected by incarceration. This study did not aim to produce generalizations that apply beyond the research sample.

Nevertheless, it is essential to compare what was discovered in this study with what is documented in the literature. This study found that the majority of counselor educators were not covering mass incarceration or families of the incarcerated in their coursework, nor had they received training to do so. The findings of this study also provide the beginnings of a blueprint for what counseling programs and faculty can do to prepare students to work with children and families affected by incarceration.

For this study, comparing our findings with a body of literature is difficult because such literature does not exist, excepting the study by Wachter Morris and Barrio Minton (2012). Wachter Morris and Barrio Minton reported that 57.51% of professional counselors reported having minimal to no training in working with individual or family-level trauma and crisis preparation. Although Wachter Morris and Barrio Minton's research did not target families of the incarcerated, this population does fall under the umbrella of individual and family trauma. Like that study, the present study demonstrated that a majority of counseling students are likely not receiving intentional, purposeful training on working with the trauma associated with incarceration. Although close to 30% of our participants did include mass incarceration and families of the incarcerated in their courses, the majority of how the topics were addressed was based on whether it arose out of discussion of broader multicultural topics. It also is reasonable to conclude that because a counseling literature search focused on training students to work with children of incarcerated parents only resulted in one webinar (Brown, 2016), a large majority of professional counselors are not adequately prepared to work with this population.

The findings of the present study may generate discussion of future recommendations and directions that counselor educators and supervisors may explore and implement. The majority of faculty in this research were not trained in the topics of mass incarceration and counseling children and families of the incarcerated, and unsurprisingly the majority did not include any training for their students. As with any topic under the umbrella of multiculturalism, counseling faculty should incorporate mass incarceration and working with children of incarcerated parents when addressing implicit bias with students (Boysen, 2010). In light of the massive numbers impacted by mass incarceration, we recommend this topic be included as required content in counselor education training. One way to ensure its inclusion would be to include persons who are incarcerated and their families in accreditation standards. At a minimum, the topic should be included in textbooks and used in case examples throughout training programs.

Counselor educators should highlight the stigma and spoiled identity that children of incarcerated parents experience and describe stigma management techniques (Luther, 2016) counselors can teach when working with these children. In addition to exposing students to data on mass incarceration and discussions of implicit bias (e.g., Alexander, 2012; Kaeble & Cowhig, 2018; Phillips & Gates, 2011), specific treatment modalities and protocols need to be developed and validated that fulfill the education and

ethical expectations (ACA, 2014; CACREP, 2015) to address systemic barriers, advocacy, and cultural competence (Hipolito-Delgado et al., 2016).

Continuing education trainings could provide an opportunity for counseling associations and programs to address important content that may not receive adequate or consistent attention in required coursework. Counseling associations could choose conference themes that would encourage training and research on the needs of families of the incarcerated. Counseling programs could consider continuing education trainings as a method of communicating the program's values and priorities, such as attention to social justice. Additional benefits may include strengthening their reputation, improving retention, maintaining relationships with alumni, and building relationships with the local clinical community.

Limitations and Future Research

The researchers recognize that the small, purposive, and heterogenous sample limits generalizability of the findings. Additionally, issues with data that rely on self-report have been well documented (Coughlin et al., 2009). Although these limitations make the present study narrow in scope and generalizability, these limitations are features of the positivist tradition aimed at finding "facts" and "truth." This nascent study sought to establish a beginning understanding of how counselor educators are addressing mass incarceration in the classroom.

There are many directions for future research. It would be valuable to use qualitative research methods to learn from counselor educators who are effectively integrating and instructing on families of the incarcerated to provide a template for pedagogical inclusion. Research focusing on counseling students can serve to further the understanding of curricular experiences with mass incarceration and children of incarcerated parents. Research with practicing counselors can provide insight into the current landscape in the profession, including how families and children of incarcerated parents are affected and how professionals address these concerns. In that vein, outcome research with these children would be useful, as would the development of an instrument that can identify key clinical treatment areas.

Conclusion

Mass incarceration is a national crisis impacting more than 5 million U.S. children and their families (U.S. Department of Health and Human Services, 2018). This study was an attempt to provide a foundational understanding of the preparedness of counseling faculty and how they train students on this issue. The magnitude of the crisis, alongside the absence of counselor training, should cause counselors to consider our responsibility to ensure adequate counselor preparation in this area. By doing so and providing recommendations for programs to consider, it is hoped that more research will be undertaken to further underscore the importance of the topic and illuminate new understandings.

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Case Formulation and Intervention: Application of the Five Ps Framework in Substance Use Counseling

Scott W. Peters

Substance use and misuse is exceedingly common and has numerous implications, both individual and societal, impacting millions of Americans directly and indirectly every year. Currently, there are a variety of empirically based interventions for treating clients who engage in substance use and misuse. The Five Ps is an idiographically based framework providing clinicians with a systematic and flexible means of addressing substance use and misuse that can be used in conjunction with standard substance use and misuse interventions. Additionally, its holistic and creative style provides opportunities to address concerns at various points with a variety of strategies and interventions that will best suit clients' unique situations. It can assist both novice and experienced clinicians working with clients who present for counseling with substance use and misuse. Following a discussion of the Five Ps, a brief case illustration will demonstrate the framework.

Keywords: **substance use and misuse, Five Ps, idiographic, systematic, flexible**

Substance use and misuse in the United States is extremely common. For the year 2016, the Centers for Disease Control and Prevention (CDC) found that 18% of the U.S. population aged 12 and older had used illicit substances or misused prescription medications (CDC, 2018). The National Survey on Drug Use and Health asserted that close to 30% of respondents aged 12 and older reported use of illicit substances in the past month (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). Although these statistics are significant, it should be noted that "Most people who use abusable drugs, even most people who use them nonmedically, do so in a reasonably controlled fashion and without much harm to themselves or anyone else" (Kleiman et al., 2011, p. 2). In the context of this article, the word _abusable_ indicates substances that when taken are pleasurable enough to result in excessive dosing or increased frequency of intake (Linden, 2011).

However, there are others who use substances to such an extent that it causes significant distress and impairment in their lives, a phenomenon clinically referred to as a _substance use disorder_ (SUD). The _Diagnostic and Statistical Manual of Mental Disorders_ (5th ed.; _DSM-5_) bases an SUD on a "pathological pattern related to the use of a substance" (American Psychiatric Association, 2013, p. 483). In his report on alcohol, drugs, and health, the U.S. Surgeon General Vivek Murthy reported that more than 20 million Americans have an SUD (U.S. Department of Health and Human Services, 2016). Clients who engage in substance use and misuse can present with a variety of issues beyond use (Bahorik et al., 2017; Compton et al., 2014; Poorolajal et al., 2016). Thus, there exists a need to concurrently examine and address the potentially complex nature of client substance use and misuse.

Implications of Substance Use and Misuse

Substance use and misuse carries numerous potential repercussions. Societally, substance use and misuse consequences exceed "$400 billion in crime, health, and lost productivity" (U.S. Department of Health and Human Services, 2016, p. 2). Published data on those incarcerated appears to be several

Scott W. Peters, PhD, LPC-S, is an associate professor at Texas A&M University – San Antonio. Correspondence may be addressed to Scott Peters, One University Way, San Antonio, TX 78224, scott.peters@tamusa.edu.

years old. However, it does suggest that more than 60% had a substance use disorder and 20% were under the influence at the time of their offense (National Center on Addiction and Substance Abuse at Columbia University, 2010). Regrettably, most do not receive treatment while incarcerated (Belenko et al., 2013). Additionally, many individuals who engage in substance use and misuse have co-occurring major medical conditions, such as cancers, cardiovascular accidents (strokes), and respiratory and cardiac illnesses (Bahorik et al., 2017). This population often experiences stigma and suboptimal health care results (McNeely et al., 2018; van Boekel et al., 2013). Substance use and misuse has significant impact on the occupational sector as well. Substance use and misuse has been correlated with both higher rates of absenteeism and workplace injuries (Bush & Lipari 2015). Those who engage in substance use and misuse often have higher rates of unemployment (Compton et al., 2014; Dieter, 2011). This can result in lack of access to treatment services, contributing to increased stress.

Substance use and misuse also has a negative impact on intimate partners, such as assuming increased responsibility and navigating unpredictability (Hussaarts et al., 2012). More ominously, substance use and misuse has been correlated with intimate partner violence (Murphy & Ting, 2010). Further, substance use and misuse is a significant risk factor for suicidality (Poorolajal et al., 2016). Finally, the number of U.S. adults with a comorbid SUD and mental illness has been shown to be almost 8 million, with only about 5% receiving treatment for both (SAMHSA, 2017). Concurrently treating both is very complex, challenging, and expensive. This can be even more problematic given the lack of health care access for large numbers of Americans (Schoen, 2013).

A Holistic Alternative

Addressing client substance use and misuse can be quite complicated, and as mentioned previously, substance use and misuse impacts users and society in a variety of ways beyond substance intake. There are several approaches to managing client substance use and misuse that have demonstrated effectiveness. Among those are 12-step programs (Humphreys et al., 2004), mindfulness-based interventions (Chiesa & Serretti, 2014), evidence-based approaches such as cognitive behavioral therapy (McHugh et al., 2010), and family counseling (O'Farrell & Clements, 2012). These approaches can be accomplished via outpatient counseling, partial hospitalization programs, inpatient and medically managed substance treatment programs, as well as residential and therapeutic communities. However, each has some shortcomings. Twelve-step attendance is most beneficial with inpatient substance use and misuse treatment (Karriker-Jaffe et al., 2018). Evidence-based approaches, such as cognitive behavioral therapy, tend to be nomothetic, assuming homogeneity and generally geared toward symptom amelioration (Robinson, 2011). Mindfulness-based strategies are not as effective when used alone as when used with other approaches (Sancho et al., 2018). Research on the success of family-based interventions has methodological challenges, such as small sample sizes and the difficulty of examining long-term outcomes (Rowe, 2012).

In addition, using these approaches may result in omitting the uniqueness of clients as a consideration in treatment. SAMHSA (2020) pointed out the significance of addressing clients individually based on their distinctive needs in order to provide the best chance for recovery from substance use and misuse. SAMHSA's recommendations fit well with a more holistic framework in that such a structure allows clinicians to develop a multidimensional picture of clients. By examining and exploring clients' use or misuse within the context of a multidimensional framework, interventions can be personalized, and areas of concern can be targeted. Such a framework may enhance the effectiveness of the aforementioned interventions (Wormer & Davis, 2018). Some of these evidence-based approaches will be demonstrated later in a case illustration.

As shown above, there are numerous ways to examine and treat client substance use and misuse. For example, some interventions use an individual lens, such as cognitive behavioral therapy, which examines connections between thoughts, feelings, and behaviors (Morin et al., 2017). Other approaches observe substance use and misuse from a family or systems perspective, looking at familial patterns such as communication and normalization of substance use (Bacon, 2019). Delivery of mindfulness-based interventions may help to address stressful events that previously triggered substance use (Garland et al., 2014). In addition, there are frameworks that use a formulation model examining various aspects of clients (Johnstone & Dallos, 2013) such as causal, contributing, environmental, and personal features, providing a much more expansive view of clients' concerns.

Client substance use and misuse can be quite challenging for counselors, both novice and experienced. Case formulation, also referred to as conceptualization, is a skill new counselors often lack (Liese & Esterline, 2015). Using a framework to assist in case formulation may prove useful to beginning counselors. Experienced counselors, even with competence in a variety of approaches, can also benefit from using a framework to help address anticipated challenges (Macneil et al., 2012). Case formulations have been used in a number of areas such as those with psychosis, anxiety, and trauma (Chadwick et al., 2003; Ingram, 2012; Persons et al., 2013). One such framework is the Five Ps (Macneil et al., 2012). Macneil and his colleagues (2012) posited that diagnosing was insufficient and it was critical to include other factors such as causal, lifestyle, and personal factors in conceptualizing the case and formulating a plan. Applying this approach with clients who engage in substance use and misuse would allow more individual and flexible ways to intervene with client substance use and misuse. In addition, the collaborative nature of the Five Ps reinforces the concept of an idiographic formulation. This is in keeping with the inherent uniqueness of clients, their concerns, and a variety of factors.

The Five Ps is a type of framework utilizing five factors developed by Macneil et al. (2012). They conceptualized a way to look at clients and their problems, systematically and holistically taking into consideration the (1) Presenting problem, (2) Predisposing factors, (3) Precipitating factors, (4) Perpetuating factors, and (5) Protective factors. *Presenting problems* are concerns that clients find difficult to manage. *Predisposing factors* include biological, environmental, or personality considerations that may put clients at risk of further substance use and misuse. *Precipitating factors* are those that proximally bring about substance use and misuse and its resulting difficulties. *Perpetuating factors* are those that sustain and possibly reinforce clients' current substance use and misuse challenges. *Protective factors* are those that help to moderate actual or potential substance use and misuse impact. The Five Ps framework promotes a very clear and systematic approach to case formulation or assessment that potentially provides a wealth of data. It also provides opportunities for a variety of interventions and strategies targeted to clients and their substance use and misuse or contributing factors.

Given the variations of substances, the level of use, the functional impairment, co-occurrence with other mental disorders, and inherent client differences, an idiographically based framework seems particularly appropriate with this population. The Five Ps permits counselors to both assess and intervene essentially simultaneously. It allows for client individualization, use of a variety of strategies, ongoing assessment, and modifications as needed. Furthermore, the Five Ps helps clients and counselors explore relationships between each factor and the presenting problem. This framework is idiographic in nature, as it looks at clients individually and holistically (Marquis & Holden, 2008). Idiographic case formulation can be useful for complicated cases, such as those encountered with clients engaged in substance use and misuse (Haynes et al., 1997). It is systematic, while allowing for flexibility and creativity. It can be used in outpatient, inpatient, and residential settings and possibly as part of an aftercare program.

Following is a case illustration demonstrating how the Five Ps may be helpful in formulating and engaging in a clinical application. It should be noted that several evidence-based substance use and misuse approaches were integrated in an eclectic approach throughout the case example to demonstrate the idiographic nature of the Five Ps. Many formulation models are administered within a cognitive behavioral grounding (Chadwick et al., 2003; Easden & Kazantzis, 2018; Persons et al., 2013). The Five Ps does not adhere to any particular theoretical orientation, thus allowing for a greater repertoire of strategies to draw from to help clients with substance use and misuse.

Implementing the Five Ps: The Case of Dax

A brief description of Dax, a hypothetical client, and the events that prompted him to seek services is followed by a detailed application of the Five Ps in addressing Dax's substance use and misuse. It should be noted that the strategies and interventions applied here are used as illustrations and are specific to Dax and his concerns. In addition, the interventions demonstrated are not to be assumed the only ones that can be applied to Dax. They are examples that the author chose to illustrate the Five Ps in practice.

Dax is a 33-year-old married father of two children: a 9-year-old son, Cam, and a 7-year-old daughter, Zoe. He was recently driving home from work in the evening and law enforcement stopped him because of erratic driving. The officers evaluated him, detained him, and subsequently arrested him for driving while intoxicated. As part of his adjudication, Dax was required to attend five counseling sessions and have a clinician's report provided to the court. Dax presents as extremely frustrated and embarrassed at being mandated to attend counseling sessions. He is confident that he does not have a problem and that counseling should be reserved for those who cannot stop drinking. Dax drinks two to three times a week, usually having one or two shots of whiskey and two to three draft beers. The night he was pulled over, he had had two additional beers and one additional shot of whiskey on top of his usual consumption after a telephone argument with his wife, Sara. Additionally, he reports significant stress and conflict in his marriage as well as concerns over some upcoming diagnostic tests for their daughter related to a heart murmur. Dax denies any other negative consequences from his alcohol use. He denies any significant increase in alcohol use or any other substance use.

Presenting Problem

While being mandated to attend counseling, Dax shares concerns that he is afraid of what his daughter's test results will show. He fears that she will need open-heart surgery and that she may die. The clinician can intervene here by simply normalizing and validating his fears about the test results. A logical analysis using gentle Socratic dialogue may help to challenge his emotional reactions to his daughter's heart murmur (Etoom & Ratnapalan, 2014). In addition, mindfulness strategies can assist in helping Dax to cognitively diffuse from present to future events (Harris, 2019). He is also adamant that he does not have a problem with alcohol. Here, a conversation about what counseling entails as well as psychoeducation related to the effects of alcohol on executive functioning may prove beneficial (Day et al., 2015). Acknowledging that his reticence is due to being obligated to attend counseling may assist in relationship building (Tahan & Sminkey, 2012). The clinician may also seek more information on the cause of the reported stress between him and his wife.

Predisposing Factors

Dax reports a strong paternal history of substance use and misuse. His father started out drinking occasionally and over the years slowly developed a dependency on alcohol. Dax further reports his paternal grandfather died from liver failure. Addressing the potential genetic link to substance use and misuse may prove beneficial in raising Dax's awareness (Dick & Agrawal, 2008). For example,

the clinician may ask Dax if they can share how genes are passed on and expressed, like genes for eye color or hypertension. This may open the door to a conversation regarding how his substance use and misuse may progress to alcohol use disorder and its definition as a pattern of alcohol use leading to clinically significant problems, including increase in use, failed attempts to stop, and use leading to an impaired ability to meet role obligations (American Psychiatric Association, 2013). There could be a discussion of alcohol use disorder being a disease, not that different from any other passed-on trait or disease. Additionally, Dax often struggles with strong and painful emotions, and alcohol helps to address them. Here the clinician may utilize strategies drawn from acceptance and commitment therapy related to his control strategy of using alcohol to avoid his emotions (Harris, 2019). The ball in the pool metaphor (i.e., holding a beach ball under the water works temporarily, but eventually it pops back up) can be compared to alcohol temporarily holding those painful emotions down, eventually to resurface. The clinician may also discuss strategies to help Dax regulate his reactions using emotion-focused interventions such as positive reframing to ameliorate the stress of his daughter's cardiac condition (Plate & Aldao, 2017).

Precipitating Factors

This area explores significant occurrences that preceded or triggered the presenting problem and its consequences. Dax shares that he and his wife are conflicted about how to proceed with their daughter's medical care. Sara is unequivocal in her confidence in Zoe's cardiologist and his competence. Dax, however, is hyper-focused on surgery and seems to dismiss Sara's position. At the end of his workday, he and his wife got into an argument over the phone about an upcoming diagnostic test and the possible results. Dax was quite upset, cursed at her, and then hung up the phone. He then stopped at a local pub and had several drinks.

Here, the clinician may use reality-based strategies that address choice and consequences (Wubbolding & Brickell, 2017). This may include a direct conversation about Dax's decision to drink, resulting in his becoming impaired, with the consequence of being detained, charged, and adjudicated. Dax can then share his and his wife's perspectives on their daughter's care. This conversation can lead to investigating strategies for how each can be heard, including short role-plays with opportunities to practice (Worrell, 2015). The clinician can provide a variety of potential spousal responses, allowing for more adaptability and flexibility in Dax's responses. The goal here is to build Dax's competence in communicating, both in listening and expressing. Additionally, there may be a discussion using aspects of existentialism to process inherent anxiety and its connection to unknowable future events (May, 1950; Wu et al., 2015).

Perpetuating Factors

The emphasis here is on features that continue the presenting problem. For Dax, he shares that when he and his wife argue, it follows a very predictable pattern. They disagree, interrupt one another, yell, and he calms down by having several beers. He then withdraws and becomes sullen for a few days. Nothing gets resolved, and this cycle appears once again when they have conflict.

The clinician may discuss the concept of circularity and assist in moving from "vicious cycles" to "virtuous cycles and problem resolution" (Walsh, 2014, p. 162). This involves explaining that interactions can act as a kind of back-and-forth loop of action–reaction–action without any resolution, leaving both parties feeling unheard, misunderstood, and frustrated. The goals here are to both break the pattern and to facilitate healthy conversations. Here the clinician may incorporate a solution-focused strategy exploring a time with Dax when he and his wife have disagreed, but he did not interrupt and the outcome was positive (de Shazer, 1985). If he cannot identify a time, simple role-plays in which

Dax does not interrupt or yell and instead experiences different outcomes may provide optimism to Dax. The counselor may also assist Dax in emotional regulation, which may prevent the initiation of arguments (Aldao & Nolen-Hoeksema, 2013). In addition, aspects of narrative therapy may provide an opportunity for Dax to re-author a unique outcome that gives meaning and provides a functional identity to him as a father and husband, thus building a sense of optimism (White & Epston, 1990).

Protective Factors

Here the focus is on investigating resources and/or supports that may help prevent client substance use and misuse from further becoming problematic. This factor has generally been underutilized despite being shown as beneficial to clients (Kuyken et al., 2009). This is often the opportunity for the client to share what may help them move forward, what their assets are, who can support them, and any other self-identified skills (de Shazer, 1985). These can be in the form of personal characteristics such as tenacity, intellect, or insight. They may also present in the form of family, friends, or hobbies. Oftentimes, when the topic of protective factors is used in substance use and misuse, it is related to deterrence of substance use, notably with adolescents (Liao et al., 2018). In the Five Ps context, protective factors are used to potentially prevent substance use and misuse from having more negative impact as well as to increase client resilience. This factor differs markedly from the first four. Protective factors move away from the problem areas that need interventions to hope and optimism and look to future success and competence (Macneil et al., 2012). Once the protective factors are identified, the ensuing conversation provides opportunities to imagine future outcomes in which protective factors may come into play should situations occur that the client finds problematic. Second, it also tends to shift the conversation toward what is present and going well in their lives and away from those areas that cause distress and suffering (de Shazer, 1985).

Discussion

In implementing the Five Ps framework with Dax, the clinician chose to use psychoeducation and strategies borrowed from acceptance and commitment, reality, Bowenian family systems, and solution-focused brief therapies to assist Dax with his substance use and misuse. The choice of the above approaches is only meant as an illustration and not as definitive ways to address this particular client. It is likely that other clinicians presented with Dax would use a different combination of approaches. The Five Ps is a systematic way to look at clients and their presentation, and its idiographic construction takes clients' uniqueness into account. It also allows clinicians to target specific areas of concern (Macneil et al., 2012) and may be used in a variety of clinical settings. Moreover, the Five Ps align with SAMHSA's recommendation that clinicians tailor treatment to each client because no single treatment is particularly superior (SAMHSA, 2020).

Limitations and Future Research

There are limitations to the Five Ps framework as a way to formulate and intervene with clients' substance use and misuse. First and foremost, it should be emphasized that this particular framework has not been empirically tested with client substance use and misuse. However, as mentioned previously, case formulations have been used across a variety of client concerns (Chadwick et al., 2003; Ingram, 2012; Persons et al., 2013). Another potential limitation is that the Five Ps may not be particularly beneficial for substance use and misuse in which there is clinical evidence of an SUD that includes significant withdrawal symptoms. Client substance use and misuse at that level may need medical stabilization and detoxification prior to utilization of the Five Ps. In addition, there may be

clients who are simply not ready or able to address some or most of the dimensions of the Five Ps. Furthermore, clients like Dax who are mandated to attend substance-related counseling may have service plans that are not congruent with the Five Ps framework. In spite of these limitations, there may be several potential areas of inquiry.

Previous studies using frameworks to formulate have often used cognitive behavioral therapy as the primary intervention (Chadwick et al., 2003; Persons et al., 2013). Given that client substance use and misuse can be quite complicated, using various approaches within the Five Ps framework may yield positive results. As Chadwick et al. (2003) noted, examining positive client experiences may be one way to discover how to increase client participation in substance use and misuse treatment. Another potential area of study might involve comparing novice counselors to more experienced counselors. As mentioned previously, novice counselors often lack sufficient case formulation skills (Liese & Esterline, 2015). Examining the two groups' experiences using the Five Ps may provide insight to assist counselor training programs related to substance use and misuse skill development. The implementation of the Five Ps with clients with mild substance use and misuse and those with more significant substance use and misuse, possibly using the *DSM-5* diagnosis for SUD, may be another area to explore. This research could point to populations for whom the Five Ps is more and less effective. Studies utilizing the Five Ps with mandated clients may demonstrate its efficacy, notably with agencies that require substance-related counseling.

Conclusion

Client substance use and misuse is a significant problem in the United States, and it continues to cause difficulty for individuals, families, and society. There are numerous methods and combinations of methods to address substance use and misuse, such as family therapy, cognitive behavioral therapy, and self-help groups. Their effectiveness has been well researched, and this paper does not propose a superior way to address substance use and misuse. However, the Five Ps presents a framework in which counselors can examine and intervene with client substance use and misuse using a variety of approaches and strategies. The Five Ps can be used in a variety of settings such as a community mental health agency, primary care clinic, and inpatient or residential treatment centers. The systematic but flexible nature of this framework affords clinicians numerous ways to address substance use and misuse. For some, receiving substance use and misuse services can be stigmatizing. In fact, this stigmatization can come from those who are treating them (Luoma et al., 2007). In addition, the vast majority of those with an SUD never receive treatment (Han et al., 2015). Incorporating the Five Ps, with its holistic framework, may prove attractive to clients and counselors, thus potentially increasing the numbers of clients engaged in substance use and misuse treatment. As mentioned previously, the Five Ps is not meant to replace any other substance use and misuse intervention. It is another way to address the multifaceted and complicated nature of client substance use and misuse. Novice clinicians, who often have a more limited repertoire of strategies, may find the Five Ps valuable because of its systematic framework to clients. Experienced clinicians understandably have a larger catalogue of strategies to choose from. However, they may find this framework valuable as it provides one more way to address the often-encountered complex challenges of substance use and misuse.

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Assessment of Dispositions in Program Admissions: The Professional Disposition Competence Assessment—Revised Admission (PDCA-RA)

Curtis Garner, Brenda Freeman, Roger Stewart, Ken Coll

Tools to assess the dispositions of counselor education applicants at the point of program admission are important as mechanisms to screen entrance into the profession. The authors developed the Professional Disposition Competence Assessment—Revised Admission (PDCA-RA) as a screening tool for dispositional assessment in admissions interviews. In this study, 70 participants engaged in a video-based training protocol designed to increase the interrater reliability of the PDCA-RA. An intraclass correlations coefficient was calculated as an index of interrater reliability. Cronbach's alpha coefficients were calculated for internal consistency, and Fleiss' kappa, free-marginal kappa, and percent of agreement were calculated for absolute agreement. Calculations were made for pretest and posttest scores. Results of the study suggest that the PDCA-RA demonstrates "good" reliability in terms of interrater reliability and "excellent" reliability in terms of internal consistency. The video-based training improved interrater reliability.

Keywords: **dispositions, counselor education, interrater reliability, counseling admissions, PDCA-RA**

Beyond ethical codes and standardized education requirements, one criterion understood to be a demarcation of a profession is that it controls entry into its occupation (Miller, 2006). The stature of any profession is heavily influenced by the collective quality, preparation, and professional fit of those who are allowed to enter the profession. In the profession of counseling, counselor preparation programs, practicing counselors, field site supervisors, and state licensure boards share the overarching charge to screen for the profession (Freeman et al., 2016), but counselor educators alone bear the responsibility of initial screening of potential new entrants into the profession. The funnel of individuals seeking entrance into the profession begins with admission to graduate programs. This responsibility is a solemn one because post-admission gatekeeping can lead to high-stakes legal disputes (Dugger & Francis, 2014; Hutchens et al., 2013; McAdams et al., 2007).

Similar to other graduate programs, criteria for entrance into counselor preparation programs generally incorporate academic and career factors, but unlike many other graduate programs, the dispositions (traits and characteristics) of applicants are also critical factors for identifying appropriate candidates for the profession (Hernández et al., 2010). The use of admissions interviews is a common method for observing dispositions (Swank & Smith-Adcock, 2014). Characteristics such as interpersonal skills, warmth, emotional stability, and self-awareness are examples of traits deemed important to many counseling academic programs (Crawford & Gilroy, 2013; McCaughan & Hill, 2015), though counselor educators lack agreement about which dispositions should be screened at admission (Bryant et al., 2013).

Curtis Garner, EdD, NCC, NCSC, LCPC, is a professor and department chair at Gonzaga University. Brenda Freeman, PhD, is a professor at the University of Nevada, Reno. Roger Stewart, PhD, is a professor at Boise State University. Ken Coll, PhD, is the Dean of the School of Education at the University of Nevada, Reno. Correspondence may be addressed to Curtis Garner, 502 East Boone Ave., Spokane, WA 99258-0102, garnerc@gonzaga.edu.

Once applicants have been accepted into a counselor education program, if problematic dispositional issues arise the American Counseling Association (ACA) ethical codes require remediation (ACA, 2014), which is sometimes followed by suspension or dismissal. Therefore, *gatekeeping*, defined as the process of deterring program graduation of those lacking sufficient knowledge or skills (Koerin & Miller, 1995), begins at the point of program screening and admission (Kerl & Eichler, 2005). Bryant et al. (2013) emphasized that effective screening of applicants prior to formal admission into the academic program may greatly reduce the need to address problematic student behaviors after admission.

In addition to conducting admissions screening as a form of gatekeeping, the courts are more likely to support universities in admissions-related legal disputes if screening policies, standards for admission, and admission procedures are clear and fair (Cole, 1991). Legal research also underscores the importance of programs communicating clearly with students about the expected dispositions and other criteria from admission through exit (McCaughan & Hill, 2015). Reliable admissions tools designed to assess dispositions represent one method of showing fidelity in implementing policies (Hutchens et al., 2013). Despite the research support for sound structures to scaffold the admissions process, assessments with published psychometric properties measuring dispositions in admissions interviews are scarce (Hernández et al., 2010).

Jonsson and Svingby (2007) noted that a number of forms of reliability and validity are important in establishing the psychometric properties of admissions tools, but when multiple raters are involved, such as in the admissions process, interrater reliability for rubrics is particularly essential. Specific training in the tool is critical to improving interrater reliability (Jonsson & Svingby, 2007). Video training protocols to increase interrater reliability are becoming more important in professional dispositional research (Kopenhaver Haidet et al., 2009; Rosen et al., 2008). The use of video technology to train raters to capture behavioral observations has two advantages: the opportunity for admissions personnel to practice admissions interview ratings prior to real-time observations, and the relative ease of using modern, sophisticated recording equipment (Kopenhaver Haidet et al., 2009).

Admissions Processes and Criteria

Overwhelmingly, admission criteria and procedures for counselor education programs have focused upon undergraduate grade point average (GPA); standardized test scores, such as the Graduate Record Examination (GRE) or the Miller Analogies Test (MAT); a personal interview; and some form of personal statement (Bryant et al., 2013). Such procedures have been shown to be reasonably predictive of academic success, but less so for counselor development (Smaby et al., 2005). Some programs have utilized Carkhuff's Rating Scale (Carkhuff, 1969) or Truax's Relationship Questionnaire (Truax & Carkhuff, 1967) to measure applicants' ability to communicate the conditions of empathy, genuineness, and respect effectively (Hernández et al., 2010; Swank & Smith-Adcock, 2014). Carkhuff's Rating Scale and Truax's Relationship Questionnaire have been found to exhibit good interrater reliability and, when correlated with one another, have been found to exhibit considerable overlap (Engram & Vandergoot, 1978).

Dispositional Assessment

Following the gatekeeping dispute in *Ward v. Wilbanks* (2010), in which a graduate student in counselor education refused to work with a gay client, and the ensuing litigation upon that student's dismissal from their program, the need for a reliable method for evaluating counseling student dispositions has become increasingly apparent. This high-profile legal case also highlighted the need to monitor and document student dispositions (Dugger & Francis, 2014; McAdams et al., 2007). Correspondingly, in 2009 the Council for Accreditation of Counseling and Related Educational Programs (CACREP) released standards that made monitoring student dispositions a mandatory aspect of program evaluation. In the

2016 CACREP standards the expectation for the assessment of counselor-in-training dispositions was expanded to include the monitoring of dispositions at multiple points over the duration of time students are enrolled in a counselor education program. The accreditation expectations for screening at the point of admission are found in Section I.L., where the standards delineate the expectation that counseling programs consider dispositions (CACREP, 2015). Dispositions for consideration include relationship skills and cultural sensitivity.

As the need for dispositional appraisal has become increasingly imperative in the counselor education profession, there have been various efforts to design specific approaches to assess student dispositions (Frame & Stevens-Smith, 1995; Kerl et al., 2002; Lumadue & Duffey, 1999; McAdams et al., 2007; Redekop & Wlazelek, 2012; Williams et al., 2014). One early approach was the utilization of standardized personality tests (Demos & Zuwaylif, 1966; Utley Buensuceso, 2008). However, the use of personality tests fell into disfavor because of the potential for conflicts with the Americans with Disabilities Act (U.S. Department of Justice, 2010) as well as for their inherent deficit orientation. Consequently, the use of standardized tests has been generally replaced by rating scales and rubrics (Panadero & Jonsson, 2013).

One reason that rubrics were considered superior to rating scales was their transparency (Panadero & Jonsson, 2013). Transparency empowers students by equipping them with an understanding of expectations for performance prior to their creating a product or performing a skill. Rubrics also have greater potential to align with learning outcomes and they provide useful direct feedback to students (Alexander & Praeger, 2009; Panadero & Jonsson, 2013).

Examples of dispositional assessments for counselors include the Counselor Characteristics Inventory (Pope, 1996), an inventory that assesses personality characteristics of effective counselors. Also, Spurgeon et al. (2012) described a process that includes a Likert-style assessment of dispositional traits. In addition, Swank et al. (2012) developed the Counseling Competencies Scale (CCS), a tool for measuring counselor competence. Frame and Stevens-Smith (1995) developed a 5-point Personal Characteristics Evaluation Form, and finally, Lumadue and Duffey (1999) published a Professional Performance Fitness Evaluation to evaluate specific behaviors of pre-professional counselors. Few studies of the reliability and validity of the tools were found in published research, especially related to admissions. However, some do have limited published psychometric research and in some cases norms (Flynn & Hays, 2015; Pope, 1996; Swank et al., 2012; Taub et al., 2011).

One example of a dispositional tool for counselor education with published psychometrics is the Counselor Personality Assessment (CPA) developed by Halinski (2010). The CPA is a 28-item scale reporting a Cronbach's alpha reliability score of .82. Another tool, the CCS (Swank et al. 2012), is a 32-item rubric for measuring counseling skills, professional conduct, and professional dispositions in practicum. Cronbach's alpha for the CCS was reported at .93, and interrater reliability was reported at .57. Criterion validity was established by correlating the CCS score with the semester grade and was reported as moderate. The available psychometric data for the CPA and CCS represent exceptions. In general, lack of psychometric information may result in limited confidence in available assessment tools for appraising counselor student dispositions.

Interrater Reliability

Interrater reliability, essentially the extent to which the raters assign the same scores when observing the same behaviors (McHugh, 2012), is critical for fairness to applicants in counseling admissions interviews. Gwet (2014) stated, "If the inter-rater reliability is high, then raters can be

used interchangeably without the researcher having to worry about the categorization being affected by a significant rater factor. Interchangeability of raters is what justifies the importance of inter-rater reliability" (p. 4). Consistency ensures that the data collected are realistic for practical use. When interrater reliability is poor, interviews conducted by overly critical raters (*hawks*) naturally lead to negative bias against applicants when compared within the same applicant pool with the scores from interviews rated by less critical raters (*doves*). Epstein and Synhorst (2008) discussed interrater reliability as an approximation in which different people rate the same behavior in the same way. Thus, interrater reliability can also be understood as rater consensus.

Purpose of the Present Study

Effectively screening and selecting new entrants is one of the hallmarks that distinguishes a profession. Unfortunately, there is a dearth of available literature on assessment tools for rating admissions interviews. Further, lack of information on the reliability of the tools that exist represents a significant deficiency in professional literature (Johnson & Campbell, 2002). The Professional Disposition Competence Assessment—Revised Admission (PDCA-RA; Freeman & Garner, 2017; Garner et al., 2016) is a global rubric designed to assess applicant dispositions in brief graduate program interviews. The PDCA-RA includes a video training protocol developed to facilitate consistency across raters in scoring admissions interviews on dispositional domains.

The purpose of the study was to examine the internal stability and the interrater reliability of the PDCA-RA. The rationale for the study was that no similar rubrics assessing dispositions at admissions using training videos were found in published research, suggesting a gap in the literature. Interrater reliability was the key focus of this study because of the importance of interrater reliability for rubrics utilized in situations with multiple raters, a typical scenario for counselor education admissions processes.

Method

Sample

Raters for the study included 70 counselor educators, counseling doctoral students, adjunct faculty, and site supervisors. Counselor educators, doctoral students, and adjunct faculty at two universities were asked to participate in trainings on the new admissions screening tool. Site supervisors providing supervision for practicum and internship students at the two universities were offered training in the PDCA-RA as a component of continued professional development to maintain their supervision status. Training in both instances was free and included professional development credits. Informed consent for participation was obtained from all participants in accordance with ACA ethical codes (ACA, 2014) and IRB oversight at both universities. All participants in the study fully completed the PDCA-RA video-based training. The mean age of the raters was 43.9 (*SD* = 11.4, range 24–72). Sixty-four percent identified as female and 36% identified as male. Mean average years of experience indicated as a faculty or field supervisor was 12.2 (*SD* = 9.7, range 1–50). Ninety-three percent identified as White/Caucasian, 6% as Latino/a, and 1% as other ethnicity.

The counselor educators (27% of the sample) were primarily from two CACREP-accredited counseling programs in the Western United States. Participating universities included one private university and a state research university, both with CACREP-accredited programs. Counselor education doctoral students and adjunct faculty participants comprised 7% of the sample. The doctoral students participated in the training because they were involved as raters of master's-level

counselor education applicants in the admissions process at one institution. The remaining 66% of the participants were field site supervisors. Because field site supervisors were involved in gatekeeping, attending training in dispositional assessment was natural to their role as internship site supervisors.

Measure: PDCA-RA

The PDCA-RA was developed on the basis of the Professional Disposition Competence Assessment (PDCA; Garner et al., 2016). The PDCA, a dispositional gatekeeping tool, was revised to the Professional Disposition Competence Assessment-Revised (PDCA-R) after several rounds of use and with feedback from expert panels (Freeman & Garner, 2017). Advice from legal counsel was also reflected in the revision of the PDCA to the PDCA-R. The PDCA-R was originally used for both gatekeeping and admissions purposes, but it was determined that the PDCA-R was best used for gatekeeping, not for admissions screening, because the tool implied that the rater had prior knowledge of the student. Because this is often not the case in admissions screening, the PDCA-RA was developed.

The PDCA, PDCA-R, and PDCA-RA were conceptualized and developed through a comprehensive review of the literature, several rounds of field testing, and adjustments from expert faculty panels at two institutions. In addition to counseling literature on impairment and expert panel feedback, the Five-Factor Model, often referred to as the "Big Five" (Costa & McCrae, 1992), influenced three of the nine dispositional items. The Five-Factor Model consists of five personality traits consistently associated with positive mental health, academic success, and healthy habits and attitudes across the life span: Extraversion, Agreeableness, Conscientiousness, Emotional Stability, and Openness. The PDCA-RA dispositions are identical to the PDCA-R, with the exception of the disposition of Ethics. Ethics was removed from the PDCA-RA because the description assumed knowledge of professional ethical standards, a doubtful expectation for program applicants with no prior training in counseling. The behavioral descriptions in the PDCA-RA were narrowed so they described only those behaviors that can be observed in admissions interviews with no prior knowledge of the applicants. In addition, the rubric item descriptions were shortened to align with the practical context of brief (20- to 30-minute) admissions interviews in which there may be limited time for in-depth assessment.

If dispositions are thought of as traits, as per the definition of dispositions in the CACREP glossary (CACREP, 2015), the PDCA-RA is not technically directly measuring dispositions. Based upon advice from legal counsel, as well as the practicality of assessing applicants during short admissions interviews, the PDCA-RA assessed *behaviors* associated with dispositions and not the actual dispositions. Behaviors identified for each disposition can be observed during a short admissions interview, whereas personality traits would require a more in-depth assessment approach, one that counselor educators fear might be found legally problematic (Freeman et al., 2019; Schuermann et al., 2018).

The nine dispositions assessed in terms of observable behaviors via the rubric are Conscientiousness, Coping and Self-Care, Openness, Cooperativeness, Moral Reasoning, Interpersonal Skills, Cultural Sensitivity, Self-Awareness, and Emotional Stability. Each disposition in the PDCA-RA is rated on a scale of three levels—*developing*, *meets expectation*, and *above expectation*. The PDCA-RA is described in more detail in a manual that includes the tools as well as three suggested admissions questions for each of the nine dispositions (Freeman & Garner, 2017). The measure of internal consistency for faculty ratings of the original PDCA rubric was a Cronbach's alpha estimated at .94 (Garner et al., 2016). Cronbach's alpha for self-ratings was .82, and Cronbach's alpha for peer ratings was .89. The straightforward modifications from the original PDCA to the PDCA-RA were minimal and unlikely to significantly affect these measures of internal consistency.

Procedure

A video-based training protocol was developed for the purpose of training faculty in counselor education programs, doctoral students, site supervisors, and other admissions raters to use the PDCA-RA to assess the dispositions of graduate program applicants (Freeman & Garner, 2017; Garner et al., 2016). The video was presented to participants by a trainer. The trainer also greeted participants, obtained informed consent, passed out PDCA-RA forms when prompted by the training video, and collected completed PDCA-RA forms for later analysis. Training in the use of the PDCA-RA was important not only as a mechanism to establish interrater reliability but also as a means of informing adjustments to the tool during its initial iterative development process. Development of the video-based training protocol progressed through several stages. At first, the original 90-minute training consisted of a faculty team of seven working together as a group to read and discuss each disposition, followed by each faculty viewing an admissions interview video and rating the applicant independently. Faculty then discussed their ratings, leading to subtle adjustments in the rubric item descriptions. Additional benefits to the training were an increase in faculty self-awareness of *dove* and *hawk* tendencies when rating admissions applicants and self-awareness associated with interview bias. With continued training and feedback, the original training protocol was significantly improved.

To complete the next step in the creation of the video-based training protocol, counseling student volunteers were offered a minimal incentive to come to the film studio, and after signing waivers to allow the film clips to be used, the student volunteers were asked to respond to various admissions interview questions. The faculty filming the students instructed them to "give a strong answer" or "give a weak answer." The researchers treated all responses as unscripted role plays. The questions asked by the interviewer for each disposition were those found in the PDCA-RA materials (Freeman & Garner, 2017). Finally, the authors and developers of the training video reviewed over 100 film clips, removed those in which the acting interfered with the purpose of the video, and rated the remaining clips using the PDCA-RA, resulting in ratings of *1*, *3*, or *5*. These numerical ratings corresponded to descriptive ratings of *developing*, *meets expectation*, and *above expectation*, respectively. Clips in which the researchers found the rating to be difficult were removed from consideration. In selecting the final 18 clips (two for each of nine dispositions), the researchers considered diversity in age, ethnicity, gender, and disability of the student volunteers. The goal was to create video clips of student volunteers with diverse characteristics.

The result was a video-based training protocol that could still be completed by trainees in 90 to 120 minutes. The video training protocol began with an introduction to the PDCA-RA, followed by prompts to rate the video-recorded vignettes using the PDCA-RA prior to receiving training. This initial rating of the vignettes was considered the pretest condition. Training on the application of the PDCA-RA to the vignettes was next. Training included revealing ideal scores as determined by the authors, the reasoning behind the scoring, and opportunities to discuss scoring among participants. Following the training on the PDCA-RA, participants were, once again, given the PDCA-RA rubric along with a new set of video-recorded vignettes. This was considered the posttest condition. Participants were asked to rate the new vignettes using the PDCA-RA.

The video-based training protocol, designed for use in small groups, allowed for group discussion of ratings after each participant completed the PDCA-RA independently. This was indicated by a written message on the video reading, "Pause video for discussion." The training tape ended with a narrator discussion of how to use the PDCA-RA in actual admissions interviews, including comments on cultural sensitivity in admissions interviews.

The video-based training protocol was used as the means of training participants in dispositional assessment. The purpose of the trainings was to increase consistency of admissions raters in evaluating the admissions interviews of applicants to a master's-level counselor education program. Typically, participants completed the video training in small groups consisting of approximately six to 10 people. In addition to viewing the training video, participants also took part in group discussion and established a consensus of opinion on group ratings of video clips. Coming to a consensus on ratings, which also included feedback on rubric items and video clips, was an important aspect of the training.

Statistical Analysis

The PDCA-RA scores from the counselor education faculty, adjunct faculty, doctoral students, and site supervisors' ratings of the vignettes before training were used as the pretest or baseline interrater reliability. The PDCA-RA scores after participants were trained in the tool were used as the posttest. The intraclass correlation coefficient (ICC) was calculated as a measure of interrater reliability. Interrater reliability correlations quantify rater subjectivity (Herman et al., 1992). The ICC was calculated for pretest and posttest scores. Cronbach's alpha coefficients were calculated for internal consistency, and Fleiss' kappa (κ) was calculated for absolute agreement. In addition, Fleiss' free-marginal kappa (κ_{free}) and percent overall agreement were calculated. Calculations were made for both the pretest and posttest ratings, and a *t*-test was conducted, using SPSS, to determine whether training improved interrater reliability.

Results

The ICC estimates and associated 95% confidence intervals were calculated using SPSS statistical package version 23 and based on an individual rating, absolute agreement, 2-way random-effects model. ICC single measures for absolute agreement were calculated for the pretest administration of the PDCA-RA at .53 (95% CI [0.333–0.807]). The ICC single measures for absolute agreement were calculated for the posttest administration of the PDCA-RA at .76 (95% CI [0.582–0.920]). Cronbach's alpha was calculated at .99 for both pretest and posttest scores. Pretest and posttest ICCs were compared using a *t*-test with an a priori significance level set at .05. The test was significant (p < .05), suggesting that there was a difference between the pretest and posttest reliability, with reliability improving from the "moderate" range to the "good" range (Koo & Li, 2016) with training.

Using Excel, kappa (κ) was calculated as a measure of overall agreement for pretest and posttest scores. This particular kappa was extended by Fleiss (1971) and accommodates multiple raters like those rating the PDCA-RA. Assumptions underpinning Fleiss' kappa include categorical data (i.e., nominal or ordinal) with mutually exclusive categories, symmetrical cross-tabulations, and independence of raters. Data in this study met all assumptions. Data was ordinal with three mutually exclusive response categories for each dispositional area assessed, which resulted in all cross-tabulations being symmetrical. Although raters were trained in a collaborative setting where discussions about ratings were fostered, when the actual ratings of study participants occurred, raters did not discuss their ratings with others and were thus independent of one another. Pretest scores for the nine rubric items reflected a κ of .33, fair agreement according to Landis and Koch (1977). After training, posttest scores on the nine items reflected a κ of .55, moderate agreement according to Landis and Koch.

As an additional analysis, percent overall agreement and κ_{free} was calculated. κ_{free} is appropriate when raters do not know how many cases should be distributed into each category. In addition, κ_{free} is resistant to influence by prevalence and bias (Randolph, 2005). The percent of overall agreement is the measure of agreement between raters and historically has also been used to calculate interrater

reliability (McHugh, 2012). Table 1 illustrates that the κ_{free} for the pretest was .36 while the percent of overall agreement was 57.6%. The posttest for the κ_{free} was .56 and the percent of overall agreement was 70.4%. After examining the change in pretest to posttest calculations from both the κ_{free} and the percent of overall agreement, both offer additional support for and provide evidence that training improved the agreement of dispositional ratings on the PDCA-RA.

Table 1

Pre and Post Statistics: Percent Overall Agreement and Free-Marginal Fleiss' Kappa

Time of Rating	Percent Overall Agreement	Free-Marginal Kappa	95% CI for Free-Marginal Kappa
Before Training: Pre	57.6	.36	[.23, .49]
After Training: Post	70.4	.56	[.31, .80]

The overall κ, κ_{free} and percent of agreement results were promising, but a comparison of the percent of correct responses (the response intended by the research team) by disposition showed that the ratings of correct responses decreased by more than 2% from pre- to posttesting for three dispositions (Openness, Cooperativeness, and Moral Reasoning). Because this was an unexpected finding, the research team analyzed the ratings for incorrect responses and learned that the raters appeared to be better able to discern the difference between a rating of *1* (*developing*) and *3* (*meets expectation*) than between *3* and *5* (*above expectation*). As a post-hoc analysis, we calculated the percent of agreement with the correct score, collapsing the *3* and *5* ratings. The percent of correct responses with dichotomous categories of *1* and a collapsed category for *3* and *5* are shown in Table 2. As is evident in Table 2, using the collapsed category, the percent of correct responses for eight of the nine dispositions improved from pretest to posttest. The percent of correct responses for one disposition, Cooperativeness, decreased by more than 2% from pretest to posttest.

Table 2

Pre and Post Percent of Correct Responses by Disposition

Disposition	Pre Percent Overall Agreement 1, 3, 5 Ratings	Post Percent Overall Agreement 1, 3, 5 Ratings	Pre Percent Overall Agreement 1, 3 & 5 Collapsed	Post Percent Overall Agreement 1, 3 & 5 Collapsed
1. Conscientiousness	62.0	97.1	77.1	98.6
2. Coping & Self-Care	59.9	94.4	22.9	97.1
3. Openness	51.0	49.4	94.3	100.0
4. Cooperativeness	47.3	39.0	94.3	87.1
5. Moral Reasoning	84.1	68.8	91.4	98.6
6. Interpersonal Skills	48.0	94.4	98.6	97.1
7. Cultural Sensitivity	69.3	94.4	100.0	100.0
8. Self-Awareness	40.7	40.0	54.3	64.3
9. Emotional Stability	56.3	56.5	67.1	95.7

Discussion

The results of the study suggest that the PDCA-RA has potential as a reliable instrument for assessing counseling applicants at the point of program admission. The PDCA-RA demonstrated strong reliability from the standpoint of internal consistency. The interrater reliability, as measured by the ICC, moved from the "moderate" to the "good" range with the application of the standardized training protocol.

The results of the study also provide evidence that counselor educators, supervisors, and doctoral students can improve their agreement on ratings of student dispositions with adequate and appropriate training. Multiple statistical techniques for measuring agreement, including the ICC, κ, κ$_{free,}$ and percent agreement measured under pre-training and post-training conditions demonstrated overall improvement in rater agreement with training. The observed post-training improvement in interrater reliability corroborates the literature, underscoring the necessity of training protocols as the pathway to improved interrater reliability (Jonsson & Svingby, 2007).

The results from the second analysis conducted through collapsing the *meets expectation* and *above expectation* categories suggest that the PDCA-RA has higher reliability as a tool to screen out inappropriate candidates than to distinguish excellence within the pool of acceptable candidates. For programs seeking to eliminate problematic applicants, the PDCA-RA could prove reliable. However, for academic programs with large numbers of applicants with an objective to accept a small group of students from a large group of acceptable candidates, the PDCA-RA may be less reliable from an interrater reliability perspective. The PDCA-RA item descriptions for *above expectation* need further consideration.

The percent of correct responses after training with collapsed categories was over 87% for seven of the nine dispositions. The results suggest that the PDCA-RA or the PDCA-RA training protocol needs revision on two dispositions, Cooperativeness and Self-Awareness. The decrease in correct responses to Cooperativeness may be due to a posttest interview with a higher level of difficulty than the pretest interview. The posttest percent was 87%, suggesting that overall the rubric descriptions functioned as acceptable with this sample of raters, though not excellent. The percent of correct ratings for Self-Awareness increased from pre- to posttesting, but only to 64% agreement. One explanation could be that the Self-Awareness rubric descriptions are behavioral (as recommended by legal counsel), yet Self-Awareness as a trait is difficult to describe in behavioral terms. This could leave raters confused about the difference between their intuitive sense of the self-awareness of the applicant and the narrow behavioral descriptions on the rubric. An alternative explanation is that there is a lack of agreement in the profession on the extent of self-awareness expected from students entering the academic program, leading some raters to find the applicant's level of self-awareness acceptable, while others found the level unacceptable. In either case, the training protocol for the PDCA-RA and perhaps the rubric description need improvement. The 100% posttest agreement on the dichotomous categories for Openness and Cultural Awareness were encouraging, given the critical importance of these two dispositions (Freeman et al., 2019).

Interrater reliability is of paramount importance for the responsible use of rubrics. To improve the interrater reliability of the PDCA-RA, three issues may need to be addressed. First, the training protocol may need to be lengthened to encompass three rather than two opportunities to rate video clips. Second, structuring the discussion between raters with questions focusing attention on the gaps in ratings could be beneficial. Third, because alternate forms of the videos are being used in the training (different actors with different responses to the same question), a comparison of the

complexity of the video clips should be conducted. It may be desirable to revise the training protocol to utilize less complex responses for Part 1 training, followed by equivalent complex interviews for Part 2 training, and more complex interview responses for Part 3. More complex responses, meaning the responses are partially descriptive of two categories on the rubric, are realistic to actual admissions interviews in the field.

In conducting trainings for the PDCA-RA, a potentially interesting observation was that raters appeared predisposed to using their own subjective experience to rate the video interviews instead of applying the item descriptions in the rubric. Often the trainers observed that the disposition title, such as Self-Awareness, triggered an automatic response of high rater confidence in their ability to rate self-awareness without carefully reading the rubric descriptions. The tendency of raters to believe they are "right" rather than applying a rubric description is a potential barrier for any dispositional measure.

Implications of the Study

The implications of this study relate primarily to counselor education programs. As evident from the review of literature, careful admissions processes are critical to prevent or diminish the number of gatekeeping and remediation situations that occur in academic programs after admission. In addition to the importance of fair admissions procedures from a legal perspective, the effort required of applicants to engage in the application process justifies the importance of developing fair processes in which acceptance or denial decisions are not based solely upon the subjectivity of faculty.

For those academic programs utilizing admissions interviews, one important implication of the study is that the results suggest that without training, raters will have high variability in their ratings of admissions applicants, as illustrated by the variability of the pretest scores in this study. Structuring the rating of admissions interviews by using an assessment is one method of mitigating the variability of faculty ratings of applicants. A holistic (global) rubric such as the PDCA-RA is unlikely to ever garner the almost perfect interrater reliability associated with analytic rubrics, but the PDCA-RA is available as one practical, field-tested tool with promising reliability to help facilitate transparent and fair admissions interview rating processes.

Limitations and Future Research

In light of the lack of an established list of professional dispositions, the PDCA-RA's utility may be limited, as the selected dispositions may not align with the values of all counselor education programs. A second limiting factor is that the sample included both field site supervisors and faculty, and all participants were from the rural Western United States. The reliability of the tool is limited by the demographics of the sample. Another limitation was that the study's pretest and posttest video clips, although similar, were different from one another. The initial decision to use different pretest and posttest video clips was based on an attempt to reduce the influence of testing as a threat to internal validity. However, this also introduced the possibility that either of the sets of video clips was inherently easier or more difficult to rate than the other. Further research would include randomly juxtaposing pretest and posttest video clips, or perhaps using the same video clips pre- and posttest to eliminate the possibility that differences in pretest and posttest video clips were responsible for the improvements in score reliability rather than the intended independent variable, the training. Another potential limitation to the results is that it is possible that some of the graduate students who were filmed in the vignettes may have been known by six of the faculty members from one of the institutions. The impact of this possibility was reduced by the use of multiple student actors, but prior knowledge of the student could have influenced raters' scores.

A final issue for consideration is the decision to use site supervisors as raters for the research. Site supervisors more commonly utilize the PDCA-R rather than the PDCA-RA, the version specific to admissions screening. The PDCA-R is used by supervisors to monitor and to communicate with counselor educators and counseling program clinical personnel. Further, at least one of the counselor education programs utilizes site supervisors for the admissions process. The training protocol for both versions of the PDCA is the same, and with site supervisors routinely participating in the training, the decision was made to include site supervisors as raters. It is possible, however, that site supervisors may differ in their abilities to respond to the training protocol when compared to counselor educators, adjunct faculty, and doctoral students.

A possibility for future research is to measure the extent to which the improvement in reliability can be maintained over time. At this point, little is known about whether and how often educators and site supervisors would need training updates to function optimally as raters of student dispositions. Accordingly, rating reliability could be observed at intervals of 3 months, 6 months, or 1 year after training to monitor decay.

Future research is also needed to determine the extent to which the length of the training protocol influences interrater reliability. In addition, cultural and gender bias in the use of the PDCA-RA should be studied, as one criticism of rubrics is the potential for cultural bias.

As a tool for consistently rating counselor education program applicants, the PDCA-RA demonstrates potential, though more research needs to be conducted to increase the interrater reliability. Training improved the interrater reliability results but not to the extent that excellent interrater reliability was achieved. Adjusting the training protocol may be fruitful as a mechanism to improve interrater reliability.

Conclusion

There is a need for reliable admissions tools to assess dispositional behaviors of counseling program applicants. Interrater reliability is an important form of reliability in situations such as admissions interviews in which there are often multiple raters involved in the process. The importance of interrater reliability is founded in the critical premises of fairness and transparency to applicants, though legal protection of counselor education programs is also enhanced by using clear, standardized processes. Dispositional assessment is in its infancy, especially when applied to counselor education in general and to program admissions in particular. How exactly to define dispositions as well as how exactly the role of the counselor will serve as a means of selection and gatekeeping for the profession is yet to be determined. Yet counselor educators perceive both an ethical and professional responsibility for monitoring counseling student dispositions as a means for safeguarding the integrity of the profession (Freeman et al., 2019; Schuermann et al., 2018). The continued development of the PDCA-R and the PDCA-RA, as well as the associated training materials, represents initial steps toward standardizing and improving dispositional appraisal. The video-based training and the exploration of the training as a means of improving rater consistency will potentially increase the ability of counselor educators to consistently assess and monitor developing counseling students. Consistent dispositional ratings can also contribute to the development of a common language for discussing student progress. The current research represents a promising effort to continually improve the dispositions assessment process for counselor educators, counseling programs, and the counseling profession.

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Family Functioning and Self-Injury in Treatment-Seeking Adolescents: Implications for Counselors

Melissa Sitton, Tina Du Rocher Schudlich, Christina Byrne, Chase M. Ochrach, Seneca E. A. Erwin

A family systems framework guided our investigation of self-injurious behavior (SIB) in adolescents. As part of a larger study, we collected data examining SIB and family functioning from 29 adolescents (M_{age} = 15.66) and their caregivers. These adolescents with traits of borderline personality disorder were seeking counseling from community-based practitioners specializing in dialectical behavior therapy. Our primary aim was to better understand the family environment of these adolescents. A second aim was to elucidate interrelations among family communication, roles, problem-solving, affective involvement, affective responsiveness, behavioral control, and conflict and SIB. We found a high rate of SIB among adolescent participants. There was significant congruence between adolescent and caregiver reports of the family environment, with families demonstrating unhealthy levels of functioning in several indicators of family environment. The latent variable of family functioning significantly predicted nonsuicidal and ambivalent SIB. Counselors working with adolescents should consider family functioning when assessing risk for SIB.

Keywords: **self-injurious behavior, adolescents, family systems, borderline personality disorder, family functioning**

Although emotion dysregulation and unstable personal relationships are common for adolescents, those with symptoms of borderline personality disorder (BPD) often report more extreme experiences (A. L. Miller et al., 2008). BPD is characterized by impaired or unstable emotional and social functioning (American Psychiatric Association, 2013). Individuals with BPD—especially adolescents—may experience impairments in daily functioning as well as within interpersonal relationships (Chanen et al., 2007).

Linehan's (1993) biosocial theory proposed that BPD can result from an individual's biological predisposition toward emotion dysregulation and a social environment that amplifies this vulnerability. Given that adolescents spend a substantial amount of time with their family, it is important to examine an adolescent's familial environment to understand the etiology of BPD symptoms; such examination requires a framework like *family systems theory*, which emphasizes the relationships between family members rather than focusing on the individual members themselves (Goldenberg & Goldenberg, 2013); this includes family communication, roles, problem-solving, affective involvement, affective responsiveness, and behavioral control (I. W. Miller et al., 2000).

Self-Injurious Behavior (SIB)

Regrettably, it is common for adolescents with BPD to engage in SIB (Kaess et al., 2014). SIB is an umbrella term for all purposeful, self-inflicted acts of bodily harm, whether the intent is suicidal, nonsuicidal (i.e., nonsuicidal self-injury), or ambivalent (i.e., neither strictly suicidal nor nonsuicidal). In fact, SIB is one diagnostic criteria for BPD in adolescents and adults.

Melissa Sitton, MS, is a doctoral student at Southern Methodist University. Tina Du Rocher Schudlich, PhD, MHP, is a professor at Western Washington University. Christina Byrne, PhD, is an associate professor at Western Washington University. Chase M. Ochrach, MS, is a doctoral student at the University of Wisconsin–Madison. Seneca E. A. Erwin, BS, is a doctoral student at the University of Northern Colorado. Correspondence may be addressed to Tina Du Rocher Schudlich, 516 High St., MS 9172, Bellingham, WA 98225, tina.schudlich@wwu.edu.

Although originally developed to explain the etiology of BPD, the biosocial theory has been applied to the development of SIB as well (Crowell et al., 2009). Countless studies have examined the role of emotion dysregulation and affective reinforcement in SIB, but it is important to also consider the influence of social variables. Indeed, in their four-function model, Nock and Prinstein (2004, 2005) suggested that both affective and social variables can positively and negatively reinforce nonsuicidal SIB. Similarly, Joiner's (2005) interpersonal theory of suicidal SIB posited that social variables (particularly thwarted belongingness and perceived burdensomeness) drive the desire for suicide. Thus, although there are clear links between affective variables and SIB, social variables are also relevant. For adolescents, an important social variable related to SIB is family environment. From the family systems approach, adolescent SIB is best understood when rooted in the context of family environment. As Levenkron (1998) suggested, "the ways in which all the family members relate to each other… [is] the fuel that drives [SIB]" (pp. 125–126).

Although limited in number, some previous studies have examined family environment and SIB in adolescents. For example, Halstead et al. (2014) found that SIB was related to dysfunctional family environments. Studies have also found relationships between adolescent SIB and familial communication (Halstead et al., 2014; Latina et al., 2015) and conflict (Huang et al., 2017). Additionally, Adrian et al. (2011) demonstrated a link between stress and failure to meet expectations of familial roles. To our knowledge, no studies to date have examined SIB and familial problem-solving, affective involvement, affective responsiveness, and behavioral control. However, studies have linked SIB to an *individual's* lack of problem-solving skills (Walker et al., 2017), ability to regulate affective responses (Adrian et al., 2011), and behavioral control related to impulsivity and compulsivity (Hamza et al., 2015).

Current Study

Despite the clear influence of family members on SIB (Halstead et al., 2014) and the significant amount of time adolescents tend to spend with family members, more research is needed to evaluate family environment in relation to SIB. Specifically, we investigated the families of treatment-seeking adolescents with traits of BPD who engage in SIB. Our objectives were to: (a) assess family environment using multiple indicators of family functioning, (b) assess SIB in these treatment-seeking adolescents, including SIB done with suicidal intent, nonsuicidal intent, and ambivalence toward life, and (c) evaluate family functioning as a statistical predictor of lifetime SIB.

Method

Participants and Procedure

We used data from a larger ongoing, unpublished study on dialectical behavior therapy. In the larger study, participants were adolescents and young adults who sought counseling from community-based clinicians specializing in dialectical behavior therapy. Participants sought counseling for symptoms of BPD, particularly SIB. The counselors recruited participants for the research study by explaining voluntary research participation during their standard intake process for new clients at the clinic. The counselors also obtained informed consent for research from the participants. The counselors collaborated with researchers at a local university for this larger study, and the university's IRB approved the study.

For the current study, we used the existing pretest data from the adolescents only ($N = 29$; $M_{age} = 15.66$, $SD_{age} = 1.34$, age range = 13–18). A majority of the adolescent sample (82.8%; $n = 24$) reported no previous experience with counseling. This sample was predominately Caucasian (82.8%; $n = 24$) and most adolescents identified as female (89.7%; $n = 26$).

Caregiver participants (*N* = 29) were involved in the adolescents' treatment and the accompanying research study. Most caregiver participants were the biological mother (81.5%; *n* = 22) or adoptive mother (7.4%; *n* = 2). However, a few adolescents were accompanied by an extended family member (7.4%; *n* = 2) or their biological father (3.7%; *n* = 1). A majority of adolescents reported that at least one of their caregivers had attended some (22.2%; *n* = 6) or all (29.6%; *n* = 8) of college, or some (3.7%; *n* = 1) or all (29.6%; *n* = 8) of graduate school.

Most adolescents reported they currently lived with both biological parents (58.6%; *n* = 17) or at least one biological parent (31.0%; *n* = 9), though some lived with non-biological parents or caregivers (10.3%; *n* = 3). Most adolescents (86.2%; *n* = 25) also reported having at least one sibling; 58.6% of adolescents (*n* = 17) reported having at least one biological brother, 37.9% had at least one biological sister (*n* = 11), and 24.1% had a half- or step-sibling (*n* = 7). One-way analysis of variance (ANOVA) tests demonstrated that adolescents did not differ in total SIB based on family characteristics (e.g., number of siblings, number of employed caregivers; all values of *p* > .05).

Measures
Family Functioning
The Family Assessment Device (FAD; Epstein et al., 1983) is a 53-item measure with a 4-point Likert scale used to rate agreement with statements about how the adolescents' family members interact and relate to each other (e.g., "After our family tries to solve a problem, we usually discuss whether it worked or not"). Both adolescents and caregivers completed the FAD. Subscales of the FAD assess six dimensions of family functioning, including family problem-solving, roles, communication, affective responsiveness, affective involvement, and behavioral control. The scores for each subscale are averaged, with higher scores indicating worse functioning and more problems within families. The FAD has good test-retest reliability and construct validity (I. W. Miller et al., 1985). In this study, the reliability of the FAD was excellent for both samples (Cronbach's alpha = .95 for adolescents and .96 for caregivers).

The Conflict Behavior Questionnaire (CBQ; Prinz et al., 1979) assesses self-reported familial interactions within the past two weeks. The CBQ has both an adolescent and a caregiver version; both versions consist of 20 true/false items. Scores can range from 0 to 20, with higher scores indicating more conflict between caregiver and adolescent. Studies have shown that CBQ scores delineated between distressed and non-distressed families (Robin & Foster, 1989). The CBQ has good internal consistency and test-retest reliability (Rallis et al., 2015; Robin & Foster, 1989), as well as construct validity (Prinz et al., 1979). In the current study, the reliability of the CBQ was excellent for both samples (Cronbach's alpha = .88 for adolescents and .92 for caregivers).

Self-Injurious Behavior (SIB)
We used the Lifetime Suicide Attempt Self-Injury Interview (LSASI; Linehan & Comtois, 1996) to assess participants' history of SIB, including frequency, method, and intent. Using 20 items, the LSASI asks participants to report the dates of the most recent and most severe SIB, as well as their lifetime frequency of 11 different methods of SIB with suicidal intent, without suicidal intent, and with ambivalence. Participants also report the total frequency of each SIB method (combining suicidal, nonsuicidal, and ambivalent), and the number of times medical treatment was received for the SIB method. Higher scores indicate more SIB in the past. In the current study, reliability across all SIB intent types (four variables: suicidal SIB, nonsuicidal SIB, ambivalent SIB, and total SIB) was .65. Because the LSASI was designed for clinical use rather than research, to our knowledge there are no existing studies demonstrating the reliability or validity of the LSASI. Notably, this measure was already in use at the counseling clinic, and the decision to use it for this research study was counselor-driven.

Data Analysis

As part of our preliminary analyses, we first tested all variables for the assumptions of analysis. Specifically, when examining the skew and kurtosis of the composite variables, we used ±2 as our acceptable range of values. Following advice from Tabachnick and Fidell (2019), we transformed variables that did not meet our criteria for normality.

To better understand family functioning, we conducted descriptive analyses for all seven predictive variables (problem-solving, communication, roles, affective responsiveness, affective involvement, behavioral control, and conflict) separately for adolescent and caregiver scores. We assessed the degree of healthy family functioning using I. W. Miller et al.'s (1985) suggested cut-off scores, which can be used to distinguish between healthy and unhealthy family environments. We also conducted paired sample *t*-tests to compare the adolescent and caregiver reports of family functioning.

Next, we tested the fit of our theoretical model of family functioning using structural equation modeling (SEM) with maximum likelihood as the method of estimation. We used multiple fit indices to assess the model fit. Specifically, the chi-square statistic assesses absolute model fit, demonstrating good fit when not statistically significant. The chi-square test can also be used to compare the relative fit of two models. Additionally, comparative fit index (CFI), root mean square error of approximation (RMSEA), and standardized root-mean-square residual (SRMR) are all indicators of model fit, with 0.95 or higher, 0.05 or lower, and 0.08 or lower indicating good fit, respectively (for more information on SEM fit indices, see Hooper et al., 2008). Notably, Iacobucci (2010) suggested that researchers can use SEM and establish good model fit even with small samples.

We also conducted descriptive analyses of the participants' self-reported SIB. We left these variables raw (untransformed) to evaluate how participants viewed their own SIB. We examined the specific SIB methods that participants reported using (e.g., cutting, burning) as well as three outcome variables (suicidal SIB, nonsuicidal SIB, and ambivalent SIB; all transformed because of issues with skew and kurtosis).

Lastly, we used SEM to predict SIB with the proposed model of family functioning. Given our small sample size, we conducted this analysis separately for suicidal SIB, nonsuicidal SIB, and ambivalent SIB. We set alpha at .05 for each model; given the small sample size, we did not apply corrections to the alpha for the multiple analyses.

Results

We used SPSS 24.0 and Amos 24 to analyze our data. Because this study was primarily descriptive, we conducted multiple analyses to better understand the family environment of treatment-seeking adolescents, experiences of SIB for adolescents, and the role of family environment in adolescent engagement in SIB.

Family Characteristics and Functioning

Means, standard deviations, and range of scores for the family functioning variables are shown in Table 1. With the exception of the caregiver reports on affective responsiveness and behavioral control, both adolescent and caregiver reports on every subscale of the FAD fell above the McMaster clinical cut-off (see Table 1) described by I. W. Miller et al.'s (1985) cut-off scores, indicating on average all of the families demonstrated unhealthy functioning. It is worth noting that adolescents and their caregivers reported similar levels in five of the seven indicators of family functioning from the FAD and CBQ

(e.g., there was no statistical difference between the two reports, all values of *p* > .05). As shown in Table 1, adolescent and caregiver reports only statistically differed for behavioral control (*t*[28] = 4.23, *p* < .001) and communication (*t*[28] = 2.96, *p* = .006). Specifically, adolescents reported higher levels of both behavioral control and communication; these high levels are considered indicative of unhealthy or distressed families (I. W. Miller et al., 1985).

Table 1

Descriptive Statistics and Group Comparisons of Family Functioning Variables as Reported by Adolescents and Caregivers

Variable	Cut-Off	Adolescent			Caregiver			*t*(28)	*p*
		M	*SD*	Range	*M*	*SD*	Range		
Problem-solving	2.2	2.58	0.65	1.00–3.80	2.29	0.57	1.40–3.80	1.88	.071
Communication	2.2	2.56	0.37	1.83–3.17	2.30	0.37	1.50–3.00	2.96	**.006**
Roles	2.3	2.58	0.37	1.75–3.38	2.45	0.37	1.75–3.38	1.57	.128
Affective Resp.	2.2	2.34	0.68	1.00–4.00	2.12	0.62	1.00–3.67	1.48	.151
Affective Inv.	2.1	2.37	0.28	1.71–3.00	2.44	0.23	1.86–3.00	- 1.61	.118
Behav. Control	1.9	2.12	0.44	1.00–3.11	1.77	0.41	1.00–2.78	4.23	**< .001**
Conflict	---	9.60	4.83	0.00–18.00	10.05	5.67	1.00–20.00	- 0.46	.649

Note. Cut-Off = McMaster Cut-Off score; Affective Resp. = Affective responsiveness; Affective Inv. = Affective involvement; Behav. Control = Behavioral control.

We used SEM to test the fit of our theory-driven, congeneric model of family functioning using seven subscales from each source (14 variables; seven for adolescents and seven for caregivers, with the error terms of each subscale correlated between the two sources) to predict family functioning as reported by each source (two latent variables; one for adolescents and one for caregivers). The absolute fit of the model was marginal: $\chi^2(69) = 104.39$, *p* = .004, CFI = 0.79, RMSEA = 0.14, SRMR = 0.14.

In order to reduce variables in our theoretical model, we averaged adolescent and caregiver reports for problem-solving, roles, affective responsiveness, affective involvement, and conflict because these did not statistically differ (all values of *p* > .05). However, we kept the two reports as separate predictors for communication and behavioral control. This left us with nine predictor variables for subsequent analysis (five averaged predictors and four single-source predictors).

Next, we used SEM to test the fit of the simplified model with the nine observed variables and one latent variable of family functioning. We found that the absolute model fit of this simplified model was acceptable overall. Specifically, the fit indices mostly indicated good fit (χ2[27] = 33.11, *p* = .194, CFI = 0.93, SRMR = 0.08), though one fit index suggested poor fit (RMSEA = 0.09). Differences in the chi-squares of our two models showed the simplified model was statistically better than the initial model: $\chi^2(42) = 71.28$, *p* = .003. Thus, we selected the simplified model as the final model of family functioning (see Figure 1). See Table 2 for descriptive analyses of the nine predictors in the final model. All variables were positively related to family functioning. The strongest predictors of family functioning in this model were affective responsiveness (average of adolescent and caregiver report; β = .85, *B* = 1.04, *SE B* = 0.21, *p* < .001, R^2 = .72), affective involvement (averaged; *β* = .72, *B* = 0.88, *SE B* = 0.22, *p* < .001, R^2 = .51), and problem-solving (averaged; β = .82, R^2 = .67; this was the constrained parameter used to identify the regression model).

Figure 1

The Output Structural Regression Model of Family Functioning Developed Using SEM
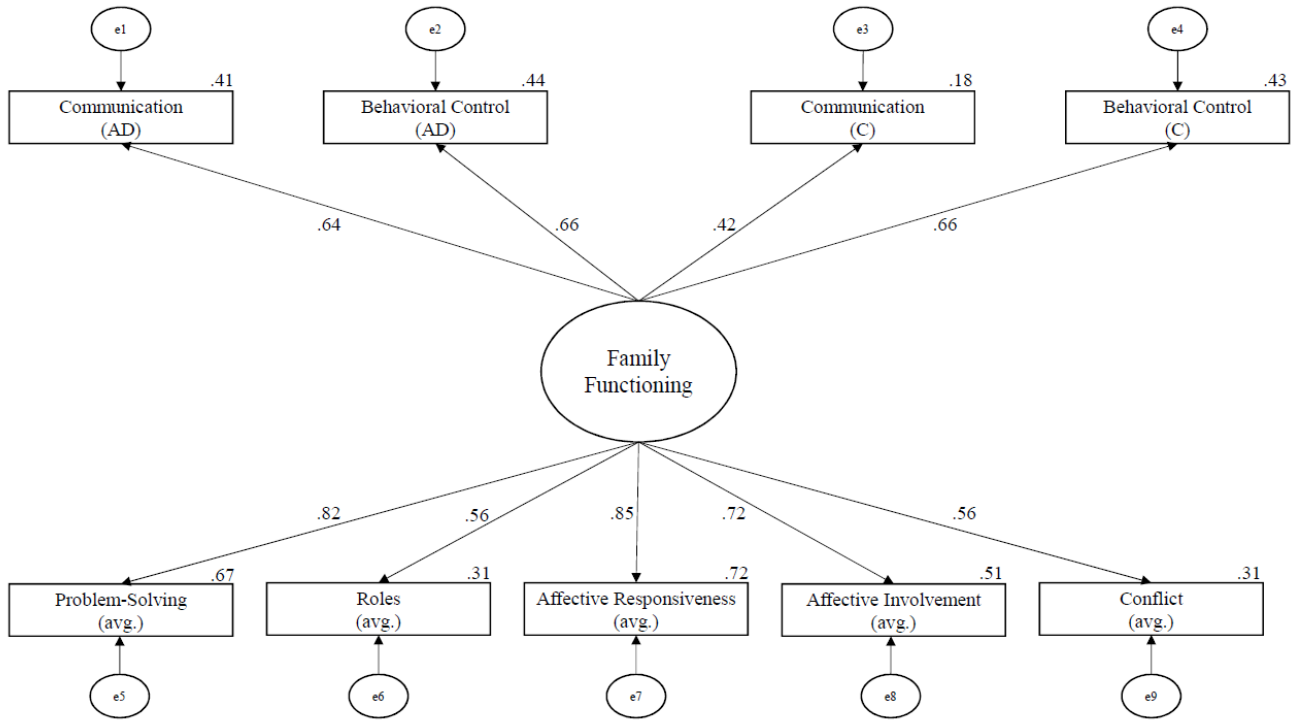
Note. The large circle represents a latent variable, boxes are measured variables, small circles (with "e") are error terms, and solid lines show regression paths. The numbers on paths are the standardized path coefficients, and the offset values on endogenous variables are the R^2 effect sizes. (AD) = adolescent report; (C) = caregiver report; (avg.) = averaged score of adolescent and caregiver report.

Table 2

Descriptive Analyses of Predictors of Family Functioning

Variable	M	SD
Problem-Solving	2.43	0.44
Roles	2.51	0.29
Affective Responsiveness	2.23	0.51
Affective Involvement	2.40	0.23
Conflict	9.82	4.56
Communication (AD)	2.56	0.37
Communication (C)	2.30	0.37
Behavioral Control (AD)	2.12	0.44
Behavioral Control (C)	1.77	0.41

Note. (AD) = adolescent report; (C) = caregiver report.

Adolescent Engagement in SIB

All adolescents reported engaging in SIB in their lifetime, and the average lifetime frequency of SIB was 438.72 (*SD* = 1,216.65, range = 1–6,079; transformed to address normality: *M* = 4.41, *SD* = 1.80). Specifically, most participants reported engaging in nonsuicidal SIB (*n* = 26) and using it with higher frequency than SIB with other intent (i.e., suicidal or ambivalent SIB), with a lifetime average of 340.16 (*SD* = 975.22, range = 0–4,565; transformed: *M* = 3.49, *SD* = 2.25). Many adolescents also reported engaging in ambivalent SIB (*n* = 18), with moderate average frequency rates (*M* = 22.28, *SD* = 52.02, range = 0–248; transformed: *M* = 1.62, *SD* = 1.69). Lastly, fewer adolescents reported engaging in suicidal SIB (*n* = 18), with the lowest average lifetime frequency (*M* = 7.34, *SD* = 25.03, range = 0–136; transformed: *M* = 0.97, *SD* = 0.95). See Table 3 for descriptive information on SIB methods (e.g., cutting) used by adolescents in our sample. On average, participants used 3.78 (*SD* = 2.15) methods of SIB in their lifetime.

Table 3

Descriptive Statistics for All Self-Injurious Behavior Completed in One's Lifetime (N = 29)

Variable	*n*	*M*[a]	*SD*[a]	Range[a]	*n* of Severe Cases
Cutting	27	179.55	330.42	0–1,500	7
Hitting head/body	16	240.90	730.59	0–3,000	0
Overdosing	13	1.88	3.59	0–15	7
Burning	13	6.12	14.99	0–60	1
Strangling/hanging	8	2.18	6.42	0–30	0
Stabbing/puncturing	8	0.80	1.64	0–7	2
Asphyxiating	7	1.66	3.90	0–15.62	0
Other	6	272.92	602.33	0–1,500	2
Jumping	4	1.27	5.31	0–25	1
Drowning	4	0.40	.99	0–4	0
Poisoning	3	0.14	.36	0–1	1

Note. The descriptive statistics are based on the total self-injurious behavior, combining acts completed with suicidal intent, nonsuicidal intent, and ambivalence. Other = adolescent-reported participating in a type of self-injury that was not listed; Jumping = jumping from a high place to cause injury; Severe Cases = requiring medical treatment.
[a] The frequency that adolescents reported engaging in the various methods of self-injury.

Predicting SIB With Family Functioning

To understand the relationships between family functioning and SIB, we conducted correlational analyses of the three outcome variables and nine predictors. As shown in Table 4, problem-solving was moderately associated with ambivalent SIB (*r* = .44 , *p* = .018), conflict was moderately associated with nonsuicidal SIB (*r* = .38 , *p* = .049), and adolescent-reported communication was moderately to strongly associated with all three SIB variables (suicidal *r* = .61, *p* < .001; nonsuicidal *r* = .47, *p* = .011; ambivalent *r* = .56, *p* = .002). All associations were positive (see Table 4), meaning that worse family functioning scores were associated with more SIB.

Table 4

Bivariate Correlations Between Predictor Variables

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1. Nonsuicidal SIB	-										
2. Ambivalent SIB	.35	-									
3. Suicidal SIB	.16	.46*	-								
4. Problem-Solving	.35	.44*	.19	-							
5. Roles	.21	-.01	.27	.39*	-						
6. Affect. Resp.	.25	.36	.28	.68***	.42*	-					
7. Affect. Involv.	.22	.13	.27	.52**	.43*	.72***	-				
8. Conflict	.38*	.35	.26	.66***	.14	.45*	.15	-			
9. Comm. (AD)	.47*	.56**	.61***	.57**	.44*	.51**	.50**	.43*	-		
10. Comm. (C)	.09	.11	.04	.42*	.28	.29	.29	.27	.17	-	
11. Beh. Cont. (AD)	.27	.06	-.21	.54**	.48**	.51**	.56**	.34	.41*	.25	-
12. Beh. Cont. (C)	.27	.26	.13	.49**	.53**	.61***	.36	.38*	.33	.40*	.47*

Note. SIB = self-injurious behavior; Affect. Resp. = Affective Responsiveness; Affect. Involv. = Affective Involvement; Comm. = Communication; (AD) = adolescent report; (C) = caregiver report; Beh. Cont. = Behavioral Control.
* $p < .05$. ** $p < .01$. *** $p < .001$.

Next, we used SEM to predict SIB with our simplified model of family functioning. We tested three SIB outcomes separately because of concerns with sample size. For all models predicting SIB, we freed all FAD factors (problem-solving, roles, affective responsiveness, affective involvement, adolescent-reported communication and behavioral control, and caregiver-reported communication and behavioral control) to correlate because variables from the same measure are likely to be related.

The model predicting nonsuicidal SIB had good absolute fit: $\chi^2(7) = 4.28$, $p = .747$, CFI = 1.00, RMSEA = 0.00, SRMR = 0.04. In all, family functioning explains 20% of the variance in nonsuicidal SIB. See Figure 2 for the standardized path coefficients between family functioning variables, the latent variable of family functioning, and nonsuicidal SIB. Notably, family functioning predicted nonsuicidal SIB: $\beta = .44$, $B = 1.27$, $SE\ B = 0.62$, $p = .039$. Based on effect sizes (see Figure 2), the strongest predictors were problem-solving (averaged; $\beta = .79$, $B = 0.90$, $SE\ B = 0.03$, $p = .008$, $R^2 = .62$), communication (adolescent-reported; $\beta = .55$, $B = 0.05$, $SE\ B = 0.03$, $p = .034$, $R^2 = .31$), and conflict (averaged; $\beta = .84$, $R^2 = .71$; this was the constrained parameter used to identify the regression model).

The model predicting ambivalent SIB had good absolute fit: $\chi^2(7) = 5.69$, $p = .577$, CFI = 1.00, RMSEA = 0.00, SRMR = 0.04. In all, family functioning explains 33% of the variance in ambivalent SIB. See Figure 3 for the standardized path coefficients between family functioning variables, the latent variable of family functioning, and ambivalent SIB. Notably, family functioning predicted ambivalent SIB: $\beta = .58$, $B = 1.04$, $SE\ B = 0.46$, $p = .025$. Based on effect sizes (see Figure 3), the strongest predictors were problem-solving (averaged; $\beta = .94$, $B = 0.15$, $SE\ B = 0.07$, $p = .022$, $R^2 = .89$), communication (adolescent-reported; $\beta = .83$, $B = 0.11$, $SE\ B = 0.05$, $p = .030$, $R^2 = .69$), and affective responsiveness (averaged; $\beta = .69$, $B = 0.13$, $SE\ B = 0.07$, $p = .049$, $R^2 = .47$).

Figure 2

The Output Structural Regression Model of Nonsuicidal SIB Developed Using SEM
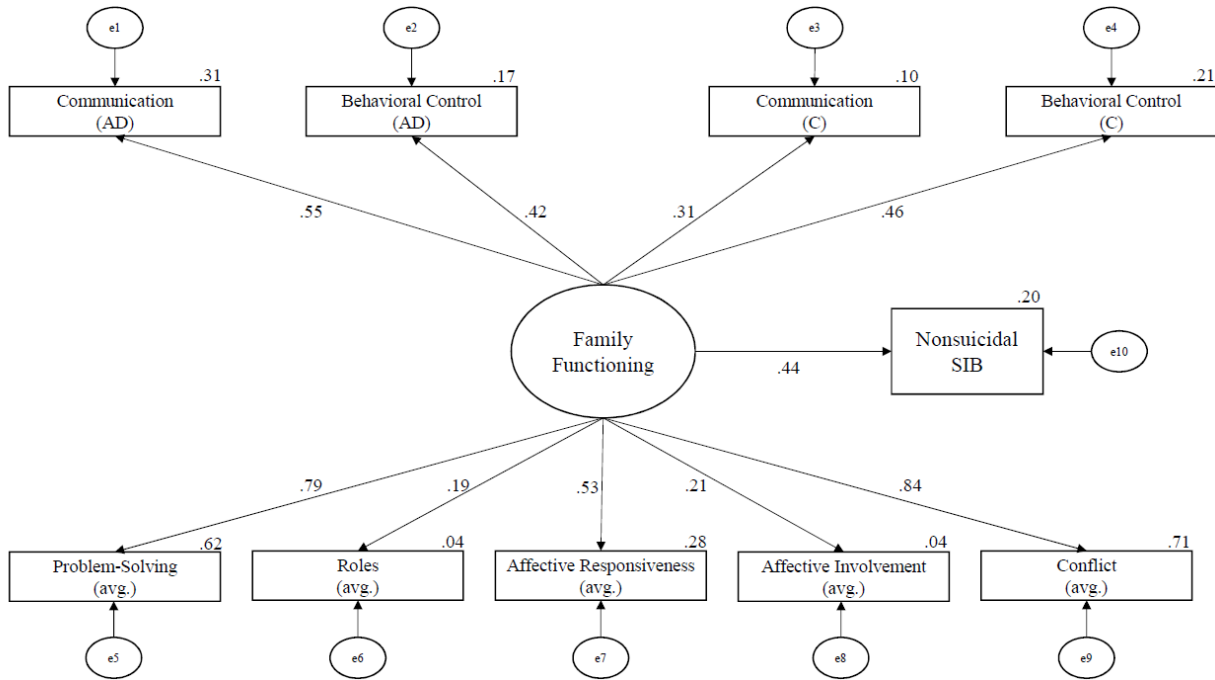
Note. The numbers on paths are the standardized path coefficients, and the offset values on endogenous variables are the R^2 effect sizes. (AD) = adolescent report; (C) = caregiver report; (avg.) = averaged score of adolescent and caregiver report.
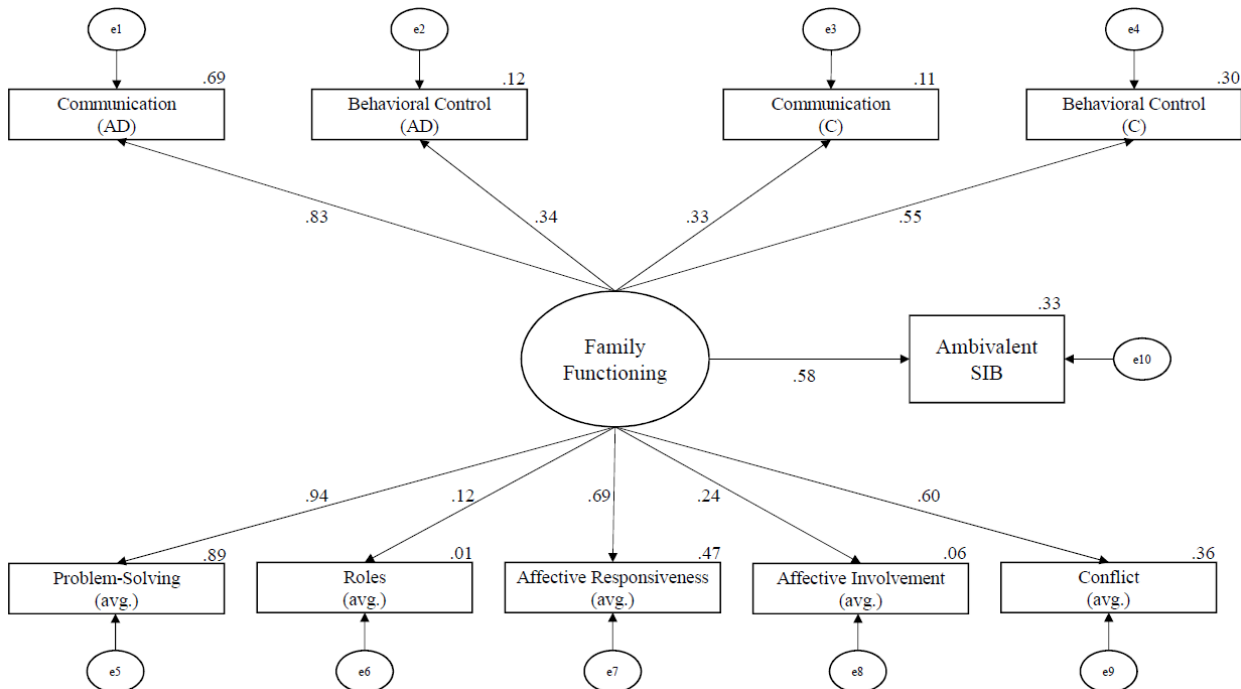
Figure 3

The Output Structural Regression Model of Ambivalent SIB Developed Using SEM

Note. The numbers on paths are the standardized path coefficients, and the offset values on endogenous variables are the R^2 effect sizes. (AD) = adolescent report; (C) = caregiver report; (avg.) = averaged score of adolescent and caregiver report.

Lastly, the model using family functioning to predict suicidal SIB was not able to successfully converge because of reaching the iteration limit, possibly because of the small sample size. After examining the suggested modification indices, the model was still not able to converge. Thus, we concluded that the suicidal SIB model was a poor model, meaning that family functioning alone was not predictive of suicidal SIB in our sample.

Discussion

The goals of the current study were to examine the family environment of adolescents seeking treatment for symptoms of BPD, as well as their experiences of SIB, and to better understand what aspects of family functioning relate to SIB. Unique strengths of this study include the emphasis on assessing models of family functioning as it relates to SIB and exploring differences between SIB intent types (suicidal SIB, nonsuicidal SIB, and SIB with ambivalence toward life). Further, because participants were clients seeking counseling from community-based master's-level clinicians and no clients were excluded from participating in this study, results may generalize to other community samples.

We found that adolescents and caregivers often reported family functioning scores that met criteria for distressed families. Interestingly, adolescents and caregivers agreed on a majority of the subscales of family functioning, suggesting that the distress is mutually experienced. Adolescents and their caregivers only differed on reports of behavioral control (e.g., "[my family does not] hold any rules or standards") and communication (e.g., "when someone [in my family] is upset the others know why"). This self-reported familial distress supports the social component of the biosocial theory (Linehan, 1993) in that the adolescents with traits of BPD engaged in SIB and experienced unhealthy family environments. Additionally, we found high lifetime rates of SIB in our sample of adolescents. As in previous studies (e.g., Anestis et al., 2015), adolescents in the current study engaged in nonsuicidal SIB more frequently than suicidal or ambivalent SIB, and cutting was the most common method.

Notably, our model of family functioning successfully predicted higher levels of both nonsuicidal SIB and ambivalent SIB. In particular, problem-solving, conflict, and adolescent-reported communication had consistently large effect sizes, suggesting that these subscales contributed more to SIB than other subscales. Although no previous studies have examined adolescent SIB and familial problem-solving to our knowledge, the findings that SIB was related to familial conflict (Huang et al., 2017) and communication (Halstead et al., 2014) corroborate the results of previous studies.

The success of the family functioning model in predicting SIB aligns with family systems theory. Specifically, adolescents in our sample may engage in SIB as a coping skill because their family lacks healthy problem-solving skills and thus models poor coping (which aligns with a description by Halstead et al., 2014). Additionally, adolescent SIB may function to temporarily end conflict in the family because it diverts the family's attention away from the immediate problems. For example, Oldershaw et al. (2008) found that parents avoided conflict and felt like they were "walking on eggshells" (p. 142) after learning of their adolescents' SIB. Another possible explanation is that the adolescents in our sample may serve as scapegoats within their family, acting as a focal point of a disturbed family system. From a structural family systems perspective, when there are problems within family subsystem relationships, oftentimes the child—typically the most vulnerable one—becomes the focus of the family's problems (Wetchler, 2003); this trend is consistent with our findings.

It is worth noting that family functioning alone did not sufficiently predict suicidal SIB. One possible explanation is that our family functioning variables did not encompass the factors of thwarted belongingness and perceived burdensomeness, both of which Joiner (2005) suggested may lead to suicide.

Limitations and Future Directions

A strength of this study is that the results may generalize to other real-world settings in which adolescent clients seek counseling services from community-based master's-level clinicians who specialize in dialectical behavior therapy. However, this ecological validity comes with some relative limitations.

One notable limitation of this study is that we examined family functioning at one point in time, when the adolescent was beginning treatment. Given this single timepoint, we are unable to fully describe the relationship between family functioning and SIB. Considering the biosocial theory, it seems likely that the distressed family environment preceded the SIB; however, it is possible that the SIB caused greater familial distress. Therefore, it would be useful to assess changes in family functioning and SIB across time.

Another limitation is our SIB measure; as Crowell et al. (2013) explained, the LSASI is commonly used in clinical practice but not often in research. In addition to issues with reliability, the LSASI is a lifetime measure as opposed to one focusing on recent behavior. Although all participants reported engaging in SIB in the past year, it is unclear how recently they engaged in SIB relative to the time of the study. Despite the benefit of creating more variability in the data by allowing participants to report their specific frequency of SIB, the alternative of a dichotomous variable of current SIB might be more compatible with our measures of current family functioning.

Additionally, the small sample size limits the power of our analyses as well as the generalizability of our results. A small sample increases the likelihood of a Type II error, meaning an increased likelihood of not finding significant results. However, it is notable that we found statistically significant results (e.g., good model fit of family functioning) despite our low power. Nevertheless, replication studies with much larger samples are needed.

Implications for Practice

Our findings suggest that family functioning is related to SIB in adolescents, particularly nonsuicidal and ambivalent SIB. Although counselors often include families when working with young children, it is common for counselors to work with adolescents individually. This practice is consistent with state laws allowing adolescents to consent to their own mental health treatment, and there are many presenting concerns and situations in which individual counseling may be the most effective modality. However, the connection between family functioning and SIB in adolescents in our sample indicates that it may be important to include family members in treating adolescent SIB; in fact, dialectical behavior therapy for adolescents (originally adapted by A. L. Miller et al., 1997) encourages family involvement in treatment. Counselors therefore need to educate parents and caregivers who may be reluctant to engage in the counseling process with their teen that SIB is an issue for which their participation in counseling could make a positive difference in treatment outcome. Further, from a family systems perspective, it can be challenging for teens to successfully use the coping skills and strategies they learn in counseling if the rest of the family system remains unchanged. Including at least some family members may therefore help adolescents maintain changes gained through the counseling process.

When including family members in counseling with adolescents who have engaged in nonsuicidal and ambivalent SIB, findings from our study suggest that three important targets for assessment and intervention include the domains of familial problem-solving, familial conflict, and adolescent-reported communication. Two of these, conflict and communication, were previously identified in the literature, and our study supports those findings. Our study newly identified familial problem-solving as an additional important predictor of SIB in adolescents. Counselors must keep in mind, however, that these variables were not sufficient in predicting suicidal SIB in adolescents. For these teens, we encourage the use of a broader assessment that includes elements of Joiner et al.'s (2009) interpersonal theory of suicide, especially the crucial interpersonal constructs of thwarted belongingness and perceived burdensomeness.

Conclusion

Based on our findings, it appears there is a relationship between engagement in SIB (especially nonsuicidal and ambivalent SIB) and familial environment for community-based treatment-seeking adolescents with traits of BPD. Additionally, both adolescents and their caregivers in our sample reported distressed levels of multiple indicators of family functioning, suggesting the need for family-based intervention. Counselors and service providers should consider multiple markers of family environment (particularly problem-solving, conflict, and adolescent-reported communication) when assessing risk for and treatment of adolescent SIB.

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Counseling International Students in Times of Uncertainty: A Critical Feminist and Bioecological Approach

S Anandavalli, John J. S. Harrichand, Stacey Diane Arañez Litam

Amidst the global health crisis of COVID-19, international students' safety and well-being is threatened by community- and policy-level animus. In addition to adjusting to a foreign culture, a series of draconian policies and communal hate crimes during the pandemic have placed international students in an especially vulnerable position. In this context, professional counselors must be well prepared to support this community. The authors describe the current sociopolitical events that have adversely impacted international students in the United States. Next, challenges to international students' mental health are identified to aid counselors' understanding of this community's needs. Finally, recommendations grounded in critical feminist and bioecological approaches are offered to facilitate counselors' clinical and advocacy work with international students.

Keywords: COVID-19, international students, critical feminist, bioecological, advocacy

COVID-19–related fears have resulted in social and political responses characterized by racial discrimination and xenophobia toward marginalized groups (Devakumar et al., 2020; Litam, 2020; Litam & Hipolito-Delgado, in press), including international students (Anandavalli, 2020; Zhai & Du, 2020). Rates of misleading media portrayals and xenophobic rhetoric substantially increased after President Trump referred to COVID-19 as the "Chinese virus" on March 16, 2020, and have steadily risen across social media platforms (Lyu et al., 2020). Exposure to COVID-19–related racial discrimination has deleterious effects on the mental health and life satisfaction of racial minorities (Litam, 2020; Litam & Oh, in press; Wen et al., 2020), including international students residing in the United States (Zhai & Du, 2020). The extant body of literature has clearly established lower levels of help seeking, barriers to counseling, and increased rates of mental health distress among international students compared to their domestic counterparts (Auerbach et al., 2018; Clough et al., 2018; Sawir et al., 2008; Zhai & Du, 2020). These existing challenges and psychosocial stressors may uniquely combine with current sociopolitical messages and policies to further exacerbate the unique developmental and cultural stressors encountered by international students. Thus, counselors working in various roles (e.g., college counselors, private practitioners) are called to develop a deeper understanding of the ways in which international students are negatively affected by xenophobic policies following COVID-19 and to employ culturally sensitive strategies grounded in systems approaches.

Although all counselors working with international students must consider the impact of larger systemic issues on international students' mental health, college counselors might be in a unique position to support this population because of their close proximity. Counselors must consider how the combined effects of sociopolitical influences, systemic inequity, intersectionality, and COVID-19–related experiences of xenophobia uniquely contribute to the mental health disparities of international students in a post-pandemic reality. It is vital that counselors consider the impact of

S Anandavalli, PhD, NCC, LPC-I, is an assistant professor at Southern Oregon University. John J. S. Harrichand, PhD, NCC, CCMHC, ACS, LPC, LMHC, is an assistant professor at State University of New York at Brockport. Stacey Diane Arañez Litam, PhD, NCC, CCMHC, LPCC, is an assistant professor at Cleveland State University. Correspondence may be addressed to S Anandavalli, Clinical Mental Health Counseling, Southern Oregon University, 1250 Siskiyou Blvd, Ashland, OR 97520, anandavas@sou.edu.

social and political structures, as Anandavalli (2020) found that contextual and systemic influences (e.g., elections, travel bans, anti-immigrant sentiment) have a profound impact on international students' mental health. Unfortunately, despite repeated calls to action, counselors may be unprepared to support international students in the United States (e.g., Kim et al., 2019). Even years after Yoon and Portman's (2004) critique, accredited counseling programs continue to offer little to no training to students to work effectively with international students. Perhaps as a result of years of limited training and research on international students' mental health experiences, counselors continue to have inadequate cultural competence when working with international students. In a recent study, Liu et al. (2020) noted that although Korean and Chinese international students in their study had a cautiously optimistic attitude toward their college counselors, a third of them felt hurt and disappointed by their college counselors' cultural incompetence and reported incidents of counselors' cultural ignorance and stereotyping. With limited attention to social justice and equity issues, counselors can further traumatize and alienate some international students (Jones et al., 2017).

Within the counseling literature, even the few studies that explored the mental health of international students from a relational and systemic perspective (e.g., Lértora & Croffie, 2020; Page et al., 2019) have failed to adopt a critical lens and examine the impact and accountability of larger social institutions on the community's well-being. At present, a review on PsycINFO, Google Scholar, and SocINDEX using the search terms *international student mental health*, *international students counseling bioecological model*, and *international students multicultural critical race theory* yielded no counseling literature that addressed strategies to support the mental health of international students in the United States from a critical perspective. Thus, the following article contributes to the extant body of literature on the topic by (a) describing the ways in which current sociopolitical events and policies send denigrating messages that devalue international students, (b) outlining the mental health challenges of international students, and (c) offering specific suggestions for counselors working with this vulnerable population through a critical feminist and bioecological lens.

Sociopolitical Policies Affecting International Students

According to the Institute of International Education (IIE; 2019), as the most popular study abroad destination, the United States hosts more than 1 million international (foreign-born) students. However, in the context of the racialized COVID-19 pandemic, Chirikov and Soria (2020) found that as many as 17% of the surveyed international students have experienced xenophobic actions that threaten their safety and presence. Further, they found these rates were higher among students from East Asian and Southeast Asian countries such as Japan, China, and Vietnam (22%–30%), given increasing Sinophobia (anti-Chinese sentiment) in the country. In addition to pursuing higher education, each year thousands of international students seek post-education professional experiences to receive practical training through an H-1B visa. An H-1B visa authorizes international students and professionals to work in the United States because of their experience in specialty occupations of distinguished merit and ability (U.S. Department of Labor, n.d.). On June 22, 2020, H-1B visa holders were notified that effective June 24, 2020, the U.S. embassy would not be issuing new H-1B visa stamps; additionally, the ruling dictated that without a valid H-1B visa stamp, individuals could not enter the United States until December 31, 2020 (The White House, 2020). This xenophobic proclamation left thousands of international professionals stranded and placed them at risk of losing their employment. The announcement to ban H-1B visa holders devalued international students and professionals in the United States and reminded international students of their fragile futures and conditional status.

The most recent incident in the upsurge of xenophobic sociopolitical messages negatively affecting international students was introduced by the U.S. Immigration and Customs Enforcement (ICE) on

July 6, 2020. A few weeks prior to the fall 2020 semester, international students were informed that they would be deported to their home countries if they were enrolled in fully online programs (ICE, 2020). International students became tasked with an impossible decision to either prioritize their health or their education. Unlike domestic students, who could safely attend programs online, the proclamation required international students to attend in-person classes to remain in the country (ICE, 2020). Although the proclamation was later amended to allow international students to attend online courses without deportation (ICE, 2020), the disparaging messages toward international students could not be overlooked. The presence of a discriminatory order that forced international students to choose between their safety and educational training is reflective of larger anti-immigration sentiments that push many students toward an emotional breakdown (Garcini et al., 2020).

Mental Health Challenges for International Students

Although international students contributed about $45 billion to the U.S. economy and to the development of 450,000 new jobs in the United States in 2018–19 (National Association of Foreign Student Advisers [NAFSA], 2020), worldviews that position international students as harbingers of innovation, intellectual diversity, economic success, and a necessity for sustaining higher education institutions are uncommon within American society (Williams & Johnson, 2011). Sadly, experiences of hate crimes are so frequent that many international students perceive them as normal consequences of being an international person in the United States (Lee & Rice, 2007; Pottie-Sherman, 2018). According to George Mwangi et al. (2019), for many international students, universities are far from being spaces of inclusivity and openness. Often, they were described as sites of oppression and "Americanization." Interviews with international students from Africa indicated that due to their intersecting identities as racial and cultural minorities, participants in the study endured constant messages and actions undermining their culture and knowledge. In fact, persistent incidents of prejudice and discrimination made the participants feel "crazy" (George Mwangi et al., 2019). Chronic exposure to xenophobia, discrimination, and anti-immigrant sentiments has been documented to have profound impacts on international students' psychological well-being (Houshmand et al., 2014; Ong et al., 2013). As a result of multiple factors, including xenophobia, international students suffer from severe psychological symptoms. One example is a recent study by Dovchin (2020), who found that parochial attitudes toward non-native English speakers and embedded linguistic racism had "serious 'psychological damages'" (p. 815) on the international students' mental health. Notably, the impact of "ethnic accent bullying" (p. 815) on her international student participants included development of social anxiety symptoms and suicidal ideation. Given that many of the instances of linguistic racism were found within classrooms, it is imperative that college counselors consider the pervasive influence of systemic inequities on international students' mental health.

Critical Feminist Perspectives

Critical feminist paradigms acknowledge the powerful role of systemic influences and focus on change at structural levels. These paradigms challenge larger social structures (e.g., national and institutional policies) and promote the pursuit of social justice through clinical practice and inquiry (Moradi & Grzanka, 2017; Mosley et al., 2020). Thus, critical feminist paradigms are grounded in the philosophy that current social landscapes are inequitable and therefore unjust (Bonilla-Silva, 2013). Specifically, the critical feminist theory of *intersectionality* describes how systems of oppression and the social constructions of race, socioeconomic class, gender, and other identities interact in ways that influence one's social positioning (Crenshaw, 1989). Given many international students' intersecting identities as linguistic, racial, and ethnic minorities, counselors must consider how their unique combination of marginalized and privileged identities contribute to their social position and worldview as outlined in the Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2015). Consistent

with the focus on addressing the pervasive role of sociopolitical systemic influences, the analysis and recommendations offered in this article are grounded in the critical feminist paradigm.

Bioecological Systems Theory

Oppression and change occur across multiple levels of human interactions, and each level may require varied strategies for advocacy on the part of the counselor (Ratts et al., 2015). These interactions range from everyday occurrences in one's immediate surroundings (e.g., classrooms) to international policies (e.g., travel bans). To address the powerful influence of multiple systems on the mental health of international students, a critical feminist paradigm was applied to Bronfenbrenner's (1979) bioecological systems theory. The bioecological systems theory outlines how systems and environment interact with an individual in ways that impact their overall well-being. According to the model (Bronfenbrenner, 1994), individuals experience a bidirectional relationship (directly and indirectly) as a result of interacting with environmental systems where the impact of the relationship is dependent on the amount of interaction taking place. The bioecological theory is represented by five concentric circles that expand to represent multiple levels of permeable systems that affect one's development (Bronfenbrenner, 1994). The systems within Bronfenbrenner's model include: (a) *microsystem*, the immediate environment (e.g., family, school, peer group, neighborhood); (b), *mesosytem*, connections within the immediate environment, such as college campus and roommates; (c) *exosystem*, external environmental settings that only indirectly affect development, such as religious institutions outside of one's faith; (d) *macrosystem*, which refers to one's larger cultural context; and (e) *chronosystem*, encompassing patterns and transitions over the course of time and development (Bronfenbrenner, 1994).

Although the bioecological model represents a relatively robust theory, the model is not without its limitations. Christensen (2016) noted that the theory fails to account for the effects of globalization and technological developments that affect various parts of the world differently. These disparities can be addressed by combining the bioecological model with the critical feminist paradigm, which challenges institutions and structures that cut across national boundaries. Both models combine to create a unique framework that may guide concrete recommendations for counselors actively seeking to support and advocate for international students.

Implications for Counseling International Students

As the extant counseling literature on international students suffers from a limited emphasis on a critical feminist and bioecological lens, the current manuscript offers a systemic framework for counseling international students. We invite college counselors to adopt a critical feminist and systems perspective to hold larger systems accountable for their harmful role in international students' mental health concerns (e.g., a university's unwillingness to engage in culturally responsive and linguistically inclusive teaching strategies; Archer, 2007). The following counseling recommendations were developed from the authors' direct experiences through counseling international students, and through a review of relevant literature. Although these recommendations may apply to all counselors irrespective of their settings, some may be specific to a particular role (e.g., college counselor).

Microsystem

The microsystem level includes the bidirectional relationships between the international student and the people with whom they regularly interact (Bronfenbrenner, 1979). College counselors and community counselors working with this population can support international students at the microsystem level by asking them to identify and deeply explore "safe" and "unsafe" relationships that exist within their college/university campus, neighborhood, and relevant religious group. Next, counselors can empower

international students by framing their concerns as part of a larger systemic issue to minimize self-blame (i.e., seeing themselves as the cause of their challenges; Sue & Sue, 1990). Here, the focus is placed on empowering international students to engage in self-advocacy within the systems they occupy (Haskins & Singh, 2015). The reframe may also aid in enhancing the international student's critical consciousness (Ratts, 2017; Ratts & Greenleaf, 2017) and help them shift their perspectives from self-blame to acknowledging the role(s) of external oppressive forces (e.g., racism, xenophobia, Sinophobia; Manzano et al., 2017). Indeed, engaging in the internalization of problems in response to stressors is prevalent among many international cultures (Wong et al., 2013).

Interventions at this level might involve the use of *microinterventions* (Sue et al., 2019) to empower international students. Sue et al. (2019) defined microinterventions as deeds and interactions that communicate affirmation and validation to targets of microaggressions. These interventions have the potential to enhance the psychological well-being and self-efficacy of the target and disarm the effects of microaggressions by challenging the perpetrator. Counselors can provide psychoeducation on microinterventions, using caution and clinical judgment to avoid further harm to the student. It is imperative that counselors recognize and educate the international student that it could be dangerous to employ microinterventions without understanding the specificities of the context. Sue et al. noted that the minoritized individual (*target*) employing microinterventions must be intentional about picking their battles, as endless responses to each encountered incident of microaggression can be damaging to the target's well-being. The target should be aware of the context of the microaggression and modify their response as the situation requires. Given that racism and oppression permeate classroom spaces, college counselors can also provide opportunities for practicing microinterventions through role plays (Litam, 2020). One microintervention is making the "invisible" visible by responding to instances of racial discrimination on campus, making the offending party (e.g., domestic students, staff) aware of their offensive actions or words, and/or compelling them to consider their impact (Sue et al., 2019). Counselors may further guide international students in educating the offender (Sue et al., 2019). Litam (2020) noted that although it is of critical importance to avoid placing the onus of responsibility on minoritized individuals (e.g., international students) to educate and/or confront their offenders, when they do engage in thoughtful responses the opportunity to educate can result in positive changes and healthier relationships.

Finally, counselors can support international students to incorporate mindfulness and self-compassion as culturally sensitive tools to address the xenophobic experiences of COVID-19–related racial discrimination (Litam, 2020). Compassion meditation may help international students release their feelings of anger and intentionally cultivate experiences of self-compassion and positive regard toward self and others. Self-compassion may be cultivated by encouraging international students to attend to their immediate needs by remaining present and non-judgmental (Germer & Neff, 2015). Grounded in the Buddhist concept of loving-kindness, international students may be trained to pay attention to their somatic experiences with a non-judgmental curiosity. For instance, as these students confront chronic racism, they may benefit from opportunities to be kind to themselves. Counselors may also guide them to engage in mindful breathing to ground themselves in the face of chronic stress (Germer & Neff, 2015).

Additionally, empowering international students to cultivate a strong sense of ethnic identity may also represent an important strategy at this level. Extant research continues to identify the role of ethnic identity as a protective factor for experiences of racial discrimination (Carter et al., 2019; Chae & Foley, 2010; Choi et al., 2016; Tran & Sangalang, 2016), including experiences of COVID-19–related racial discrimination (Litam & Oh, in press).

Mesosystem

Counselors working with international students at the mesosystem level may continue to strengthen the interventions at the microsystem level while exploring mental health stressors that may arise through interactions between the student and their peers and/or members of the college/ university campus community. Counselors who interact with various social groups uniquely position themselves in ways that establish new relationships, building support with spiritual and religious leaders (Sue et al., 2019) and mid- and senior-level administrators who are then able to directly or indirectly support international students on and off campus (Mac et al., 2019).

Leveraging their network within the university system, college counselors can explore how faculty members, administrators, and staff may improve their cultural humility and competence by collaborating with them in efforts to support international students within the campus (Hook et al., 2013). For instance, faculty members and staff could be invited to on-campus ethnic interest groups, cultural festivals, or language clubs on a regular basis to immerse themselves in their students' cultural practices. Additionally, many international students on campus occupy shared housing. College counselors can teach international students' roommates, peers, and resident advisors to detect signs of distress and isolation. This can potentially help student leaders and other residents better support international students and promote wellness in the student body more broadly. Engaging the community in culturally relevant strategies for promoting the mental health of international students and recognizing their distress may help college counselors in early detection of distress for this community.

Exosystem

The exosystem level examines social settings that indirectly impact the student but in which the student has no direct impacts (e.g., local politics, medical and social services; Bronfenbrenner, 1979). Interventions at the exosystem level might examine how educational training grounded in Eurocentrism may further marginalize international students and negatively impact their academic standing and their overall mental health and well-being (George Mwangi et al., 2019; Ploner & Nada, 2020). Counselors working with international students at the exosystem level must shift their perspectives from interpersonal interventions toward a greater examination of systemic influences. Counselors may utilize the MSJCC (Ratts et al., 2015) to consider the intersecting ways in which the privileged and oppressed identities of international students uniquely influence their mental health experiences. A detailed description of how counselors can apply the MSJCC to counseling international students can be found in Kim et al. (2019).

College counselors working at the exosystem level must play an active role in advocating on behalf of international students by working to dismantle White supremacy in college/university counseling settings (Ratts, 2017) and academic settings (Haskins & Singh, 2015). Furthermore, counselors working at the exosystem level are called to advocate for inclusive spaces and educational curricula that incorporate diversity of thought and pedagogical practices that cater to all student groups. Other examples of exosystem-level advocacy include involvement with academic units, institutions, organizations such as NAFSA and the American College Personnel Association, and communities that indirectly impact international students (Manzano et al., 2017). Trainings for educators and staff at colleges/universities about the importance of dismantling systemic racism and facilitating anti-oppressive pedagogy may also be provided (Berlak, 2004).

Furthermore, community counselors working with this population may collaborate with various social groups (e.g., host families) to develop antiracist approaches that address internalized racism and White supremacy (Kendi, 2019; Singh, 2019). These collaborations may also aid in facilitating the

help-seeking behavior of international students and countering the embedded stigma against seeking mental health support (Liu et al., 2020).

Macrosystem

The macrosystem-level focus is on cultural norms, values, and laws that influence the international student without being directly influenced by the student (Bronfenbrenner, 1979). At this level, college counselors may collaborate with other health specialists (e.g., community mental health counselors, social workers, medical doctors) and explore how current U.S. political structures impact the mental health and well-being of international students. These alliances can help students as counselors engage in advocacy initiatives and tackle public policy on behalf of the student (Chan et al., 2019). For example, college counselors can engage in advocacy efforts similar to those that encouraged college and university administrators to oppose the ICE policy by President Trump that targeted international students.

In addition to seeking change to public policies that discriminate against international students, college counselors working at the macrosystem level can also advocate for equitable practices within college and university systems and promote an educational climate that celebrates international students on campuses. Forming alliances with stakeholders (e.g., administrators, legislators, legislative staff) who directly and indirectly impact cultural norms and values in society could also be a helpful strategy for counselors supporting international students at the macrosystem level (Mac et al., 2019). Similarly, community counselors can offer cultural sensitivity training programs to members of local government agencies (e.g., credit unions, DMV). Knowledge of how visa regulations and cultural norms operate can help state and national organizations better serve this population. Finally, platforms such as the National Association for College Admission Counseling and *The Chronicle of Higher Education* may offer unique spaces for collaboration among counselors, educators, and allies to advocate for this community.

Chronosystem

The chronosystem encompasses all other societal systems that directly and indirectly impact the international student over time (e.g., federal employment policies; Bronfenbrenner, 1979). Interventions at the chronosystem level could address how the transition from an international student to worker in the United States (e.g., H-1B visa–holding professional) impacts how they are perceived by American society. For example, counselors can design programs that identify and address the needs of international students based on past and current sociopolitical events (e.g., 9/11 attacks, COVID-19 pandemic). Furthermore, college counselors may consider how these sociopolitical events might lead to disparaging attitudes toward international students and actively work to facilitate workshops, webinars, or trainings that identify and dispel harmful notions. Both college and community counselors must critically consider how systems continue to evolve over time (Chan et al., 2019). Therefore, they need to be actively attuned to the needs of international students, stay abreast of the current events that affect them, and actively participate in professional advocacy efforts across various systemic levels (e.g., institutional, state, national) to continue supporting this vulnerable community.

Future Directions

Using the search terms listed earlier, we completed an extensive review of the counseling literature. A paucity of empirical research exists in the counseling profession on international students' mental health needs and experiences from a critical and systemic perspective. Empirical data can help counselors discern which types of interventions are most effective for international students within the counseling setting across various systems. In this article, we highlight that because of racial, linguistic, gender, and other differences within the international student

community, an intersectional approach to inquiry is necessary. For instance, the experiences of a White, German, male international student will be vastly different from the experiences of a Black, Ghanaian, female student. Thus, inquiry on the experiences of this community must be positioned in the intersectionality framework (Crenshaw, 1989). Limited access to critical scholarship on the mental health experiences of international students within the counseling setting puts counselors at risk for retraumatizing their minoritized clients (Jones et al., 2017) through potential use of microaggressions and stereotypes, as shared by participants in the study by Liu et al. (2020). Thus, a tutorial stance grounded in cultural humility (Hook et al., 2013) and openness may be needed to build a safe and meaningful therapeutic relationship (Gonzalez et al., 2020). Future inquiries may help practitioners develop training modules and culturally responsive resources to improve their counseling skills and advocacy work with international students.

Conclusion

This article outlines a critical feminist and bioecological systems approach to supporting international students who are at higher risk for mental health distress because of xenophobic policies, racial discrimination, and systemic barriers. Discriminatory attitudes and behaviors toward international students have heightened during the current COVID-19 pandemic. Amidst this burgeoning crisis, counselors practicing in all settings are called to consider how each of these factors uniquely contribute to the mental health and overall well-being of this vulnerable population. Future research is needed to establish specific interventions that are most effective in mitigating the effects of pandemic-related stressors on the mental health of international students. Counselors are called to engage in advocacy efforts that dismantle systems of oppression at various levels, including within the community, in university/college settings, and in state and federal policies.

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A Confirmatory Factor Analysis of the School Counselor Knowledge and Skills Survey for Multi-Tiered Systems of Support

Jacob Olsen, Sejal Parikh Foxx, Claudia Flowers

Researchers analyzed data from a national sample of American School Counselor Association (ASCA) members practicing in elementary, middle, secondary, or K–12 school settings (*N* = 4,066) to test the underlying structure of the School Counselor Knowledge and Skills Survey for Multi-Tiered Systems of Support (SCKSS). Using both exploratory and confirmatory factor analyses, results suggested that a second-order four-factor model had the best fit for the data. The SCKSS provides counselor educators, state and district leaders, and practicing school counselors with a psychometrically sound measure of school counselors' knowledge and skills related to MTSS, which is aligned with the ASCA National Model and best practices related to MTSS. The SCKSS can be used to assess pre-service and in-service school counselors' knowledge and skills for MTSS, identify strengths and areas in need of improvement, and support targeted school counselor training and professional development focused on school counseling program and MTSS alignment.

Keywords: school counselor knowledge and skills, survey, multi-tiered systems of support, factor analysis, school counseling

The role of the school counselor has evolved significantly since the days of "vocational guidance" in the early 1900s (Gysbers, 2010, p. 1). School counselors are now called to base their programs on the American School Counselor Association (ASCA) National Model for school counseling programs (ASCA, 2019a). The ASCA National Model consists of four components: *Define* (i.e., professional and student standards), *Manage* (i.e., program focus and planning), *Deliver* (i.e., direct and indirect services), and *Assess* (i.e., program assessment and school counselor assessment and appraisal; ASCA, 2019a). Within the ASCA National Model framework, school counselors lead and contribute to schoolwide efforts aimed at supporting the academic, career, and social/emotional development and success of all students (ASCA, 2019b). In addition, school counselors are uniquely trained to provide small-group counseling and psychoeducational groups, and to collect and analyze data to show the impact of these services (ASCA, 2014; Gruman & Hoelzen, 2011; Martens & Andreen, 2013; Olsen, 2019; Rose & Steen, 2015; Sink et al., 2012; Smith et al., 2015). School counselors also support students with the most intensive needs by providing referrals to community resources, collaborating with intervention teams, and consulting with key stakeholders involved in student support plans (Grothaus, 2013; Pearce, 2009; Ziomek-Daigle et al., 2019).

This model for meeting the needs of all students aligns with a multi-tiered systems of support (MTSS) framework, one of the most widely implemented and researched approaches to "providing high-quality instruction and interventions matched to student need across domains and monitoring progress frequently to make decisions about changes in instruction or goals" (McIntosh & Goodman, 2016, p. 6). In an MTSS framework, there are typically three progressive tiers with increasing intensity of supports based on student responses to core instruction and interventions (J. Freeman et al., 2017). Schoolwide

Jacob Olsen, PhD, is an assistant professor at California State University Long Beach. Sejal Parikh Foxx, PhD, is a professor and Chair of the Department of Counseling at the University of North Carolina at Charlotte. Claudia Flowers, PhD, is a professor at the University of North Carolina at Charlotte. Correspondence may be addressed to Jacob Olsen, College of Education, 1250 Bellflower Boulevard, Long Beach, CA 90840-2201, jacob.olsen@csulb.edu.

universal systems (i.e., Tier 1), including high-quality research-based instruction, are put in place to support all students academically, socially, and behaviorally; targeted interventions (i.e., Tier 2) are put in place for students not responding positively to schoolwide universal supports; and intensive team-based systems (i.e., Tier 3) are put in place for individual students needing function-based intensive interventions beyond what is received at Tier 1 and Tier 2 (Sugai et al., 2000).

Strategies for aligning school counseling programs and MTSS have been thoroughly documented in the literature (Belser et al., 2016; Goodman-Scott et al., 2015; Goodman-Scott & Grothaus, 2017a; Ockerman et al., 2012). There is also a growing body of research documenting the impact of this alignment on important student outcomes (Betters-Bubon & Donohue, 2016; Campbell et al., 2013; Goodman-Scott et al., 2014) and the role of school counselors (Betters-Bubon et al., 2016; Goodman-Scott, 2013). In addition, ASCA recognizes the significance of school counselors' roles in MTSS implementation, highlighting that "school counselors are stakeholders in the development and implementation of a Multi-Tiered System of Supports (MTSS)" and "align their work with MTSS through the implementation of a comprehensive school counseling program" (ASCA, 2018, p. 47).

The benefits of school counseling program and MTSS alignment are clear; however, effective alignment depends on school counselors having knowledge and skills for MTSS (Sink & Ockerman, 2016). Despite consensus in the literature about the knowledge and skills for MTSS that school counselors need to align their programs, there is a lack of psychometrically sound surveys that measure school counselors' knowledge and skills for MTSS. Therefore, the validation of such a survey is a critical component to advancing the process of school counselors developing the knowledge and skills needed to contribute to MTSS implementation and align their programs with existing MTSS frameworks.

Knowledge and Skills for MTSS

The core features of MTSS include (a) universal screening, (b) data-based decision-making, (c) a continuum of evidence-based practices, (d) a focus on fidelity of implementation, and (e) staff training on evidence-based practices (Berkeley et al., 2009; Center on Positive Behavioral Interventions and Supports, 2015; Chard et al., 2008; Hughes & Dexter, 2011; Michigan's Integrated Behavior & Learning Support Initiative, 2015; Sugai & Simonsen, 2012). For effective MTSS implementation, school staff need the knowledge and skills to plan for and assess the systems and practices embedded in each of the core features (Eagle et al., 2015; Leko et al., 2015). Despite this need, researchers have found that school staff, including school counselors, often lack knowledge and skills of key components for MTSS (Bambara et al., 2009; Patrikakou et al., 2016; Prasse et al., 2012). For example, Patrikakou et al. (2016) conducted a national survey and found that school counselors understood the MTSS framework and felt prepared to deliver Tier 1 counseling supports. However, school counselors felt least prepared to use data management systems for decision-making and assessing the impact of MTSS interventions (Patrikakou et al., 2016).

As a result of the gap in knowledge and skills for MTSS, the need to more effectively prepare pre-service educators to implement MTSS has become an increasingly urgent issue across many disciplines within education (Briere et al., 2015; Harvey et al., 2015; Kuo, 2014; Leko et al., 2015; Prasse et al., 2012; Sullivan et al., 2011). This urgency is the result of the widespread use of MTSS and the measurable impact MTSS has on student behavior (Barrett et al., 2008; Bradshaw et al., 2010), academic engagement (Benner et al., 2013; Lassen et al., 2006), attendance (J. Freeman et al., 2016; Pas & Bradshaw, 2012), school safety (Horner et al., 2009), and school climate (Bradshaw et al., 2009). This urgency has been especially emphasized in recent calls for MTSS knowledge and skills to be included in school counselor preparation programs (Goodman-Scott & Grothaus, 2017b; Olsen, Parikh-Foxx, et al., 2016; Sink, 2016).

Given that many pre-service preparation programs have only recently begun integrating MTSS into their training, the opportunity for school staff to gain the knowledge and skills for MTSS continues to be through in-service professional development opportunities at the state, district, or school level (Brendle, 2015; R. Freeman et al., 2015; Hollenbeck & Patrikakou, 2014; Swindlehurst et al., 2015). For in-service school counselors, research shows that MTSS-focused professional development is related to increased knowledge and skills for MTSS (Olsen, Parikh-Foxx, et al., 2016). Further, when school counselors participate in professional development focused on MTSS, the knowledge and skills gained contribute to increased participation in MTSS leadership roles (Betters-Bubon & Donohue, 2016), increased data-based decision-making (Harrington et al., 2016), and decreases in student problem behaviors (Cressey et al., 2014; Curtis et al., 2010).

The knowledge and skills required to implement MTSS effectively have been established in the literature (Bambara et al., 2009; Bastable et al., 2020; Handler et al., 2007; Harlacher & Siler, 2011; Prasse et al., 2012; Scheuermann et al., 2013). In addition, it is evident that school counselors and school counselor educators have begun to address the need to increase knowledge and skills for MTSS so school counselors can better align their programs with MTSS and ultimately provide multiple tiers of support for all students (Belser et al., 2016; Ockerman et al., 2015; Patrikakou et al., 2016). Despite this encouraging movement in the profession, little attention has been given to the measurement of school counselors' knowledge and skills for MTSS. Thus, the development of a survey that yields valid and reliable inferences about pre-service and in-service efforts to increase school counselors' knowledge and skills for MTSS will be critical to assessing the development of knowledge and skills over time (e.g., before, during, and after MTSS-focused professional development).

Measuring Knowledge and Skills for MTSS

A critical aspect of effective MTSS implementation is evaluation (Algozzine et al., 2010; Elfner-Childs et al., 2010). Along with student outcome data, MTSS evaluation typically includes measuring the extent to which school staff use knowledge and skills to apply core components of MTSS (i.e., fidelity of implementation), and there are multiple measurement tools that have been developed and validated to aid external evaluators and school teams in this process (Algozzine et al., 2019; Kittelman et al., 2018; McIntosh & Lane, 2019). Despite agreement that school staff need knowledge and skills for MTSS to effectively apply core components (Eagle et al., 2015; Leko et al., 2015; McIntosh et al., 2013), little attention has been given to measuring individual school staff members' knowledge and skills for MTSS, particularly those of school counselors. Therefore, efficient and reliable ways to measure inferences about school counselor knowledge and skills for MTSS are needed to provide a baseline of understanding and determine gaps that need to be addressed in pre-service and in-service training (Olsen, Parikh-Foxx, et al., 2016; Patrikakou et al., 2016). In addition, the validation of an instrument that measures school counselors' knowledge and skills for MTSS is timely given that school counselors have been identified as potential key leaders in MTSS implementation given their unique skill set (Ryan et al., 2011; Ziomek-Daigle et al., 2016).

The purpose of this study was to examine the latent structure of the School Counselor Knowledge and Skills Survey for Multi-Tiered Systems of Support (SCKSS). Using confirmatory factor analysis, the number of underlying factors of the survey and the pattern of item–factor relationships were examined to address the research question: What is the factor structure of the SCKSS? Results of this study provide information on possible uses and scoring procedures of the SCKSS for examining MTSS knowledge and skills.

Method

Participants

The potential participants in this study were a sample of the 15,106 ASCA members who were practicing in K–12 settings at the time of this study. In all, 4,598 school counselors responded to the survey (30% response rate). In addition, 532 only responded to a few survey items (i.e., one or two) and were therefore excluded from the analyses. The final sample size for the analyses was 4,066. The sample used for this study mirrors school counselor demographics nationwide (ASCA, 2020; Bruce & Bridgeland, 2012). Overall, 87% of participants identified as female, 84% as Caucasian, and 74% as being between the ages of 31 and 60. Most of the school counselors in the sample reported being certified for 1–8 years (59%), working in schools with 500–1,000 students (40%) in various regions across the nation, and having student caseloads ranging from 251–500 students (54%). In addition, 25%–50% of their students were eligible for free and reduced lunch, and 54% reported that their students were racially or ethnically diverse. Lastly, most participants worked in suburban (45%) high school (37%) settings.

Sampling Procedures

Prior to conducting the research, a pilot study was conducted to assess 1) the clarity and conciseness of the directions and items on the demographic questionnaire and SCKSS, and 2) the amount of time it takes to complete the demographic questionnaire and survey (Andrews et al., 2003; Dillman et al., 2014). Four school counselors completed the demographic questionnaire and survey. Following completion, the school counselors were asked to provide feedback on the clarity and conciseness of the directions and items on the demographic questionnaire and survey as well as how much time it took to complete both measures. All pilot study participants reported that the directions were clear and easy to follow. Based on the feedback from the pilot study, the demographic questionnaire and survey were expected to take participants approximately 10–15 minutes to complete.

After obtaining approval from the IRB, SurveyShare was used to distribute an introductory email and survey link to ASCA members practicing in K–12 settings. After following the link, potential participants were given an informed consent form on the SurveyShare website. Participants who completed the survey were given the opportunity to participate in a random drawing using disassociated email addresses to increase participation (Dillman et al., 2014). Following informed consent, participants were directed to the demographic questionnaire and SCKSS. A follow-up email was sent to potential participants who did not complete the survey 7 days after the original email was sent. After 3 weeks, the link was closed.

Survey and Data Analyses
School Counselor Knowledge and Skills Survey for Multi-Tiered Systems of Support

The SCKSS was developed based on the work of Blum and Cheney (2009; 2012). The Teacher Knowledge and Skills Survey for Positive Behavior Support (TKSS) has 33 self-report items using a 5-point Likert scale to measure teachers' knowledge and skills for Positive Behavior Supports (PBS; Blum & Cheney, 2012). Items incorporate evidence-based knowledge and skills consistent with PBS. Conceptually, items of the TKSS were developed based on five factors: (a) Specialized Behavior Supports and Practices, (b) Targeted Intervention Supports and Practices, (c) Schoolwide Positive Behavior Support Practices, (d) Individualized Curriculum Supports and Practices, and (e) Positive Classroom Supports and Practices. A confirmatory factor analysis (CFA) conducted by Blum and Cheney (2009) indicated reliability coefficients for the five factors as follows: 0.86 for Specialized Behavior Supports and Practices, 0.87 for Targeted Intervention Supports and Practices, 0.86 for Schoolwide Positive Behavior Support Practices, 0.84 for Individualized Curriculum Supports and Practices, and 0.82 for Positive Classroom Supports and Practices.

Table 1

Items, Means, and Standard Deviation for the SCKSS

Rate the following regarding your knowledge on the item:	M	SD
1. I know our school's policies and programs regarding the prevention of behavior problems.	3.66	0.95
2. I understand the role and function of our schoolwide behavior team.	3.58	1.12
3. I know our annual goals and objectives for the schoolwide behavior program.	3.33	1.19
4. I know our school's system for screening with students with behavior problems.	3.35	1.20
5. I know how to access and use our school's pre-referral teacher assistance team.	3.23	1.43
6. I know how to provide access and implement our school's counseling programs.	4.20	0.84
7. I know the influence of cultural/ethnic variables on student's school behavior.	3.83	0.87
8. I know the programs our school uses to help students with their social and emotional development (schoolwide expectations, conflict resolution, etc.).	3.92	0.95
9. I know a range of community services to assist students with emotional/behavioral problems.	3.72	0.93
10. I know our school's discipline process—the criteria for referring students to the office, the methods used to address the problem behavior, and how and when students are returned to the classroom.	3.72	1.03
11. I know what functional behavioral assessments are and how they are used to develop behavior intervention plans for students.	3.35	1.12
12. I know how our schoolwide behavior team collects and uses data to evaluate our schoolwide behavior program.	3.12	1.29
13. I know how to provide accommodations and modifications for students with emotional and behavioral disabilities (EBD) to support their successful participation in the general education setting.	3.34	1.09
14. I know our school's crisis intervention plan for emergency situations.	3.74	1.06
Rate how effectively you use the following skills/strategies:		
15. Approaches for helping students to solve social/interpersonal problems.	4.04	0.71
16. Methods for teaching the schoolwide behavioral expectations/social skills.	3.62	0.96
17. Methods for encouraging and reinforcing the use of expectations/social skills.	3.80	0.84
18. Strategies for improving family–school partnerships.	3.35	0.92
19. Collaborating with the school's student assistance team to implement student's behavior intervention plans.	3.50	1.11
20. Collaborating with the school's IEP team to implement student's individualized education programs.	3.53	1.09
21. Evaluating the effectiveness of student's intervention plans and programs.	3.38	1.01
22. Modifying curriculum to meet individual performance levels.	3.10	1.09
23. Selecting and using materials that respond to cultural, gender, or developmental differences.	3.26	1.02
24. Establishing and maintaining a positive and consistent classroom environment.	3.71	0.98
25. Identifying the function of student's behavior problems.	3.52	0.92
26. Using data in my decision-making process for student's behavioral programs.	3.39	1.01
27. Using prompts and cues to remind students of behavioral expectations.	3.67	0.95
28. Using self-monitoring approaches to help students demonstrate behavioral expectations.	3.48	0.96
29. Communicating regularly with parents/guardians about student's behavioral progress.	3.64	0.97
30. Using alternative settings or methods to resolve student's social/emotional problems (problem-solving, think time, or buddy room, etc. **not a timeout room**).	3.45	1.06
31. Methods for diffusing or deescalating student's social/emotional problems.	3.76	0.87
32. Methods for enhancing interpersonal relationships of students (e.g., circle of friends, buddy system, peer mentors).	3.62	0.92
33. Linking family members to needed services and resources in the school.	3.72	0.91

The TKSS was adapted in collaboration with the authors to develop the SCKSS (Olsen, Blum, et al., 2016) to specifically target school counselors and to reflect the updated terminology recommended in the literature (Sugai & Horner, 2009). To update terminology, *multi-tiered systems of support (MTSS)* replaced *Positive Behavior Supports (PBS)* throughout the survey. In addition, *school counselor* replaced *teacher* to reflect the role of intended participants. Finally, item 6 was updated from "I know how to access and use our school's counseling programs" to "I know how to provide access and implement our school's counseling programs" because of school counselors' roles and interactions with their own programs. Further, item 6 was adjusted to be an internally oriented question about the delivery of the school counseling program rather than the school counselor's knowledge of another school service or system in order to assess participants' perceived mastery of school counseling program implementation rather than their perception of another service not already measured in the SCKSS. A description of the 33 SCKSS items and the means and standard deviations of each item for the current study are located in Table 1.

Data Analyses

A cross-validation holdout method was used to examine the data–model fit of the SCKSS. Prior to statistical analyses, data were screened for missing data, multivariate outliers, and the assumptions for multivariate regression. Less than 5% of the data for any variable was missing and Little's MCAR test (χ^2 = 108.47, *df* = 101, *p* = .29) indicated missing values could be considered as missing completely at random. Multiple imputation was used to estimate missing values. Although there were some outliers, results of a sensitivity analysis indicated that none of the outliers were overly influential. The assumptions of linearity, normality, multicollinearity, and homoscedasticity suggested that all the assumptions were tenable. The original sample (*N* = 4,066) was randomly divided into two sub-samples (*N* = 2,033). The first subset was used to conduct exploratory analyses and develop a model that fit the data. The second subset of participants was used to conduct confirmatory analyses without modifications.

Exploratory Factor Analysis (EFA). Using the first subset from the sample, an EFA was conducted, using SPSS, to explore the number of factors and the alignment of items to factors. The number of factors extracted was estimated based on eigenvalues greater than 1.0 and a visual inspection of the scree plot. Several rotation methods were used, including varimax and direct oblimin with changing the delta value (from 0 to 0.2). The goal of the EFA was to find a factor solution that was theoretically sound.

Confirmatory Factor Analysis (CFA). The estimation method employed for the CFA was maximum likelihood robust estimation, which is a more accurate estimate for non-normal data (Savalei, 2010). Although the data were ordinal (i.e., Likert-type scale), Mplus uses a different maximum likelihood fitting function for categorical variables. The Satorra-Bentler scaled chi-square difference test was used to determine the best model. The pattern coefficient for the first indicator of each latent variable was fixed to 1.00. Indices of model–data fit considered were chi-square test, root-mean-square error of approximation (RMSEA), standardized root-mean-square residual (SRMR), comparative fit index (CFI), and Akaike information criterion (AIC). Browne and Cudeck (1993) suggested that values greater than .10 might indicate a lack of fit. In this study, an upper 90% confidence interval value lower than .08 was used to suggest an acceptable fit. CFI values greater than .90, which indicate that the proposed model is greater than 90% of the baseline model, served as an indicator of adequate fit (Kline, 2016). Perfect model fit is indicated by SRMR = 0, and values greater than .10 may indicate poor fit (Kline, 2016). Reliability was assessed using Cronbach's alpha (α). CFAs were used in both the exploratory and confirmatory phases of this study. In the exploratory phase (i.e., using the first subset from the sample), the researchers used the residual estimates and modification indices to identify local misfit. Respecification of correlated error variances was expected because of the data collection method (i.e., counselors responding to a single survey) and similar wording of the items.

Results

Exploratory Phase

Exploratory Factor Analysis

An EFA was used to evaluate the structure of the 33 items on the SCKSS. Principal axis factoring was used as the extraction method. The Kaiser-Meyer-Olkin test value was .97, which suggests the sample was acceptable for conducting an EFA. The decrease in eigenvalues leveled off at five factors, with four factors having eigenvalues greater than 1.0. Parallel analysis confirmed that four factors should be retained in the solution. An oblique rotation, which was selected to allow correlation among the factors, was performed and used to determine the number of factors and item pattern.

The total variance accounted for by four factors was 64%. The item communalities were all above 0.5. Item pattern (i.e., > 0.4) and structure (i.e., > 0.5) coefficients were examined to determine the relationship of the items to the factors. Twenty-nine items clearly aligned to one factor and three items loaded in multiple factors. In a review of the item patterns, it was determined by the researchers that the three items theoretically fit in specific factors. The fourth factor only aligned with three items. In an expert review, it was determined that the three items differentiated enough from the other factors to warrant a separate factor. The alignment of items and factors are reported in Table 2.

Table 2

Alignment of Items and Factors based on EFA

Factor	Items
Individualized Supports and Practices	11, 13, 16, 17, 22, 23, 25, 26, 27, 28, 29, 30, 31, 32
Schoolwide Supports and Practices	1, 2, 3, 4, 5, 8, 10, 12, 14, 24
Targeted Supports and Practices	6, 7, 9, 15, 18, 33
Collaborative Supports and Practices	19, 20, 21

The first factor was named *Individualized Supports and Practices*. This factor contained 14 items focused on school counselors' knowledge and skills for supporting students individually based on need. Examples of items on the Individualized Supports and Practices factor included: "Selecting and using materials that respond to cultural, gender, or developmental differences" and "Methods for diffusing or deescalating student's social/emotional problems." The second factor was *Schoolwide Supports and Practices*, with 10 items focused on school counselors' knowledge and skills of schoolwide and team-based efforts aimed at supporting all students and preventing student problem behavior and academic decline. Examples of items on the Schoolwide Supports and Practices factor included: "I know our annual goals and objectives for the schoolwide behavior program" and "I know our school's crisis intervention plan for emergency situations." Factor 3 was named *Targeted Supports and Practices* and contained six items. These items focused on school counselors' knowledge and skills related to providing targeted supports for small groups of students not responding positively to schoolwide prevention efforts. Examples of items on the Targeted Supports and Practices factor included: "I know the influence of cultural/ethnic variables on student's school behavior" and "Strategies for improving family–school partnerships." The fourth and final factor was *Collaborative Supports and Practices*, which contained three items focused on school counselors' knowledge and skills related to collaborating with school personnel to implement student interventions. An example item of the Collaborative

Supports and Practices factor was: "Collaborating with the school's IEP team to implement student's individualized education programs." This four-factor model served as our preferred model, but competing models were explored using CFA on the first subset from the sample.

CFA Using First Subset Sample

The competing models were examined to determine the best data–model fit by conducting a CFA using MPlus. The following models were tested: (a) one-factor model, (b) four-factor model, and (c) second-order four-factor model. Model modifications were allowed during the exploratory phases. The results of the CFA are reported in Table 3.

Table 3

Results of the Confirmatory Factor Analyses for the Exploratory Phase

	Competing Models	Chi-square	*df*	SRMR	RMSEA	90% CI, RMSEA	TLI	CFI	AIC
	Exploratory Analyses								
1	One-Factor (initial)	8,518.75	495	.057	.084	[.083, .086]	0.79	.80	168,279.20
	One-Factor (modification) [a]	4,465.60	478	.048	.060	[.059, .062]	0.89	.90	162,654.94
2	Four-Factor (initial)	5,619.01	489	.058	.068	[.066, .069]	0.86	.87	164,253.62
	Four-Factor (modification) [b]	3,866.27	481	.048	.055	[.054, .057]	0.91	.92	161,407.48
3	Four-Factor second order	5,632.53	491	.058	.068	[.066, .069]	0.86	.87	164,270.54
	Four-Factor second order (modified) [b]	3,866.27	483	.048	.055	[.054, .057]	0.91	.91	161,432.63
	Confirmatory Analysis								
	Four-Factor second order	5,424.82	490	0.058	0.066	[.065, .068]	0.87	.88	164,999.81
	Four-Factor second order (modified) [b]	4,468.62	483	0.051	0.060	[.058, .062]	0.89	.90	163,723.53

Note. All chi-square tests were statistically significant at < .001.
[a] Seventeen correlated error variances were estimated. [b] Eight correlated error variances were estimated.

The initial one-factor model did not fit the data (chi-square = 8,518.75, *df* = 495, *p* < .001; RMSEA = .084, 90% CI [.083, .086]; CFI = .80; SRMR = .057), but after modification (i.e., 17 correlated error variances between observed variables), the one-factor model had an adequate fit (chi-square = 4,465.60, *df* = 478, *p* < .001; RMSEA = .060, 90% CI [.059, .062]; CFI = .90; SRMR = .048). Reasonable data–model fit was obtained for the modified models in both the four-factor and four-factor second-order models (see Table 3). Modifications included freeing eight correlated error variances between observed variables. A content expert reviewed the suggested modification to determine the appropriateness of allowing

the error variances to correlate. In all but one case, the suggested correlated item error variances were adjacent to each other on the survey (i.e., item 2 with 3, 6 with 7, 11 with 12, 17 with 18, 20 with 21, 22 with 23, and 27 with 28). Given the proximity of the items, it was plausible that some systematic error variance between items would correlate. The only pair of items that were not adjacent were item 5 and item 19. Both of these items referred to the school's teacher assistance team. For all the models, the path coefficients were statistically significant ($p < .001$).

Results of the Satorra-Bentler scaled chi-square difference test suggested that the four-factor model was a better model than the one-factor model ($p < .001$), and there was no statistically significant difference between the four-factor model and the second-order four-factor model. Because of the high intercorrelations among the factors (ranging from .81 to .92), the second-order four-factor model was tested using the second subset from the sample.

Confirmatory Phase

The holdout sample of 2,033 participants was used to verify the second-order four-factor model. The initial model (see bottom of Table 3) with no modifications suggested the model marginally fit the data (chi-square = 5,424.82, RMSEA = .066, CFI = .88, SRMR = .058). After modifying the model by allowing for the eight correlated error variances, which were the same eight correlated error variances identified in the exploratory stage, as expected there was an improvement in the model fit (chi-square = 4,468.62, RMSEA = .060, CFI = .90, SRMR = .051). The observed item loading coefficients and standard errors are reported in Table 4. All coefficients are statistically significant and all above 0.50, suggesting stable item alignment to the factor being measured. Coefficient alpha values were 0.95 for total score with all items, 0.88 for Factor 1 (Individualized Supports and Practices), 0.86 for Factor 2 (Schoolwide Supports and Practices), 0.78 for Factor 3 (Targeted Supports and Practices), and 0.65 for Factor 4 (Collaborative Supports and Practices). The results provide evidence that the SCKSS has potential to provide inferences about counselors' knowledge and skills for MTSS.

Discussion and Implications

The SCKSS was based on the TKSS, which measured teachers' knowledge and skills related to PBS. After adapting the survey to align to MTSS and the role of school counselors, this study aimed to examine the latent structure of the SCKSS for examining MTSS knowledge and skills. Using both exploratory and confirmatory factor analyses, results suggest that a second-order four-factor model had the best fit. The findings indicate that the SCKSS has high internal consistency with Cronbach's alpha for the total score at 0.95, and a range between 0.65 and 0.88 for each of the four factors. The first factor, Individualized Supports and Practices, contains 14 items; the second factor, Schoolwide Supports and Practices, contains 10 items; the third factor, Targeted Supports and Practices, contains six items; and the fourth factor, Collaborative Supports and Practices, is composed of three items. These findings confirm that the SCKSS yields valid and reliable inferences about school counselors' knowledge and skills for MTSS. Previous measures that were specific to school counselors focused on confidence and beliefs in implementing response to intervention (RtI; Ockerman et al., 2015; Patrikakou et al., 2016). Although these studies contribute to the literature by aligning RtI with the ASCA National Model, they did not focus on the specific knowledge and skills related to MTSS.

Table 4

Loading Coefficients and Standard Errors for Best Fitting Model

Factor 1	Individualized Supports and Practices	Item	Loading	SE
		11	.652	.014
		13	.735	.011
		16	.712	.013
		17	.762	.011
		22	.645	.014
		23	.674	.013
		25	.801	.009
		26	.736	.012
		27	.779	.010
		28	.799	.009
		29	.709	.012
		30	.753	.012
		31	.774	.010
		32	.772	.010
Factor 2	Schoolwide Supports and Practices			
		1	.816	.009
		2	.817	.010
		3	.813	.010
		4	.805	.010
		5	.612	.016
		8	.731	.012
		10	.755	.011
		12	.773	.011
		14	.659	.014
		24	.567	.017
Factor 3	Targeted Supports and Practices			
		6	.685	.015
		7	.664	.014
		9	.729	.012
		15	.766	.011
		18	.729	.012
		33	.764	.012
Factor 4	Collaborative Supports and Practices			
		19	.760	.013
		20	.618	.017
		21	.806	.012
	Higher order coefficients	F1	.968	.006
		F2	.872	.009
		F3	.911	.008
		F4	.944	.010

The four factors of the SCKSS can be used to support improvement practices through the use of targeted professional development. This extends previous research that found when school counselors received MTSS-focused training, there was an increase in knowledge and skills (Olsen, Parikh-Foxx, et al., 2016). Accordingly, the four factors of the SCKSS may provide a baseline of school counselors' knowledge and skills related to MTSS and help determine gaps that need to be addressed in pre-service and in-service training. Through targeted professional development and pre-service training activities, school districts and counselor educators can identify areas in which practitioners need additional training to increase knowledge and skills related to MTSS.

The four factors of the SCKSS align with MTSS tiers and school counselor roles recommended in the ASCA National Model (2019a). The first factor, Individualized Supports and Practices, aligns with the role of school counselors providing individualized indirect services (e.g., data-based decision-making, referrals) for students who need Tier 3 supports (Ziomek-Daigle et al., 2019). The second factor, Schoolwide Supports and Practices, aligns with the role of school counselors providing Tier 1 universal supports (e.g., school counseling lessons, schoolwide initiatives, family workshops) for all students (Sink, 2019). The third factor, Targeted Supports and Practices, aligns with Tier 2 supports provided by school counselors, including small group counseling and psychoeducational group instruction for students who do not successfully respond to schoolwide support services (Olsen, 2019). Finally, the fourth factor, Collaborative Supports and Practices, aligns with the school counselor's role across multiple tiers of support, providing access to community resources through appropriate referrals and collaborating and consulting with intervention teams (Cholewa & Laundy, 2019).

The SCKSS survey can also be used to improve current school counseling practices. This is an important consideration given Patrikakou et al. (2016) found that although school counselors reported feeling prepared to deliver Tier 1 counseling support services, they felt least prepared to collect and analyze data to determine the effectiveness of interventions. Given that the ASCA National Model (2019a) has a theme entitled Assess, school counselors should be trained to engage in program improvements that move toward positively impacting students. As such, using the SCKSS to improve MTSS practices has the potential to improve ASCA National Model–related activities.

Limitations

There are several limitations in the current study. First, respondents were from a national school counseling association. Their responses could have been influenced by having access to professional development and literature related to MTSS. Second, this was a self-report survey, so the respondents could have answered in a manner that was socially desirable. Third, given the 30% survey return rate, generalizing these results to the population of counselors is not recommended. Fourth, rewording item 6 to an internally oriented question about delivery of the school counseling program rather than school counselors' knowledge of another school service or system may have impacted the best fit model. Finally, because this was an online survey, only those with access to email and internet at the time of the survey had the opportunity to participate.

Future Research

Although participants in this study included a large national sample of school counselors, they were all members of a national association. Therefore, researchers could replicate this study with school counselors who are non-members and conduct further testing of the psychometric properties of the survey. Second, research could examine how professional development impacts specific aspects

of knowledge and skills in relation to student outcomes. That is, if school counselors have targeted professional development around each of the four factors, does that affect student outcomes in areas such as discipline, social/emotional well-being, school climate, or even academic performance? Finally, future studies could explore other variables that impact the development and application of school counselors' knowledge and skills for MTSS.

Conclusion

There is growing evidence supporting the impact of school counseling program and MTSS alignment (Betters-Bubon et al., 2016; Betters-Bubon & Donohue, 2016; Campbell et al., 2013; Goodman-Scott, 2013; Goodman-Scott et al., 2014). In order for school counselors to align their programs with MTSS and contribute to MTSS implementation, foundational knowledge and skills are essential. Given that research has shown that key factors such as school level (i.e., elementary, middle, high) and MTSS training impact school counselors' knowledge and skills for MTSS (Olsen, Parikh-Foxx, et al., 2016), the development and validation of an MTSS knowledge and skills survey to measure school counselors' knowledge and skills over time is an important next step to advancing school counseling program and MTSS alignment. The four factors of the SCKSS (i.e., Individualized Supports and Practices, Schoolwide Supports and Practices, Targeted Supports and Practices, Collaborative Supports and Practices) provide school counselors with an opportunity to reflect on their strengths and areas in need of improvement related to the tiers of the MTSS framework. Further application research and validation of the SCKSS is needed; however, this study indicates the SCKSS provides counselor educators, pre-service school counselors, and in-service school counselors with a tool to measure the development of MTSS knowledge and skills.

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What Is Known About Bilingual Counseling?
A Systematic Review of the Literature

Atsuko Seto, Nancy L. A. Forth

Results from a systematic review of the empirical literature on bilingual counseling published between 2000 and 2019 are presented. The findings from 15 articles are divided into three areas: counselor perspectives, client perspectives, and training and supervision. The review revealed that the studies published within the past two decades have focused on examining counselors' perspectives on bilingual counseling. Studies that seek to understand clients' perspectives as well as training and supervision of bilingual counselors seemed to be scarce. Recommendations drawn from the existing literature are provided for future research, counselor preparation, and the practice of counseling with linguistically diverse clients.

Keywords: bilingual counseling, counselor perspectives, client perspectives, training and supervision, linguistically diverse

The bilingual population in the United States is diverse (Pérez Rojas et al., 2014). According to the American Community Survey from the U.S. Census Bureau (2015), over 350 languages, including 150 native North American languages, are spoken in the United States. This data, collected from 2009 to 2013, reflects the total U.S. population older than five years of age. In 2018, over 41 million people in the United States spoke Spanish at home, followed by approximately 3.47 million Chinese-speaking and 1.76 million Tagalog-speaking individuals (U.S. Census Bureau, 2018). Furthermore, the total number of bilingual populations in the country has nearly doubled since 1980, with one in five individuals speaking a language other than English at home (Grosjean, 2018). In considering this staggering data, counselors in both community and school settings are encouraged to increase competencies necessary for work with linguistically diverse clients.

Several scholars in the mental health professions have discussed the significance of bilingualism within counseling practices, specifically with the Latinx population. First, both the English and Spanish language are essential to a Latinx person's day-to-day living and interactions with the mainstream society and the ethnic community (Cofresi & Gorman, 2004). Second, an individual's language proficiency is instrumental in gaining access to mental health services and is a critical component of counseling (Delgado-Romero et al., 2018). When clients have considerably limited English proficiency, they are less likely to seek counseling services that require comprehension of the language. Third, to develop appropriate treatment plans, counselors are encouraged to consider clients' language background (Santiago-Rivera & Altarriba, 2002). Finally, because of potential language barriers and cultural mismatch, a shortage of Spanish–English-speaking mental health providers may discourage individuals of Latinx descent from seeking professional help (Delgado-Romero et al., 2018). It is also important to acknowledge the considerable diversity that exists within the Latinx population, and other terms, such as *Hispanic/Latino* (Santiago-Rivera & Altarriba, 2002; Smith-Adcock et al., 2006), *Latino* (Cofresi & Gorman, 2004), and *Latino/a* that (Pérez Rojas et al., 2014) appear in the existing literature on counseling with Spanish–English-speaking clients. Although these aforementioned points specifically refer to the Latinx client population, they speak to the need for increased efforts to understand counseling services for linguistically diverse clients.

Atsuko Seto, PhD, NCC, ACS, LPC, is an associate professor at The College of New Jersey. Nancy L. A. Forth, PhD, NCC, LPC, is a professor and program coordinator at the University of Central Missouri. Correspondence may be addressed to Atsuko Seto, 2000 Pennington Road, Ewing, NJ 08628, seto@tcnj.edu.

Despite the growing number of individuals who speak more than one language, the use of bilingual counseling and its effectiveness are underrepresented in the current literature (Ali, 2004; Ivers & Villalba, 2015; Santiago-Rivera & Altarriba, 2002; Softas-Nall et al., 2015). Gallardo-Cooper (2008) defined bilingual counseling as "therapeutic discourse that accommodates the client's linguistic characteristics and incorporates bilingual or multilingual factors as vital components of psychological and contextual functioning" (p. 1022). In 2004, Fuertes published a review of the existing literature on this topic and conceptualized bilingual counseling as "a special form of counseling" (p. 85). Fuertes' review underscored the need for more studies in this area, stating that "there has been a dearth of conceptual and empirical literature on the topic of bilingual counseling and virtually no conceptual or empirical research on the topic of bilingual supervision" (p. 84). Moreover, coming to a consensus on what is bilingual can be difficult because different dimensions (e.g., reading, writing, speaking) need to be assessed to determine a person's language proficiency (Santiago-Rivera & Altarriba, 2002). To gain a more accurate understanding of the current practice of bilingual counseling, its effectiveness, and related training and supervision, a systematic review of the literature published in the past two decades was conducted in this study.

Method

Two counselor educators formed a research team for this study. The team used the work of Edwards and Pedrotti (2008) as a guide for developing the steps to conduct a comprehensive search of relevant articles. First, several keywords were identified with the intent to identify journal articles that paid particular attention to bilingual counseling. The keywords included *counseling, counselling, therapy,* and *psychotherapy* combined with the words *bilingual, multilingual, bi-lingual,* and *multi-lingual* (e.g., *bilingual counseling, multilingual counselling, bilingual therapy, multilingual psychotherapy*). Additionally, the keywords *bilingual client, bi-lingual client, multilingual client,* and *multi-lingual client* were included to conduct searches as thoroughly as possible. Each team member independently ran multiple searches on major online databases (e.g., PsycINFO, ERIC, PsycARTICLES) by using the keywords to locate as many peer-reviewed journal articles published between 2000 and 2019 as possible. Collectively, the searches generated over 750 hits. Second, the abstracts of the articles from our respective searches were reviewed to determine whether they specifically focused on bilingual counseling. Third, the results from the two independent reviews were compiled into a list of potential articles for a final review. Forty articles were selected for this final review process. Upon the review of all 40 abstracts and discussion on the applicability of each article for this study, it was determined that 22 articles addressed the practice of bilingual counseling as the primary content. Of these articles, seven of them were removed from the list because they did not offer findings from an original study. Hence, the remaining 15 articles were included in this systematic review (see Table 1).

Results

The selected articles provided insights into the experiences of clients and/or counselors in bilingual counseling settings, including interpreter-mediated sessions. Additionally, a few articles (Ivers & Villalba, 2015; Mirza et al., 2017; Trepal et al., 2014) discussed experiences of graduate counseling and psychology students and their perceived cultural competency. The present review is organized into three areas: client perspectives, counselor perspectives, and training and supervision. Some of the articles are included in two sections (e.g., counselor perspectives and training and supervision) because the study findings covered more than one aspect of bilingual counseling.

Table 1

Articles About Bilingual Counseling (N = 15)

Study	Design	Sample	Focus
Costa & Dewaele, 2014	Mixed	101 counselors (84 women and 17 men; 18 monolingual and 83 bilingual)	Co
Ivers & Villalba, 2015	Quantitative	178 master's-level students (142 women, 33 men, 1 transgender, and 2 didn't identify; 71 bilingual)	T/S
Johal, 2017	Qualitative	11 bilingual counselors (10 women and 1 man)	Co, T/S
Kokaliari, 2013	Qualitative	10 bilingual counselors (7 women and 3 men)	Co
Mirza et al., 2017	Qualitative	6 clients with limited English proficiency (6 men) 5 interpreters (1 woman and 4 men) 1 doctoral-level psychology student	Co
Nguyen, 2014	Qualitative	9 bilingual counselors	Co
Pérez Rojas et al., 2014	Quantitative	63 bilingual Latinx university students (51 women and 12 men)	Cl
Ramos-Sánchez, 2007	Quantitative	65 Mexican American college students (40 women and 25 men) 4 master's-level psychology students (4 women)	Cl
Ramos-Sánchez, 2009	Quantitative	65 Mexican American college students (40 women and 25 men)	Cl
Rolland et al., 2017	Mixed	109 bilingual clients (92 women and 17 men)	Cl
Santiago-Rivera et al., 2009	Qualitative	9 English–Spanish-speaking bilingual counselors (6 women and 3 men)	Co
Smith-Adcock et al., 2006	Mixed	55 student services administrators	T/S
Trepal et al., 2014	Qualitative	6 bilingual practicum/internship students (5 women and 1 man)	Co, T/S
Vaquero & Williams, 2017	Qualitative	8 English–Spanish-speaking bilingual counselors (7 women and 1 man)	Co, T/S
Verdinelli & Biever, 2009	Qualitative	13 English–Spanish-speaking bilingual counselors (9 women and 4 men)	Co

Note. Cl = Client; Co = Counselor; T/S = Training and Supervision

Client Perspectives

Four of the 15 studies (Pérez Rojas et al., 2014; Ramos-Sánchez, 2007, 2009; Rolland et al., 2017) addressed the perspectives of clients as part of the investigation. Of those studies, the participants in only one (Rolland et al., 2017) consisted of actual clients. In this study, Rolland et al. (2017) conducted an online survey with over 100 participants. Collectively, these participants represented

42 nationalities and had experienced counseling as a client in 19 different countries. The participants reported that they switched languages or used words in another language (*code-switching*) to express certain emotions, recall particular memories, or translate words and phrases into another language. For expression of emotions or recalling specific memories, some participants used a second language to distance themselves from painful experiences, whereas others used their primary language to express their feelings more accurately. Participants reported that they were more likely to engage in code-switching or language switching when they knew that their counselor was also bilingual. Although the participants generally appreciated their counselors' efforts to switch languages and felt connected with their counselors in doing so, a few stated that they felt disconnected from their counselor when they were asked to switch languages. Rolland et al. offered insight into the intricacy of bilingualism in counseling and noted that

> language has the power to transport the speaker to a different place, and depending on how this is handled the client may be able to share a different part of themselves with the therapist, or may find themselves disconnected, alone with the memories and inner self. (p. 81)

Another noteworthy point from this study was that the client's language background was often unaddressed in sessions. Over half of the study participants stated that they never discussed their linguistic background with their counselors, and roughly 89% did not recall discussing with their counselors which language(s) could be utilized in sessions.

Three articles (Pérez Rojas et al., 2014; Ramos-Sánchez, 2007, 2009) discussed the effects of the language-switching technique on counseling relationships and clients' perceptions of counselors, particularly in Spanish–English simulated counseling settings. Participants in these studies were college students as opposed to actual clients. In the study by Pérez Rojas et al. (2014), 51 Latina and 12 Latino students were asked to review one of two 15-minute recorded counseling sessions. In one session, a bilingual counselor invited a client to switch from English to Spanish in order to express the client's feelings and thoughts, whereas in another session, a bilingual counselor did not invite a client to switch languages. Results in this study did not support the authors' main hypothesis that a counselor's invitation to switch to Spanish would foster a therapeutic bond with a client. Furthermore, the participants did not perceive the bilingual counselor as more culturally competent and credible than the counselor who only spoke English with the client. The authors speculated that bilingual clients may have varying reactions to counselors when being prompted to switch languages in sessions and that evaluation criteria for bilingual counselors may differ from that of non–mental health bilingual individuals.

In the area of perceived counselor credibility, past studies have typically focused on counselor ethnicity (Atkinson et al., 1989; Coleman et al., 1995). In 1999, Ramos-Sánchez et al. explored perceived counselor credibility by Mexican Americans regarding language. Because of the lack of findings, Ramos-Sánchez suggested further exploration in language switching and conducted another study. The findings from this subsequent study, using the same sample of 65 Mexican American college students, were presented in two articles (Ramos-Sánchez, 2007, 2009). Each participant played the role of a client in one of four experimental groups: a session led by a Mexican American counselor who only spoke English, a European American counselor who only spoke English, a Mexican American bilingual counselor, or a European American bilingual counselor. In addition to exploring the participants' perspectives as a client in an interview, four observers rated clients' emotional expressions in these four different conditions (Ramos-Sánchez, 2007). Results revealed that participants were more likely

to engage in emotional disclosures in the language-switching conditions than the participants in the English-only settings (Ramos-Sánchez, 2007). The findings also suggested that ethnic and language differences or similarities between clients and counselors did not have a significant impact on the participants' perceptions of counselor credibility and multicultural competency (Ramos-Sánchez, 2009). It is notable to mention that the Mexican American English-only speaking counselors were rated the highest among all counselors. Moreover, the European American bilingual counselors were rated higher than the Mexican American bilingual counselors. The findings support the idea that strong counseling relationships can be established despite ethnic differences between counselors and clients. Additionally, the findings may speak to the importance of training both Latinx and non-Latinx counselors on bilingual counseling in order to support Spanish–English-speaking clients (Ramos-Sánchez, 2007, 2009).

The primary limitations among the aforementioned studies (Pérez Rojas et al., 2014; Ramos-Sánchez, 2007, 2009) include having a small sample size and using volunteer college students in a controlled laboratory setting as opposed to actual clients. Although the participant group in Rolland et al.'s (2017) study consisted of actual clients, the study relied on the participants' recollections of their counseling experiences and did not include the perspectives of counselors.

Counselor Perspectives

Nine articles (Costa & Dewaele, 2014; Johal, 2017; Kokaliari et al., 2013; Mirza et al., 2017; Nguyen, 2014; Santiago-Rivera et al., 2009; Trepal et al., 2014; Vaquero & Williams, 2019; Verdinelli & Biever, 2009) offered counselors' perspectives on bilingualism in the counseling process and its impact on therapeutic relationships. Of those articles, six studies (Kokaliari et al., 2013; Mirza et al., 2017; Santiago-Rivera et al., 2009; Trepal et al., 2014; Vaquero & Williams, 2019; Verdinelli & Biever, 2009) were conducted in the United States. In terms of counselor theoretical orientations, this present review found two articles (Kokaliari et al., 2013; Nguyen, 2014) with psychoanalytic/psychodynamic framework, whereas some studies included counselors from a wide range of theoretical orientations. For example, the participants in Costa and Dewaele's study (2014) employed integrative approaches, cognitive behavior therapy, systemic approaches, and psychodynamic therapy. A qualitative study (Santiago-Rivera et al., 2009) with nine Spanish–English-speaking counselors reported using cognitive behavior, person-centered, family systems, psychodynamic, and/or psychoanalytic theory in their practice.

Of these nine articles, six articles (Kokaliari et al., 2013; Mirza et al., 2017; Santiago-Rivera et al., 2009; Trepal et al., 2014; Vaquero & Williams, 2019; Verdinelli & Biever, 2009) explored bilingual counselors' insights into working with linguistically diverse clients. Three articles in particular (Santiago-Rivera et al., 2009; Vaquero & Williams, 2019; Verdinelli & Biever, 2009) involved Spanish–English-speaking bilingual counselors, and four articles included bilingual and multilingual counselors with various language combinations. One article (Costa & Dewaele, 2014) included both monolingual and bilingual counselors, and one article (Mirza et al., 2017) focused on a monolingual counselor's experience working with bilingual mediators to support clients whose primary language was not English.

Perceived Challenges

The existing studies suggested that utilization of more than one language within therapeutic relationships could become a source of anxiety for some counselors. The factors associated with their anxiety included speaking a different dominant language than clients, counseling clients in languages other than English despite receiving their training only in English, having an accent that is not familiar to clients, and being an entry-level counselor. Verdinelli and Biever (2009) indicated that some of the native Spanish-speaking bilingual counselors in their study perceived potential difficulty communicating with native English-speaking clients and were concerned about how their clients perceived their accents.

Non-Latinx bilingual counselors in Vaquero and Williams' (2019) study shared their concerns about their limited vocabulary in Spanish and their ability to facilitate clients' emotional expressions effectively. Similarly, bilingual counselors in Johal's (2017) study expressed their discomfort in using languages other than English in their practice and did not believe bilingual counseling strengthened a counseling relationship. Johal further explained that these participants received their formal training in English only, which may partially explain the findings. Master's-level interns who participated in the study by Trepal et al. (2014) also stated that anxiety related to providing counseling services in languages other than English was exacerbated by their novice status as a counselor and a lack of training they received in bilingual counseling.

Participants in Verdinelli and Biever's (2009) study spoke about the complexity of the bilingual counseling process. Specifically, some of the *heritage* Spanish speakers, who acquired a second language later on in their lives, discussed the challenges of conducting counseling sessions in Spanish because of language variations that exist within Spanish-speaking communities. Although the participants in Vaquero and Williams (2019) were seasoned professionals who had worked with bilingual families for an average of 15 years, they recognized the challenge of switching languages without excluding a particular family member. Specifically, speaking Spanish to connect with a parent or an adult caregiver whose primary language is Spanish might have excluded a child client whose primary language is English.

Contexts within which clients live may also influence therapeutic relationships. Nguyen (2014) interviewed bilingual counselors from seven different countries. Together, the participants spoke 14 languages in addition to English. Some of the participants believed that the shared identity of being bilingual fostered therapeutic relationships with clients. However, a few participants recounted situations in which a client became concerned about a possible breach of confidentiality because the counselor not only spoke the client's language but also shared the same cultural background with the client, resulting in being a member of the same local ethnic community. Kokaliari et al. (2013) had similar findings in their study, in which a few participants described how the sameness between clients and counselors could blur therapeutic boundaries when counselors are unaware of potential transference or countertransference in sessions. Although having the same language background may foster counseling relationships, it could also present concerns for clients depending on the social contexts in which this similarity occurs.

Time was another challenging factor in findings by Trepal et al. (2014) and Johal (2017). In Johal's study, some of the participants who provided bilingual counseling (in their second language) were often challenged by the amount of time it took to translate what they would say in their primary language to the language spoken by their clients. Similarly, participants in the study by Trepal et al. found that they often rehearsed speaking their second language (e.g., role-playing with a bilingual family member) as a means to feel better prepared for their sessions.

Perceived Benefits

These challenges notwithstanding, participants from five studies (Costa & Dewaele, 2014; Kokaliari et al., 2013; Trepal et al., 2014; Vaquero & Williams, 2019; Verdinelli & Biever, 2009) stated that the shared language and ethnic background with clients nurtured therapeutic bonds. For example, Latinx bilingual counselors reported switching languages—in this case, English to Spanish or vice versa—effortlessly to build rapport with clients (Vaquero & Williams, 2019). Participants in three studies (Costa & Dewaele, 2014; Kokaliari et al., 2013; Nguyen, 2014) reported that they became more mindful of the danger of overidentifying with clients who shared the same linguistic and cultural background. Both monolingual and bilingual counselors in Costa and Dewaele's study (2014) agreed that they were

more attentive to the client's statements and nonverbal communication in bilingual counseling settings than in working with native English-speaking clients.

Several scholars explored counselors' understanding of clients' intention behind switching languages in counseling sessions. These included clients' attempts and desires to: (a) express emotions more accurately and comprehensively (Kokaliari et al., 2013; Verdinelli & Biever, 2009); (b) enhance communication with a counselor (Kokaliari et al., 2013; Verdinelli & Biever, 2009); (c) recall specific memories such as traumatic events and dreams (Kokaliari et al., 2013); or (d) emphasize their point of view to a counselor (Kokaliari et al., 2013). As discussed earlier, these findings significantly overlapped with the clients' perceptions of the roles of language in counseling (Rolland et al., 2017). In the study by Vaquero and Williams (2019), the counselors worked with bilingual families—young children and their parents/caregivers. These counselors noted that caregivers spoke with their children in Spanish to communicate their affection, whereas English was often used to discipline children.

The participants in Verdinelli and Biever's study (2009) noticed that clients tended to discuss particular events in the language in which those experiences occurred. According to Kokaliari et al. (2013), the participants explained how some clients used their non-native language to discuss topics that are considered culturally taboo (e.g., sexual abuse, sexual orientation) or not consistent with their cultural framework. According to Verdinelli and Biever (2009), some participants believed that clients switched languages to avoid engaging in a deeper level of self-exploration. A similar observation was made by the participants in Kokaliari et al.'s (2013) study, in that clients seemed to use a second language when they needed to process highly emotional events such as trauma. In this case, participants perceived the client's decision to switch languages as a form of self-protection.

With regard to a counselor's intention to switch languages, Santiago-Rivera et al. (2009) indicated that Spanish–English-speaking bilingual counselors in their study switched from English to Spanish in order to establish a strong rapport with clients, engage or redirect clients in session, facilitate a client's self-reflection and emotional expression, or foster self-awareness. According to Vaquero and Williams (2019), the Spanish–English bilingual counselors stated that they often deliberately switched to Spanish to connect with parents/caregivers in a counseling session, whereas they switched to English to build rapport with child clients. These counselors also switched languages to strengthen caregiver–child relationships.

Collaboration With Interpreters
To meet the needs of linguistically diverse clients, counselors, when possible and appropriate, may work with an interpreter. Mirza et al. (2017) examined potential challenges and benefits of collaboration with interpreters in counseling sessions. In this study, a doctoral-level psychology student served as the counselor and conducted interpreter-mediated counseling sessions with six clients whose primary language was not English. This counselor encountered a few challenges, including feeling excluded from side talks between the interpreter and the client, difficulty ensuring the accuracy and thoroughness of interpretations, and redirecting the interpreter to facilitate a session. The counselor perceived that using simple words and concise statements, checking in with clients periodically for clarification, and *consecutive interpretations* (translation following a statement by a counselor or a client) as opposed to *simultaneous interpretations* were helpful to a therapeutic relationship. To make an interpreter-mediated session beneficial to clients, the counselor in this study found it critical that both the interpreter and the counselor make the necessary adjustments to the counseling or interpretation approach as well as clearly defining each other's roles in a session. In other words, when there is a synergy between a counselor and an interpreter, the interpreter's involvement is likely to foster a counselor–client relationship and offer additional support to a client.

Several scholars (Johal, 2017; Kokaliari et al., 2013; Mirza et al., 2017; Nguyen, 2014; Vaquero & Williams, 2019) mentioned a small sample size as a common limitation of their studies. Focusing only on one set of a bilingual combination (Santiago-Rivera et al., 2009) or a particular ethnic group (Verdinelli & Biever, 2009) also made it challenging to generalize study findings to larger populations. Nguyen (2014) and Santiago-Rivera et al. (2009) cautioned that study findings were based only on counselors' perceptions, which may differ from that of clients. In addition to Nguyen and Santiago-Rivera et al., Johal (2017) and Trepal et al. (2014) also noted the importance of acknowledging the potential effects of researcher bias on data collection and analysis of qualitative research studies.

Training and Supervision

In reviewing the 15 selected articles for this present study, five of them (Ivers & Villalba, 2015; Johal, 2017; Smith-Adcock et al., 2006; Trepal et al., 2014; Vaquero & Williams, 2019) focused on implications and recommendations for training and supervision in counseling practice. Two groups of scholars (Ivers & Villalba, 2015; Trepal et al., 2014) conducted their studies examining the effects of bilingualism with counseling students at a university in the southwest region of the United States. One common theme regarding the connection between counselors-in-training and their clients emerged in the two studies—when counselors-in-training shared the same language as the client during sessions, they felt more connected with their clients and more confident, as they perceived a higher level of multicultural counseling skills and awareness.

Supervision was specifically addressed in three of the 15 selected articles. Both Trepal et al. (2014) and Johal (2017) shared challenges experienced by supervisees who provided bilingual counseling with clients. Vaquero and Williams (2019) explored counselors' perceptions of bilingual supervision as part of their study. The participants in Johal's study stated that the practice of bilingual counseling was minimally addressed in their training, and they received little support from their employers and supervisors in this area. Several participants in the study by Trepal et al. (2014) stated that they needed to translate client session tapes for their supervisors—who were not bilingual—before receiving supervision, which added more involved time on their part. Participants in all three studies (Johal, 2017; Trepal et al., 2014; Vaquero & Williams, 2019) believed supervision was more effective when their supervisors spoke the same language that they used with their clients. For example, some bilingual supervisors were able to help the participants learn different terms and provide a clear example of a counseling process in Spanish (Vaquero & Williams, 2019).

Smith-Adcock et al. (2006) conducted a survey study with district-level directors of student services in Florida. They sent questionnaires to assess the needs of bilingual school counselors of Hispanic/Latinx children and families in their school districts. Specifically, the majority of the participants in this study reported that their school district needed more bilingual counselors, and 82% stated that students and families would benefit from receiving educational materials in Spanish. In addition, the participants believed that school counselors should be equipped to educate school communities on Hispanic/Latinx cultures, be aware of community resources, and engage in outreach efforts to involve parents in their children's school experiences. These results suggest that bilingual counselors may be expected to fulfill various needs of linguistically diverse students and clients in addition to providing counseling services. Although this study did not specifically address training and supervision in bilingual counseling, the findings underscore the importance of developing training programs that are responsive to the specific needs of bilingual and multilingual communities.

Of the five articles that addressed training and supervision, four of them (Ivers & Villalba, 2015; Johal, 2017; Trepal et al., 2014; Vaquero & Williams, 2019) shared a common limitation to their studies that is typically found in research. These authors believed their results might not be generalized to all populations and settings because a small number of participants were used in their respective studies. As mentioned previously, Trepal et al. (2014) and Johal (2017) suggested that personal bias might have occurred, affecting their results. Finally, Ivers and Villalba (2015) cautioned that their use of a self-report instrument might have resulted in skewed findings.

Discussion

The purpose of this study was to gain a greater understanding of the topics that have been addressed in the existing literature regarding bilingual counseling, training, and supervision. Fifteen empirical articles were included in this study. Results reveal that more studies have explored perspectives of counselors on bilingual counseling than that of clients. Only one study involved current or former clients of counseling services. This may be due to the fact that recruitment of actual clients is more difficult than relying on convenience samples.

The results also suggest that more studies are needed for reaching consensus among scholars on what makes bilingual counseling therapeutic and effective. For example, participants in several qualitative studies (e.g., Kokaliari et al., 2013; Trepal et al., 2014; Vaquero & Williams, 2019; Verdinelli & Biever, 2009) perceived that speaking in the client's primary language positively contributed to counseling relationships. Rolland et al. (2017) postulated that language switching, when used appropriately, is beneficial to clients because it can facilitate a deeper level of self-reflection and exploration. On the contrary, no statistical significance was found on the effects of the language switch on therapeutic bonds in two quantitative studies (Pérez Rojas et al., 2014; Ramos-Sánchez, 2007, 2009). These quantitative studies were conducted in a lab setting with college students, which the authors mention as a potential limitation of their studies. These findings may suggest that switching languages is an art of counseling; it is multifaceted, and its effectiveness may be contextually based. Additionally, more studies that explore the perspectives of both clients and counselors as well as examine variables that impact bilingual counseling relationships are needed. Pérez Rojas et al. (2014) helps to explain these inconclusive findings by stating that "the role that language switching plays in psychotherapy may be more complex than what has been theorized so far" (p. 71).

In terms of the specific language combinations that have been included in the previous studies, the Spanish–English-speaking population seems to be the group that has been most represented in the literature. This finding may not be surprising given the fact that Spanish is the second most spoken language in addition to English in the United States. Strong advocacy to support Spanish-speaking populations may also explain why this specific language combination has received the most attention in the profession. It is important to acknowledge that some scholars (e.g., Kakaliari et al., 2013; Rolland et al., 2017) in more recent years have conducted studies that involved multiple languages. Equally encouraging is an increased attention to the training and supervision of bilingual counselors. Although the existing literature in this area is considerably limited, several scholars (e.g., Ivers & Villalba, 2015; Johal, 2017; Trepal et al., 2014) have shed some light on the experiences of bilingual counselors and graduate counseling students and have offered some helpful recommendations for the training and supervision of counselors.

Implications

Counseling Practice

Findings from the present study suggest that switching languages, when done appropriately, may bolster therapeutic relationships with clients and facilitate clients' self-exploration and expression. However, a few studies included in the present analysis also revealed that in some cases, the language match between the counselor and client may not strengthen therapeutic relationships. Determining when to switch languages may depend on a client's preference, presenting concerns, history of language acquisition (e.g., growing up bilingual or acquiring another language as an adult), and level of language proficiency with each language spoken. Consequently, meeting the needs of bilingual clients requires counselors to know how to assess a client's language background accurately. Only one study (Rolland et al., 2017) in the present analysis addressed clients' perceptions of the assessment of their language background by counselors. As discussed previously, many participants reported counselors neither asked about their language backgrounds nor discussed which language(s) could be used in session. Cofresi and Gorman (2004) recommend that counselors assess the client's language background (e.g., how they acquired a second language) and proficiency, dominant language, preferred language, and level of acculturation. They also suggest that, where possible and feasible, assessments should be conducted in the language "most compatible with the bilingual client's language proficiency and dominance" (p. 104).

Bilingual clients have the ability to choose which language better offers a vehicle for the expression of ideas. Therefore, framing bilingualism as a client's strength rather than deficiency or barrier (Santiago-Rivera & Altarriba, 2002) is crucial in fostering a genuine rapport with the client. The acquisition of an additional language has been associated with advanced cognitive abilities, including in the areas of problem-solving, reading, spelling, and memory recall (Ivers et al., 2013). Instead of assuming language barriers with a bilingual client, counselors are highly encouraged to communicate their genuine curiosity to learn about the client's experience as a bilingual individual, explore benefits of bilingualism, and work to create a therapeutic environment that appreciates linguistic diversity.

Findings from the present study suggest that clients may switch languages for several different reasons. These include but may not be limited to expressing emotions more fully, recalling and discussing particular memories or events, and improving communication with others. In some cases, clients preferred to use a second language to process traumatic events and intense emotions or discuss topics that are considered culturally taboo or sensitive (Kokaliari et al., 2013; Verdinelli & Biever, 2009). In addition to asking clients about their preferences for using a particular language in session, discussing potential benefits and limitations of bilingual counseling may be helpful during the initial phase of counseling. Doing so may encourage clients and counselors to engage in ongoing and open discussions about the impact of languages on the client's progress and counseling relationships.

Counselor Preparation

There is a significant shortage of training programs that equip counselors-in-training to provide bilingual counseling. Delgado-Romero et al. (2018) explained: "While professional mental health organizations recognize the need to provide linguistically and culturally appropriate services, there are limited opportunities to learn or use a second language in graduate mental health counseling programs" (pp. 341–342). This point was reflected in Trepal et al.'s (2014) study, in which the counseling interns expressed their concerns about engaging in bilingual counseling because they had not received any training on bilingual counseling. Trepal et al. also noted that some counseling interns in their study might have experienced increased anxiety for not only practicing counseling for the first time but having to do so in a bilingual setting. As counselor programs work to prepare more students for working with

linguistically diverse clients, it seems imperative to provide appropriate supervision and additional support to those who are expected to provide bilingual counseling services during their clinical experiences. For example, the participants in Trepal et al.'s study recommended that programs assist bilingual students in forming a peer support group that allows exchange of information on bilingual counseling and promotes bilingualism.

The participants in Johal's study (2017) made an essential point; that is, it should not be assumed that bilingual counselors know how to provide counseling in more than one language simply because they speak the language. Developing training programs that prepare students to work with bilingual clients (Costa & Dewaele, 2014; Santiago-Rivera & Altarriba, 2002) as well as increasing the number of bilingual counselors (Ivers & Villalba, 2015) are therefore critical steps to serving linguistically diverse client populations. Four of the 15 articles reviewed for this study (Ivers & Villalba, 2015; Johal, 2017; Trepal et al., 2014; Vaquero & Williams, 2019) offered one common suggestion for counseling training programs. All spoke of the importance of providing additional training that increases awareness in culture and language. Several scholars whose studies focused on supporting the Latinx population offered helpful recommendations for graduate counselor education and training programs, including: (a) integrating a community-engagement and collaboration component into the training curriculum (Smith-Adcock et al., 2006); (b) creating opportunities for cultural immersion experiences (Ivers & Villalba, 2015); (c) offering courses in both English and Spanish (Ramos-Sánchez, 2007); (d) delivering some content (e.g., diagnostic terms) in Spanish (Vaquero & Williams, 2019); and (e) developing standards for evaluating counselor competency in providing bilingual counseling (Verdinelli & Biever, 2009). Additionally, training programs should emphasize the significance of understanding history, nationality, culture, community, and geographic settings (e.g., living in an urban vs. rural community) of linguistically diverse clients (Vaquero & Williams, 2019). These recommendations may be applicable and helpful to counselor education programs that are committed to preparing students for providing bilingual counseling services to meet the needs of their local communities. Furthermore, some counselors may have an opportunity to offer counseling services to clients in collaboration with an interpreter. It is essential that specialized training is available to counselors and interpreters who are interested in joining forces to serve clients within the context of mental health service delivery. Such training curricula should address the effectiveness of evidence-based approaches to providing interpreter-mediated counseling services (Mirza et al., 2017).

Conclusion and Future Research

Scholars who have written about the current practice of bilingual counseling encourage researchers to explore the following areas in future studies: (a) associations between counselor language proficiency and clients' perceptions of counselors and counseling relationships (Ramos-Sánchez, 2009; Trepal et al., 2014; Verdinelli & Biever, 2009); (b) actual clients' experiences of mental health services (Johal, 2017; Ramos-Sánchez, 2009); (c) effectiveness, roles, and use of language switching in counseling (Costa & Dewaele, 2014; Pérez Rojas et al., 2014; Ramos-Sánchez, 2007, 2009; Santiago-Rivera & Altarriba, 2002; Vaquero & Williams, 2019); (d) relationships between counselors' bilingualism and their multicultural counseling competency by combining self-reports and external observations (Ivers & Villalba, 2015); and (e) efficacy of bilingual supervision and training models on bilingual counseling (Trepal et al., 2014).

The purpose of this study was to gain a more accurate understanding of the practice of bilingual counseling, its effectiveness, and related training and supervision by conducting a systematic review of the literature published over the past two decades. It is important to note that the search results for this present review were limited by the selected keywords and available databases. In addition, some of the

dissertation studies might have not been included unless they were published in peer-reviewed journals. With this in mind, this systematic analysis of existing literature on bilingual counseling suggests that very few studies have examined the experiences of linguistically diverse clients in counseling settings.

Similarly, there is a lack of literature that discusses how graduate-level counseling programs are addressing bilingual counseling and supervision as part of their curriculum. However, it is encouraging to see that more recently conducted studies have collectively begun to examine the complexity of bilingual counseling in both clinical settings and training programs. Given the Latinx population being by far the largest bilingual group within the United States, this group seems to have received the most attention among linguistically diverse groups. While continuing to undertake studies with this particular population, conducting more studies that involve clients, counselors, and graduate students of other bilingual backgrounds may contribute to the existing body of the literature.

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