

# Teen Dating Violence: Examining Counseling Students' Responses to Gendered Vignettes



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Teen dating violence (TDV) is an ongoing epidemic in the United States. Subsequently, gender symmetry regarding the experience and perpetration of violence continues to be a prevalent debate in American society. TDV is a clinical concern that can impact clients' safety; therefore, counselors must be adequately trained and cognizant of any biases that may influence the assessment and treatment of survivors of abuse. We conducted a qualitative research study using case vignettes to explore how counseling students conceptualize and propose treatment of TDV with male and female clients. Six overarching categories and 19 corresponding themes emerged, with gender bias as the most notable finding of the study. We conclude by discussing the implications for counseling and providing recommendations for educational standards and best practices to reduce gender bias and promote more inclusive treatment.

**Keywords:** teen dating violence, abuse, counseling students, gender bias, educational standards

Teen dating violence (TDV) is an adverse childhood experience that often shapes future relationship patterns throughout adulthood (Emelianchik-Key et al., 2022; Offenhauer & Buchalter, 2011). As a result, TDV has become a significant public health concern among adolescents in the United States (Centers for Disease Control and Prevention [CDC], 2021). After a compilation of prevalence rates, dating violence victimization rates range from 20%–53% in early adolescence (Goncy et al., 2017). In 2019 alone, one in 12 high school students reported physical and sexual violence within a dating relationship (CDC, 2021). Of those who reported intimate partner violence, 11 million women and 5 million men noted experiences of TDV before age 18 (CDC, 2021). TDV is characterized by physically or sexually violent acts that one adolescent perpetrates against another whom they are dating (CDC, 2021). This is inclusive of maladaptive behaviors, such as stalking and emotional abuse. In fact, emotional abuse (e.g., stonewalling, insulting language, social isolation, name-calling, gaslighting) exceeds the expression of physical violence within most teen dating relationships (Offenhauer & Buchalter, 2011).

TDV compromises the physical and emotional safety of American youth and can potentially impair adolescent development (CDC, 2021; K. E. Hunt et al., 2022), including how young people learn emotional regulation and form healthy relationships. K. E. Hunt et al. (2022) noted that many complicated variables play a role in the development and the prevention of dating violence, with family of origin belief systems and peers contributing to social learning. This was apparent in Emelianchik-Key et al.'s (2022) qualitative study, which determined that young college-aged females consistently normalized and accepted toxic relationship behaviors as common and justified because of norms created by family, peers, and society.

Further, the consequences of TDV on an adolescent's psychological well-being and decision-making may be severe and persist over time, causing problems later in life. For example, Temple et al. (2013) determined a significant increase in the internalization of emotions in adolescent girls who experienced TDV. Youth with pre-existing mental health conditions are also at increased risk for traumatization by a relationship partner (Temple et al., 2013). Because TDV may lead to various mental health concerns,

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such as substance misuse, eating disorders, antisocial behaviors, self-injury, and suicidality (Foshee et al., 2013), counselors play an integral role in TDV prevention and intervention. Many young clients may choose to initially disclose personal experiences of TDV or unhealthy relationship behaviors in a therapeutic setting, making counselor preparedness critical.

### **Gender Symmetry in TDV**

TDV has also led to strong debates regarding the issue of gender symmetry. Several studies have found that TDV is reciprocal, with both partners exhibiting aggressive or toxic behaviors in response to each other (Eisner, 2021; Emelianchik-Key et al., 2022; K. E. Hunt et al., 2022). However, some studies indicate vastly disproportionate rates of TDV victimization among adolescent girls (Kann et al., 2018), mainly in instances of extreme physical brutality or sexual violence (Swahn et al., 2010). The inconsistent rates may be related to social perceptions of TDV as a female concern, decreased male reporting (often attributed to stigma), conceptualization and understanding of violence, and a lack of validated measures that encompass diverse cultural and gendered experiences (Eisner, 2021; Walker et al., 2020). These contradictory reports make it even more challenging for clinicians.

### **Counselor Preparedness**

Currently, there are several gaps in the literature regarding counselor education and TDV, including training, competency, and expertise (Murray et al., 2016). In a small sample of programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), Henriksen et al. (2010) found that graduate counseling programs minimally addressed specialty training areas, requiring graduates to acquire additional skills independently. CACREP (2015) standards do not include TDV in training criteria, thus leaving the inclusion of these topics to the discretion of faculty. Further, Wozny (2005) found that 34% of marriage and family therapy programs had a domestic violence course, compared to 4% of counselor education programs. Similarly, in a sample of practicing school counselors, only 10% reported specific domestic violence training and continuing education at their workplace in the past 2 years (Khubchandani et al., 2012). Among the participants, 19% reported no formal education or training on TDV, and 83% of the participants' settings did not assess TDV amongst the students within their school system (Khubchandani et al., 2012). This is alarming, given that 72% of sexual harassment and 28% of dating violence incidents occur in schools (Turner et al., 2011). A lack of preparation for crisis training, intervention, and prevention may cause serious detriment and endangerment to clients and counselors (Morris & Minton, 2012).

### **Counselor Bias**

Gender bias related to survivors of relationship abuse is prevalent among trainees and professional counselors, reflecting stigmas among the general population (Maghsoudi, 2018). Karakurt et al.'s (2013) study on counselor attitudes toward perpetrators of violence revealed that most participants believed female offenders were justified in their violent actions and were not as dangerous as their male counterparts. Results also indicated that participants expressed less empathy for male survivors and more confidence in treating male perpetrators (Karakurt et al., 2013). Counselors may perpetuate stigma regarding female survivors by over-pathologizing, minimizing their complaints, and invalidating their feelings (Maghsoudi, 2018). Maghsoudi (2018) contended that there is a lack of training, but more importantly, there are limited opportunities within the educational curriculum for trainees to explore implicit biases regarding violence among partners.

The development of counselor self-awareness regarding personally held biases and beliefs can mitigate widespread assumptions about TDV. In addition, counselor self-awareness is a focal point of counselor education programs. This study sought to examine if there were differences in how counseling students

conceptualize and work with male and female survivors of TDV. Using a qualitative design, we utilized case vignettes to examine how counseling students conceptualize, assess, and treat TDV. The overarching research question was: How do counseling students conceptualize and propose treatment for the experience of TDV in both female and male clients?

## Method

### Data Collection

After receiving IRB approval, the primary researcher, Kelly Emelianchik-Key, recruited a convenience sample of participants over 6 months in three counselor education programs. Emails were sent to the clinical placement coordinators to request the dissemination of the study details to their students. The three clinical placement coordinators agreed and sent the email with links to a Survey Monkey for students 2 years or more into their academic studies. The students received an email containing study information, a link to the electronic consent forms, demographic questions, and a case scenario with open-response questions. After completing the consent and demographic form, participants were randomly assigned one of two client case vignettes. The scenarios were identical vignettes (located in the Appendix) containing details of a struggling teen client experiencing TDV. The only difference in cases was the identified gender of the client. One case had a male client with a female partner while the other had a female client with a male partner. Counseling students were then asked questions about the vignette to better understand their clinical impressions of the client, a diagnosis (if warranted), any concerns regarding the case, and treatment ideas and considerations. The case vignettes and written responses were collected and analyzed until saturation was achieved (Braun & Clarke, 2021). To assess data saturation, we evaluated the data for completeness and at specific intervals of the data analysis process. Data saturation was met with 45 participants, with 22 responses to the female case and 23 responses to the male case.

### Participants

The inclusion criteria for this study required that participants 1) were current students in a CACREP-accredited counseling program (any specialization) and 2) had completed all program-related content coursework, with only clinical field placements remaining. Of the 45 participants, eight self-identified as male and 37 self-identified as female. The participants' degree track specializations were as follows: clinical mental health counseling ( $n = 21$ ; 51%), school counseling ( $n = 8$ ; 17%), rehabilitation counseling ( $n = 6$ ; 13%), marriage and family therapy ( $n = 2$ ; 4%), doctoral counselor education students ( $n = 3$ ; 6%), and non-degree seeking students who already held a master's degree in counseling ( $n = 3$ ; 6%). All students were either enrolled in a clinical experience or had completed their clinical experiences. Participants ranged from 21 to 52 years of age, with a mean of 26.8. We did not collect data on participants' race/ethnicity or sexual orientation in the demographic form, as it was not a variable of consideration in our study.

### Procedure

In the present study, we aimed to understand how counseling students conceptualize clients experiencing TDV while considering differences in approach based on client gender. We used a qualitative case vignette design with a deductive approach to better understand gender-based assumptions, myths, or stigmas that may affect counseling students' conceptualization and approach to treating TDV. The vignette design allows for assessing attitudes, values, norms, and perceptions regarding sensitive social science issues in qualitative research (Hughes, 1998). It may also be beneficial in exploring topics such as gender equality, gender norms, gender discrimination, drug use, mental illness, and emotional and behavioral difficulties (de Macedo et al., 2015). The case vignettes were

created using a three-phase approach to test for content validity in health care education research (St. Marie et al., 2021): 1) Developing the vignette and associated questions, 2) sending the vignette to three experts in counseling and domestic violence research, and 3) testing the revised vignette with a small group of participants that suggested edits for clarity. The Appendix contains the vignette for a female teen client. An identical vignette for a male teen client was also utilized during the study. The only difference in the cases was the identified gender of the client and their partner; names, scenarios, and all non-gendered wording remained the same.

We approached this research from a post-structural feminist theoretical lens, conceptualizing TDV as reciprocal and challenging the common sociocultural notions of women as “powerless” and men as “powerful” in a patriarchal society. For this reason, we did not specify the client’s cultural background and used binary gender identities and heterosexual relationships in the case examples. Case vignettes with varying intersecting identities may have elicited other forms of bias, such as internalized homophobia, heteronormativity, gender-normative assumptions, and ethnocentric views, further compounding the dynamics and potentially leading to misinterpretations of the qualitative findings. Our hope is that this study can provide a framework for future research to incorporate additional layers of identity and address existing gaps in the TDV literature.

### **Research Team Positionality**

The researchers’ experiences, qualities, personalities, or histories can potentially influence qualitative research outcomes (B. Hunt, 2011). Therefore, we engaged in reflexivity throughout the research process to minimize bias during data analysis. Our research team consisted of three cisgender female faculty in counselor education. All are licensed mental health counselors and one is also a licensed marriage and family therapist. We also have diverse counseling experiences in various mental health settings, including schools, university counseling centers, residential treatment facilities, domestic violence shelters and outreach programs, and private practice. Our related research interests include TDV, intimate partner violence, gender issues, sexuality, and culturally responsive approaches to counseling and research. Consistent with the qualitative research process, we continually engaged in dialogue and a self-reflective process to examine personal beliefs and challenge biases in TDV literature to ensure that our positionality did not impede the research process.

### **Data Analysis and Trustworthiness**

Thematic analysis is a grouping of methods that examines commonalities and differences in research. Theoretically flexible, thematic analysis is a useful and practical approach to counseling research (Clarke & Braun, 2018). In this study, we utilized reflexive thematic analysis to form themes from codes, which were also grouped by major categories based on our questions to participants (Braun & Clarke 2013, 2021). Thematic analysis can also be expansive, ranging from research with rich descriptions to research that aims to describe and summarize (Clarke & Braun, 2018). The recommended steps for a reflexive thematic analysis were followed (Braun & Clarke, 2013, 2021; Clarke & Braun, 2018). We independently reviewed all data for familiarization, which included detailed documentation of thoughts, field notes, and decisions that were made individually. We met weekly to develop initial codes that were placed into a codebook to chart the developing analysis. Per Braun and Clarke’s (2013) recommendations, we set the data into central organizing concepts or categories to communicate and develop the themes. Within each category, we further grouped data by gender of the client to assess gender normative assumptions that may be guiding counseling students’ decision-making processes. Meetings took place over 6 weeks (one category per week) to discuss and group initial overarching themes for each vignette. Once this phase was complete, the themes were refined, defined, and named; the outcome was a final report.



To promote trustworthiness, we followed Nowell et al.'s (2017) recommendations for methodological rigor within Braun and Clarke's (2013, 2021) steps for thematic analysis. These included a review of responses at various points prior to analysis. Peer debriefing took place during the 6-week coding process, along with an audit trail of documentation and codebooks connecting themes and content. Based on consensus coding, codebook refining took place weekly (Nowell et al., 2017). As a final step, member checking took place by sending the resulting themes and subthemes to the respective programs where students were recruited. Because the participants were anonymous, the programs disseminated findings to all students, asking anyone who initially participated to check for credibility in the results and reach out via email or anonymously through a Qualtrics link if they found inaccuracies (Braun & Clarke, 2013; Nowell et al., 2017). No participants responded or objected to the findings after three rounds of email blasts.

## Findings

We determined six emergent categories that spanned across both cases: (a) case conceptualization and clinical impressions, (b) diagnostic impressions, (c) relationship considerations, (d) clinical concerns, (e) treatment approaches, and (f) gender bias. Within these six categories, 19 themes emerged, which are defined below in their corresponding category.

### Case Conceptualization and Clinical Impressions

The case conceptualization and clinical impressions category captured counseling students' perceptions of the presenting problem, resulting in the two themes of *interpersonal* and *intrapersonal concerns*. Although both vignettes aimed to illustrate specific cases of TDV, counseling students presented various explanations regarding the cause of the client's symptoms. The *interpersonal* theme focused on aspects outside the client's immediate control, including limited peer support, the dating relationship, and academic concerns. For example, a counseling student responding to the male client's case suggested that he needs "to get involved in more extracurricular activities and find things that he enjoys doing" or "extra support from school and family." Students responding to the female case also focused on relational issues, indicating that "she needs to build better relationships with her family, friends, and partner." Participants also considered *intrapersonal* factors related to the client's mood, level of assertiveness, self-esteem, and self-confidence. For example, in responding to the male client case, counseling students indicated that the client "has poor or low self-esteem" or "should be able to stand up for himself in all areas of his life." The female case elicited similar responses from participants, such as "she needs to stop being so codependent" and "she could get better if she wanted to."

### Diagnostic Impressions

The second category was grouped based on diagnostic criteria. Four themes emerged: *mood disorders*, *personality disorders*, *stress disorders*, and *neurodevelopmental disorders*. Three subthemes were also identified: *insufficient information*, *no diagnoses warranted*, and *only symptomology*. Counseling students provided various responses regarding whether a diagnosis was warranted in the case vignette. Some participants responded with multiple possible diagnoses for the client presented in the case scenario. Others prefaced the diagnosis with statements alluding to uncertainty with making a concrete diagnosis, such as "possibly is experiencing depression," or noting a diagnosis followed by "but more information will be needed to confirm." About half of the participants stated a concrete diagnosis while providing support and examples from the case vignette.

Although many diagnoses overlapped in both scenarios, there were differences regarding the frequency of endorsement. The most common diagnoses for the male client included adjustment disorder ( $n = 9$ ) and attention-deficit/hyperactivity disorder (ADHD;  $n = 7$ ). Conversely, the female client was most frequently diagnosed with a dependent personality disorder or style ( $n = 8$ ). The female client was never diagnosed with ADHD and was only determined to have “attention problems.”

### Dating Relationship Considerations

Participants drew attention to relational concerns in the client’s life within this category. The identified themes included *unhealthy relationships*, *support*, and *dating violence*. The *unhealthy relationship* theme was evident in both client cases. Several participants ( $n = 15$ ; seven in the male client case and eight in the female client case) noted comments like “unhealthy relationship” while providing examples of unhealthy behaviors, such as the partner’s communication style and controlling behaviors. Several responses highlighted the theme of *support*. Participants appeared to skirt around labeling relationship violence and resorted to more general comments, such as “the client needs relationship support” or “better communication in the relationship is needed.” Additionally, one counseling student noted the lack of support in the relationship and questioned the need for such a serious relationship at this “young age,” demonstrating judgment and bias (further discussed in Category 6). This theme also captured counseling students’ recommendations for enhanced relational support (e.g., date nights).

The final theme within this category, *dating violence*, was evident in six responses that labeled the relationship as “violent” or mentioned “dating abuse” as a concern. In responses that noted abuse, three mentioned “emotional abuse,” and two identified “sexual abuse” in the female case. The word “sexual pressure” was also used by two counseling students that completed the female case, but it was not explicitly noted as abuse or violence. In the female case, two participants mentioned “rape” four times, whereas “rape” was never mentioned in the male case. In the male case, the only comment that slightly implied relationship violence noted: “needs to discuss relationship boundaries with his partner, so she doesn’t pressure him to advance sexually.”

### Treatment Approaches

Treatment approaches were categorized and counted based on theoretical orientations. Most participants responded with similar treatment considerations for both presented cases. The five grouped themes included *cognitive behavioral therapy* ( $n = 15$ ), *solution-focused therapy* ( $n = 11$ ), *family therapy* ( $n = 9$ ), *couples counseling* ( $n = 3$ ), and *other* ( $n = 7$ ). The *other* theme resulted from various suggestions that were not specific approaches for individual therapy but could support the client. These suggestions included tutoring, group therapy, and peer support. Several counseling students made referral recommendations instead of offering treatments or approaches that the counselor could directly utilize with these clients. For example, a suggestion included psychiatric evaluation or referral for the female survivor ( $n = 10$ ). This suggestion was not recommended as often for the male survivor ( $n = 2$ ). Additionally, one respondent suggested that the female survivor should “get a referral for a gynecologist.” In contrast, no responses indicated a medical referral for the male client.

### Practice Considerations

Participants answered questions regarding any apprehension or reservations they might experience while treating the proposed clients, categorized as practice considerations. The themes that emerged were *ethical and legal concerns*, *family concerns*, and *school concerns*. Almost a quarter of participants ( $n = 11$ ) indicated clinical concerns related to ethical or legal implications or limits of confidentiality because of the clients’ ages. Some counseling students mentioned “involving parents” or “disclosing

to parents” without explaining what warranted disclosure. One participant was concerned for the client’s safety because of sexual violence (i.e., rape) and specifically mentioned reporting to authorities. Nearly half of the participants ( $n = 20$ ) identified the client’s family issues as problematic, offered solutions to repair relationship ruptures within the family dynamic, and mentioned strategies for improved communication. Additionally, participants ( $n = 22$ ) identified school-related difficulties, such as decreased grades, as an area of concern for the client. Examples of commentary provided by those participants included, “Jordan needs a tutor” or “Jordan needs to be evaluated educationally at school to see if there are learning challenges and get an IEP.”

### Gender Bias

The sixth category was identified because of the overwhelming gender biases that emerged throughout the participants’ responses. This category was further grouped into two themes: *language* and *judgments and myths*. The researchers compared the *language* counseling students used to describe male and female clients. Although the counseling students described the male and female clients with similar terms (i.e., influenced, boundaries, codependence), the frequency across all responses grossly varied. For example, participants used the term “abuse” twice as many times when describing the female client’s relationship ( $n = 23$ ) as opposed to the male client’s relationship ( $n = 11$ ). Similarly, counseling students utilized the term “survivor” to describe the female client ( $n = 13$ ), but not the male client ( $n = 0$ ). The male client was often described as “withdrawn” ( $n = 28$ ) and experiencing “attention” difficulties ( $n = 43$ ), “adjustment” ( $n = 29$ ), and “codependence” issues ( $n = 23$ ). Conversely, the female client was more likely to be described as “influenced” ( $n = 19$ ), “manipulative” ( $n = 22$ ), and experiencing “dependency” ( $n = 47$ ) concerns. Although these counts could highlight one participant using the word one or more times in a response, they illuminate the disparity and lack of discernment in the language used to describe both clients.

Within the theme of *judgments and myths*, the counseling students consistently referenced and discussed the female partner (perpetrator) in the male client scenario. These comments made inferences or judgments about the female partner (perpetrator) even though she was not the identified client. Counseling students made various comments about the female perpetrator, including, “she is controlling,” “nasty,” or “needy,” alluding to the fact that she is causing these issues for the male client. Counseling students also provided clinical impressions, recommendations, and diagnoses for the male client’s partner (female perpetrator). Conversely, participants who completed the female client case noted clinical recommendations for the female client’s partner (male perpetrator), such as general “relationship help” and “anger management and self-help.” These comments and recommendations were less frequent and judgmental of the female client’s partner (male perpetrator). Relatedly, no participants provided a diagnosis for the male perpetrator. Overall, counseling students frequently mentioned the female partner (perpetrator) rather than focusing on the identified client, although this was less frequent for the male partner (perpetrator).

Additionally, many judgments about the survivors arose, perpetuating myths and the stigma surrounding TDV and survivors. For example, one student noted the female survivor “could get better if she wanted to” and “she needs to express her feelings to her partner.” Another student wrote that the male survivor needed to “be more assertive in the relationship and not get walked all over” and “seems like he is a people pleaser and needs to take more control over his situation.” Furthermore, the few times relationship violence was discussed, the female client was always referred to as a “victim” or “survivor,” whereas the male client was referred to by name or “the client.”

## Discussion

This study aimed to examine how counseling students conceptualize and propose treatment for the experience of TDV in both female and male clients. The results indicate that gender played a significant role in counseling students' responses to a survivor's clinical needs. Data were grouped using the following categories that corresponded with questions: (a) case conceptualization and clinical impressions, (b) diagnostic impressions, (c) relationship considerations, (d) practice considerations, (e) treatment approaches, and (f) gender bias. Within these categories, 19 themes emerged, which we discuss further below.

The counseling students presented similar challenges in their case conceptualizations and diagnoses for each scenario. Sperry and Sperry (2020) noted that case conceptualization is essential for counseling students to inform clients of diagnostic, treatment, and clinical formulations. Many responses demonstrated counselor bias, limitations in practical skills and case conceptualization, and minimal depth of knowledge. As found in this study, there was a misdiagnosis of the client's presenting issue as a mental health disorder and an overemphasis on comorbid symptoms (e.g., failing grades) instead of evaluating these phenomena as a response to the trauma (i.e., TDV). This failure to conceptualize clients accurately leads to improper diagnosis and ineffective treatment.

Interestingly, although the study did not include a requirement to diagnose the fictitious clients, many of the participants still provided a diagnosis. In a systematic review of the literature, Merten et al. (2017) found that misdiagnosis and unintended overdiagnosis of mental health disorders in children and adolescents is likely more common than expected, leading to improper treatment. Qualitative research illuminates how cognitive information processing obscures diagnostic and clinical decision-making (Hays et al., 2009). This phenomenon, known as availability bias, is when clinicians determine the mental health status of clients based on personal experiences or stigma rather than the observable criterion. It is plausible that the counseling students in this qualitative study demonstrated availability bias (based on gender or age), inhibiting their future work with TDV in young clients.

Further, the study's findings show that many counseling students are unaware of evidence-based interventions to treat TDV appropriately. Students mentioned interventions like cognitive behavioral therapy (CBT), solution-focused therapy, couples counseling, and academic tutoring to reduce client distress and increase self-esteem. Although CBT is a viable treatment approach, none of the responses suggested the implementation of trauma-informed modalities or protocols (such as STAIR; American Psychiatric Association, 2019) for teens recovering from emotional and physical abuse. Trauma-informed approaches focusing on empowerment and advocacy are incredibly powerful in healing relationship trauma (Ogbe et al., 2020). Most strikingly, the counseling students appeared to overlook many critical aspects of treating trauma survivors, including screening, risk assessment, safety planning, and psychoeducation (Ogbe et al., 2020).

A promising aspect of this study is that some counseling students suggested peer support and group therapy as appropriate treatment responses for TDV. Research indicates that school-based peer groups can decrease the rate of abuse among middle and high school-aged students (Ball et al., 2015) and reduce physical dating violence following treatment (Temple et al., 2013). Studies also reveal higher success rates for the prevention of TDV when survivors perceive consistent emotional safety. Factors like school climate, group setting, peer interactions, perspectives on abuse, and opportunities for adaptive skills-building can contribute to survivor care (Ball et al., 2015).



Regarding relationship considerations, only 15 participants noted relationship concerns related to a toxic relationship, regardless of the perpetrator's gender. Only six of those who indicated relationship discord reported concerns related to sexual abuse or rape. The staggering implication is that novice clinicians cannot identify unhealthy relationship patterns and violence. Research also indicates that young people often misinterpret or minimize partner violence because of unrealistic or distorted relationship beliefs (Eisner, 2021; Walker et al., 2020), continuing into early adulthood with difficulty conceptualizing violence upon entering college (Emelianchik-Key et al., 2022). When clients and clinicians cannot label and conceptualize relationship violence, it leaves room for error in intervention and prevention measures. This extends to the demonstrated lack of knowledge regarding legal, ethical, and clinical responsibilities for treating TDV, particularly within the scope of mandatory reporting laws for the protection of minors. This issue extended to the appropriate disclosure of TDV to parents and caregivers, mainly because young people are more apt to discuss TDV in confidential settings (Cutter-Wilson & Richmond, 2011).

Other practice concerns in the data stemmed from a general inability to conceptualize the presented cases. Although the case vignette highlights academic and interpersonal problems, the client's presenting problem was TDV. The counseling students neglected to recognize adolescent relationship abuse, leading to the symptomology of academic decline, lowered self-esteem, dysthymia, and isolation (Cutter-Wilson & Richmond, 2011). Recommendations to treat other problems outside of TDV to resolve trauma from abuse can lead to the revictimization of the client by the counselor (Maghsoudi, 2018). Counseling students must be cognizant of their capacity to retraumatize TDV survivors, as victims who perceive any shame or blame during their disclosure may be reluctant to seek help in the future (Maghsoudi, 2018; Walker et al., 2020). Counselor bias is often attributed to poor training at the graduate level (Maghsoudi, 2018). With more informed preparation, counseling students may shift from a pathologized response to a strengths-based approach founded on client self-efficacy and resilience.

Consistent with prior research (Karakurt et al., 2013; Machado et al., 2020; Maghsoudi, 2018; Walker et al., 2020), gender bias was prevalent across all categories and ultimately emerged as an independent category upon final analyses. Gender discrepancies were evident in clinical diagnosis, treatment planning, ethical implications, and client descriptors. Although the content presented in each scenario was identical, counseling students diagnosed the male and female survivors differently. For example, the female survivor was diagnosed with borderline personality disorder and bipolar disorder while the male survivor received depression, anxiety, and ADHD diagnoses. With many criteria for these disorders overlapping, misdiagnosis can occur (Fruzzetti, 2017; Scott, 2017). Yet, gender bias is a common factor in misdiagnosis, especially with a diagnosis of borderline personality disorder, bipolar disorder, and ADHD (Bruchmüller et al., 2012; Fruzzetti, 2017). Counselors perpetuate stigma regarding female survivors by over-pathologizing, minimizing their complaints, and invalidating their feelings (Maghsoudi, 2018).

We contend that the most alarming finding of this study was how the counseling students portrayed several gender disparities when identifying relationship abuse. The divide between gender treatment of TDV was apparent when comparing the counseling students' view of the female client as a "survivor" and not using strengths-based terminology to identify the male client. Many statements continued to perpetuate societal stigmas about female survivors being passive while male survivors were described as needing to assert "control," further exacerbating common notions about power and control. A recent qualitative study of male survivors explained that professionals minimized and ridiculed most participants for not being the "stereotypical victim of domestic violence" (Machado et al., 2020, p. 9). Counselors must develop the necessary skills to provide equal support

and resources to populations navigating stigma concurrently with TDV (Walker et al., 2020). These findings affirm that even professional counselors are subject to the inherent and socially constructed biases regarding relationship abuse and further emphasize the importance of counselor training to increase one's professional capacity to treat all survivors of TDV. These outcomes also support a feminist conceptualization of TDV to dismantle gender disparities in treatment and the importance of empowering survivors of all genders experiencing TDV.

### **Implications for Counselors and Counseling Programs**

Collectively, the study's findings point to the need for enhanced counselor training, reflexivity, and knowledge on the intersection of age, relationship status, violence, and gender issues. Counseling students must understand that relationship violence can happen at any age and has damaging, long-lasting impacts on an adolescent's well-being, future relationships, and mental health (e.g., depression, suicidal ideation, drug use, self-injury; CDC, 2021; Kann et al., 2018). TDV has detrimental consequences on an adolescent's psychological well-being and decision-making (CDC, 2021; K. E. Hunt et al., 2022), thus making it critical that counselors do not underestimate the impact dating violence can have on a relationship regardless of age. Because counselors may encounter the presence of relationship violence in teens within various settings (e.g., counseling centers, schools, and universities), they must be familiar with and adept at recognizing and addressing these factors for client safety and aid in ending the abuse cycle.

Although counselor education programs produce very competent and knowledgeable counselors, there remains an inability to comprehensively cover all the necessary content to prepare counselors for working with clients (Henriksen et al., 2010; Khubchandani et al., 2012). Some of these topic areas, like TDV, must be explored further in continuing education. More emphasis must be placed on trauma-informed approaches to assist all clients, including teens in a critical developmental age at which TDV threatens current and future mental health (Foshee et al., 2013; Temple et al., 2013). Strengths-based and advocacy-informed trauma approaches have been influential in healing relationship trauma (Ogbe et al., 2020) by assisting teens in preventing pervasive patterns of violence in future relationships.

At the same time, other relevant factors, such as unacknowledged biases, should be examined personally and within supervision. Counseling students, new professionals, and supervisors must be willing to broach biases and assumptions regarding gender in counseling and supervision to prevent them from affecting clients. Counselors must understand the impact of gender and age on highly stigmatized topics, such as TDV and sexuality, to prevent biases and misunderstandings from guiding assessment and treatment. Counselor educators can teach students about TDV using theoretical lenses that deconstruct stigma. For example, a feminist perspective could lend to classroom dialogue uncovering societal power differentials. At the same time, structural functionalism theory or conflict theory could offer unique lenses to discuss systemic inequities in the quality and delivery of mental health care.

Counselor education programs are essential in helping counseling students develop strong case conceptualization skills that affirm diverse clients and consider strengths-based and trauma-informed interventions. Therefore, counselor training must incorporate instruction and practice for adolescent risk assessment of TDV. Counseling students who gain experience using TDV screening tools may increase their confidence when clinical decision-making is required, such as disclosing abuse. Mandatory reporting is not always transparent for students. Instructional role plays and a review of the limitations of confidentiality may also prompt further growth and development for counseling students, in addition to reviewing state laws and any differences with our profession's ethical

guidelines. Research demonstrates that teens fear the information counselors report to their parents or caregivers from counseling sessions. In contrast, caregivers can often lack the ability to respond appropriately to this information (Black et al., 2015). Thus, counselors must understand the critical role of establishing trust and rapport with teens experiencing TDV to strengthen the therapeutic relationship and ability to work together and increase support and trust within the family system.

### **Limitations and Future Research Directions**

Research findings must always be considered in the context of the existing limitations. One limitation was that the study included a sample of counseling students across three universities in the southern region of the United States and we did not delineate the number of students affiliated with each university. The study may have benefited from a more diverse sample across many CACREP-accredited programs. The students in the study pertained to four different tracks (school, mental health, marriage and family therapy, and rehabilitation counseling), with some non-degree-seeking students and doctoral students. Although this illuminates overarching gaps in the counseling profession, future researchers may examine differences between specializations, allowing for more in-depth assessments and recommendations for training and continuing education.

Additionally, we did not inquire about counseling students' strategies and decision-making processes to develop their case conceptualizations and treatment decisions. This data would have been beneficial for counselor educators to address these areas early on in training. A final limitation of the study included the use of binary gender identities and heterosexual relationships in the case vignettes. Although the present research may provide a framework for future studies to build upon, it is essential to note that TDV occurs across diverse populations, including LGBTQ+ youth. As such, future research should examine counseling students' conceptualization of TDV within diverse communities and relationships. This would further illuminate disparities and challenges in the conceptualization and treatment of TDV, shedding light on areas needing attention in counselor training.

### **Conclusion**

Counseling students must develop self-awareness and knowledge of TDV to treat the transgenerational cycle of violence, thereby preventing or addressing potential mental health consequences. To do so, students must understand the etiology of violence, manifestations of violence in relationships, and trauma-informed conceptualization and treatment of violence. Although such training must begin in counselor education programs and continue after graduation (Murray et al., 2016; Wozny, 2005), this study revealed the importance of reflexivity and self-awareness on existing biases, assumptions, and beliefs on TDV. Counselor biases can significantly impact client treatment outcomes (Karakurt et al., 2013). Therefore, personal biases must be recognized early in training to prevent harmful and stigmatizing treatment of clients experiencing TDV.

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## Appendix

### Female Case Vignette

Jordan is a 17-year-old female in her junior year of high school. Her teacher referred her for assistance from the school counselor after she began struggling academically. Jordan's parents had also become concerned when Jordan's grades dropped from As and Bs to Cs and a D in less than one school year, and she had begun isolating herself from her friends, even quitting the basketball team that she had loved.

During her initial session with her school's guidance counselor, Jordan discussed being increasingly distracted in class and being unable to complete her assignments on time. Jordan also discussed being happy and in her first serious relationship with a boyfriend during this past year but reports that she hasn't quite felt like herself lately. Jordan disclosed that she quit the basketball team to spend more time with her boyfriend because she wanted to prove her love to him, as he would become anxious whenever she was without him. She states they love each other very much and proves this by spending as much time as she can with him and sharing everything, including the passwords for all her social media accounts. Jordan notes that her boyfriend was more physically experienced with relationships, and her past boyfriends "strayed," so these were things she wanted to do to make him feel "safe and secure." She also stated that she had past relationships, but nothing serious or that went beyond kissing. The couple recently advanced in their sexual relationship because her boyfriend said he couldn't date someone who wasn't physically and emotionally close to him. Jordan didn't want to lose him and went ahead with what she called the "next step" in their sexual relationship so he would not break up with her.

Jordan wasn't sure why her grades were slipping but said things were fine at home, and she loved having a boyfriend. She appears to discuss her friends and basketball teammates fondly, but says her relationship is better without them. When Jordan was in basketball, her boyfriend would call and text her 20 plus times after practice let out until he heard back. She said quitting helped with his anxiety and her stress of dealing with all the calls. She stated that she had no energy to commit to basketball or hanging out with friends. Her focus was on school and her boyfriend.

Jordan appeared willing to try to improve her grades and said her boyfriend and parents supported these efforts. She reports her boyfriend has been tutoring her and helping her study when they are together because he told her he doesn't want a "stupid girlfriend." Jordan reports this as "playful teasing" and his "way to motivate" her. Jordan wants to go to college, but she is concerned that her recent drop in grades will affect her school admission. She is unsure why she cannot concentrate. She has been tired lately and said she's just "in a funk" that she needs to shake off.

Her parents reported wanting her grades to improve, and Jordan seems preoccupied lately. Her parents don't know how to improve her focus in school and at home but seem supportive. They said they appreciate her boyfriend's "tutoring" as Jordan refers to it. Jordan was cooperative and pleasant in the session.

*Note.* The case vignette presented here is that of a female teen client. An identical vignette for a male teen client was also utilized during the study. The only difference in cases was the identified gender of the client and their partner; names, scenarios, and all non-gendered wording remained the same.

## Questions

1. Provide a brief case conceptualization for this client. Be as specific as possible and note any clinical impressions.
2. What is your diagnosis (if you feel one is warranted) or any diagnostic impressions related to Jordan's behaviors? Please be specific and include any V codes if you believe they are justified.
3. What would be your treatment approach when working with Jordan, and what areas would be your treatment goals for Jordan?
4. Are there any relationship considerations to incorporate in your work with Jordan?
5. Are there any additional clinical or practice concerns you might have in working with Jordan?
6. Is there anything else you would like to share about working with Jordan that has not been mentioned elsewhere?

