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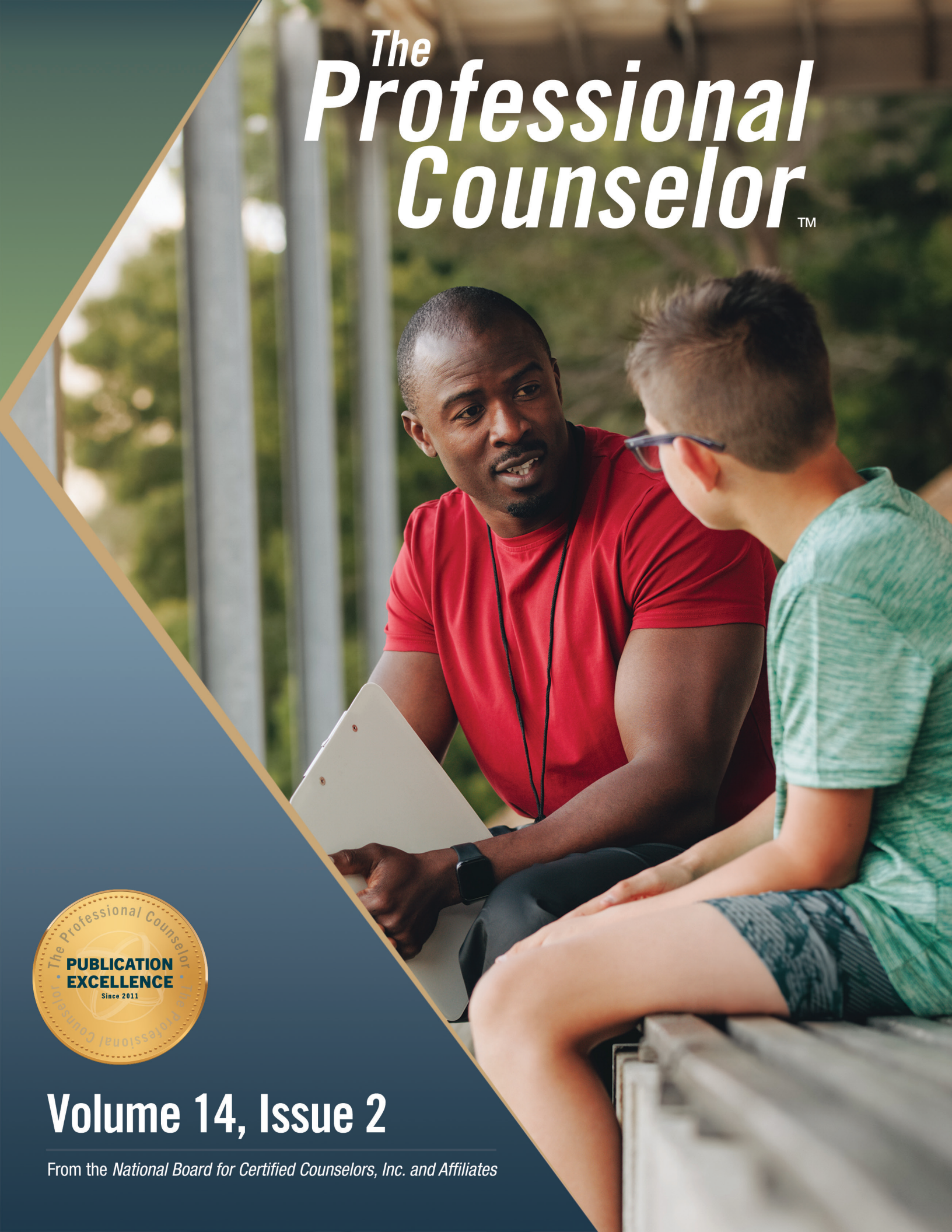

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Examination of the Bystander Intervention Model Among Middle School Students: A Preliminary Study

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Researchers have utilized the Bystander Intervention Model to conceptualize bullying bystander behavior. The five-step model includes Notice the Event, Interpret the Event as an Emergency, Accept Responsibility, Know How to Act, and Decision to Intervene. The purpose of this study was to examine outcomes of an evidence-based bystander training within the context of the Bystander Intervention Model among middle school students ($N = 79$). We used a quasi-experimental design to examine differences in outcomes between bystanders and non-bystanders. We also assessed which of the steps were uniquely associated with post-training defending behavior. Results indicated a significant increase in Know How to Act for both groups. In contrast, we found increases in Notice the Event, Decision to Intervene, and defending behavior among bystanders only. Finally, Notice the Event and Decision to Intervene were uniquely associated with post-training defending behavior. We discuss implications of these findings for counselors.

Keywords: **Bystander Intervention Model, bullying, bystander training, defending behavior, middle school**

School bullying is a significant problem in the United States, with one out of four students reporting being a target of bullying (U.S. Department of Education, 2019). Bullying is defined as any unwanted aggressive behavior(s) by another youth or group of youths, who are not siblings or currently dating, that involves an observed or perceived power imbalance, and is repeated multiple times or is highly likely to be repeated (Centers for Disease Control and Prevention [CDC], 2020). Bullying peaks in middle school, with 28% of middle school students reporting being a target of school bullying (CDC, 2020). According to a meta-analysis examining consequences of bullying victimization, among middle school students, targets of bullying reported a wide range of socio-emotional consequences, including anxiety, post-traumatic stress, depressive symptoms, poor mental and general health, non-suicidal self-injury, suicidal ideation, and suicide attempts (Moore et al., 2017). Researchers have also established mental health risks associated with witnessing bullying among middle school students, including anxiety and depressive symptoms (Doumas & Midgett, 2021; Midgett & Doumas, 2019).

The Role of Bystanders

The majority of students (80%) have reported observing bullying as a bystander (Wu et al., 2016). A bystander is a student who witnesses a bullying situation but is not the target or the perpetrator (Twemlow et al., 2004). Bystanders can respond to bullying in several ways, including encouraging the bully by directly acting as "assistants" or indirectly acting as "reinforcers," walking away from bullying situations acting as "outsiders," or attempting to intervene to help the target by acting as "defenders" (Salmivalli et al., 1996). As such, bystanders play an important role in inhibiting or exacerbating bullying situations. Although most students intentionally or unintentionally reinforce bullying by acting as "assistants," "reinforcers," or "outsiders" (Salmivalli & Voeten, 2004), a single high-status student or group of students acting as "defenders" can shift attention and power away from the perpetrator (Salmivalli et al., 2011), thereby discontinuing reinforcement, modeling

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prosocial behavior, and providing social support for targets. Thus, there is a need to train bystanders to intervene to both reduce bullying and buffer both bystanders and targets from the negative consequences associated with witnessing bullying.

Researchers have found that mobilizing bystanders to intervene to stop bullying is an important part of bullying prevention (Polanin et al., 2012). Bullying decreases when bystanders intervene as "defenders" (Salmivalli et al., 2011); however, many students reported they lack the skills to intervene (Bauman et al., 2020) and only 20% reported using defending behavior when they witness bullying (Salmivalli et al., 2005). Researchers investigating bullying bystander behavior have identified factors associated with defending targets, including perceived pressure to intervene (Porter & Smith-Adcock, 2016), basic moral sensitivity to bullying (Thornberg & Jungert, 2013), self-efficacy (Thornberg & Jungert, 2013; van der Ploeg et al., 2017), and empathy (van der Ploeg et al., 2017). However, these studies have focused primarily on one or two specific factors in relation to defending, rather than the process that leads to defending behavior. Because bullying involves many interacting factors, a comprehensive model is needed to understand the complex social behavior of bystander intervention in bullying.

The Bystander Intervention Model

The Bystander Intervention Model (Latané & Darley, 1970) provides a conceptual framework of necessary conditions for bystanders to intervene to help targets of bullying. This model outlines five sequential steps that a bystander must undergo in order to take action: (a) notice the event, (b) interpret the event as an emergency that requires help, (c) accept responsibility for intervening, (d) know how to intervene or provide help, and (e) implement intervention decisions. Nickerson and colleagues (2014) developed a measure, the Bystander Intervention Model in Bullying Questionnaire, as a way to assess the five steps of the Bystander Intervention Model in bullying and sexual harassment situations among high school students. Results of structural equation modeling analyses revealed a good model fit, with engagement in each step of the Bystander Intervention Model being influenced by engagement in the previous step, providing a measurement model that can inform bullying intervention efforts. Researchers have also examined an adapted version of the Bystander Intervention Model in Bullying Questionnaire for middle school students, with confirmatory factor analysis supporting the five-step model and demonstrating positive correlations between engagement in each step of the Bystander Intervention Model and defending behavior in bullying situations (Jenkins & Nickerson, 2016). Applying the Bystander Intervention Model to school-based bullying prevention programs can inform program development and evaluation, with the goal of helping counselors understand how to equip students with skills to engage in all steps of the model, enhancing program outcomes through an increase in defending behavior. To date, however, no researchers have examined bystander training within the context of the Bystander Intervention Model.

The STAC Intervention

STAC (Midgett et al., 2015), which stands for four bystander intervention strategies—Stealing the Show, Turning It Over, Accompanying Others, and Coaching Compassion—is a brief bullying bystander intervention. The program is designed to provide education about bullying, including the definition of bullying and its negative associated consequences; emphasize the importance of intervening in bullying situations; and teach students prosocial skills they can use to intervene as a "defender" when they witness bullying. As a school-based program, STAC was developed to be delivered by school counselors during classroom lessons (Midgett et al., 2015). Research indicates STAC is effective in reducing bullying victimization (Moran et al., 2019) and bullying perpetration (Midgett et al., 2020; Moran et al., 2019) among middle school students. Additionally, researchers have found that middle school students trained in the STAC program reported a decrease in depressive symptoms

(Midgett & Doumas, 2020; Midgett et al., 2020), social anxiety (Midgett & Doumas, 2020), and passive suicide ideation (Midgett et al., 2020), while also experiencing a positive sense of self after implementing the STAC strategies (Midgett, Moody, et al., 2017).

Alignment Between the Bystander Intervention Model and the STAC Intervention

The STAC intervention includes didactic and experiential components that are aligned with the five steps of the Bystander Intervention Model. First, the facilitators of the STAC program provide education about bullying, what it is and what it is not, and the negative associated consequences of bullying. This information can promote student engagement in the first two steps of the Bystander Intervention Model (i.e., Notice the Event and Interpret the Event as an Emergency). Next, facilitators of the STAC program emphasize the importance of intervening in bullying situations, which can promote student engagement in the third step of the Bystander Intervention Model (i.e., Accept Responsibility). Finally, facilitators of the STAC program train students to use prosocial skills they can use as bystanders to intervene as a "defender" when they witness bullying. The program also includes skills practice for strategy implementation through role-play activities and booster sessions. Skills training and practice are aligned with the last two steps of the Bystander Intervention Model (i.e., Know How to Intervene and Decision to Intervene). Although research indicates that middle school students trained in the STAC program report increases in knowledge and confidence (Midgett et al., 2015; Midgett & Doumas, 2020; Midgett, Doumas, et al., 2017; Moran et al., 2019) and use of the STAC strategies post-training (Midgett & Doumas, 2020; Moran et al., 2019), to date, no research has examined the impact of the STAC intervention on student engagement in the five steps of the Bystander Intervention Model or how engagement in the five steps is related to post–STAC training defending behavior.

The Present Study

The purpose of this study is to expand the literature by examining changes in engagement in the five steps of the Bystander Intervention Model among middle school students. First, using a quasi-experimental design, we aim to examine changes in engagement between bystanders and non-bystanders. We also aim to assess which of the five steps are associated with post-training defending behavior. Researchers have demonstrated that each of the five steps of the Bystander Intervention Model correlates with defending behavior among middle school students (Jenkins & Nickerson, 2016). To date, however, no study has examined if bystander training increases engagement in the five steps of the model and if the five steps are related to defending behavior after bystander training. The STAC bystander intervention teaches bystanders to act as defenders by providing education about bullying and equipping students with the knowledge and skills to intervene in bullying situations (Midgett et al., 2015). To date, however, no researchers have examined the impact of the STAC intervention on student engagement in the five steps of the Bystander Intervention Model or how engagement in the five steps is related to defending behavior after bystander training. To address this gap, we used a quasi-experimental design to answer the following research questions:

Research Question 1: Are there differences in student engagement in the five steps of the Bystander Intervention Model from baseline (T1) to the 6-week follow-up (T2) between bystanders and non-bystanders?

Research Question 2: Is there a difference in defending behavior from baseline (T1) to the 6-week follow-up (T2) between bystanders and non-bystanders?

Research Question 3: Engagement in which of the five steps of the Bystander Intervention Model uniquely predicts defending behavior at the 6-week follow-up (T2)?

Methods

Participants

The sampling frame for recruitment included all students in grades 6–8 at a single private school in the Northwest. The school had a total enrollment of 362 students in grades K–8, with a student body comprised of 80% of students identifying as White, 14% Hispanic, 3% Two or More Races, 1% Asian American, 1% Black/African American, and < 1% Native American or Native Hawaiian. The researchers invited all students in grades 6–8 to participate ($N = 127$). Inclusion criteria included being enrolled in sixth, seventh, or eighth grade; speaking and reading English; and having parental consent and student assent to participate. Exclusion criteria included inability to speak or read English and not having parental consent or not assenting to participate. Of the 127 students invited, 90 (70.9%) parents/guardians provided informed consent and 87 students (68.5%) assented to participate; 79 of those students (90.8%) completed the 6-week (T2) follow-up assessment. Among participants, 62.1% self-identified as female and 37.9% self-identified as male. Participant age ranged from 11–14 years ($M = 12.22$ and $SD = 0.92$), with reported race/ethnicity of 63.3% White, 8.9% Hispanic, 2.5% Black/African American, 3.8% Asian American, 15.2% Two or More Races, and 6.3% Other. There were no differences in gender, $c^2(1) = .01$, $p = .98$; grade, $c^2(2) = .61$, $p = .74$; race/ethnicity, $c^2(5) = 4.41$, $p = .49$; or age, $t\ (85) = .41$, $p = .52$, between students who completed the follow-up assessment and those who did not.

Procedure

The university IRB approved all study procedures. A member of our research team explained the purpose of the training and study procedures to all students during classtime, invited students to participate, and provided students with an informed consent form to take home to parents/guardians. Immediately prior to collecting baseline data (T1), our team members collected assent forms from students who had a signed informed consent form. Our team members conducted the STAC training in two 45-minute modules, followed by two weekly 15-minute booster sessions. Students completed a 6-week follow-up survey (T2). Trainers conducted the STAC intervention through six groups (two per grade level) ranging from 20–30 students per group. All students participated in the training; however, only those with informed consent and assent participated in the data collection. All procedures occurred during classroom time.

The STAC Program

Didactic Component. In the STAC program, trainers present educational information that includes (a) an overview of bullying; (b) different types of bullying (i.e., physical, verbal, relational, and cyberbullying); (c) characteristics of students who bully; (d) reasons students bully; (e) negative consequences associated with being a target, perpetrator, and/or bystander; (f) the role of the bystander and the importance of acting as a "defender"; (g) perceived barriers for intervening; and (h) the STAC strategies described below.

Stealing the Show. "Stealing the show" is a strategy aimed at interrupting a bullying situation by using humor, storytelling, or other forms of distraction to get the attention off of the bullying situation and the target. Students learn how to identify bullying situations that are appropriate to intervene in using this strategy. Students are trained not to use "stealing the show" to intervene during physical or cyberbullying.

Turning It Over. "Turning it over" involves seeking out a trusted adult to intervene in difficult bullying situations. Students learn how to identify bullying situations that require adult intervention, specifically physical bullying, cyberbullying, and/or any bullying situation they do not feel comfortable intervening in directly.

Accompanying Others. "Accompanying others" is a strategy aimed at offering support to the target of bullying. Students learn to comfort targets either directly by asking them if they would like to talk about the incident or indirectly by spending time with them.

Coaching Compassion. "Coaching compassion" is a strategy aimed at helping the perpetrator of bullying to develop empathy for students who are targets. Students learn to safely and gently confront those who are perpetrators by engaging them in a conversation about the impacts of bullying and communicating that bullying behavior is never acceptable. Trainers teach students to use this strategy only when they are friends with the perpetrator, are older than the perpetrator, or believe they have higher social status and will be respected by the perpetrator.

Experiential Component. Students participate in small group role-plays to practice each of the four STAC strategies across varying bullying scenarios. These scenarios include different types of bullying, such as spreading rumors, verbal and physical bullying, and cyberbullying. Each small group presents a role-play to the larger group and trainers provide both positive and constructive feedback to help students use the strategy more effectively in the future.

Booster Sessions. Students participate in two booster sessions to reinforce learning and skill acquisition. During the booster session, trainers review the STAC strategies, encourage students to share their experiences using the strategies, and brainstorm ways to help students be more effective defenders. The trainers invite students to share bullying situations that they have observed, including those in which they did not intervene, and then brainstorm with other students how they could intervene in the future.

Intervention Fidelity. The developer of STAC trained the trainers previously, and both trainers had experience delivering the STAC intervention prior to this study. The first author, Matthew Peck, served as one of two trainers during the intervention training used in this study; the other was a graduate student not involved in the later development of this article. The third author, Aida Midgett, was present during the training to ensure it was delivered with fidelity. Midgett completed a dichotomous rating scale (*Yes* or *No*) to evaluate whether the trainers accurately taught the material and whether they deviated from the intervention protocol, and determined that the trainers delivered the STAC training with high levels of fidelity.

Measures

Demographic Survey

Participants completed a demographic survey including questions about gender, grade, age, and race/ethnicity. Participants indicated their gender, grade, and age through open-ended questions and provided their race/ethnicity through response choices.

Bystander Intervention Model Steps

We assessed the five steps of the Bystander Intervention Model using the 16-item Bystander Intervention in Bullying Questionnaire (Nickerson et al., 2014). The original scale was developed for high school students and focused on bullying and sexual harassment. Jenkins and Nickerson (2016) adapted the scale for middle school students to focus on bullying only. The questionnaire is comprised of five scales: Notice the Event (3 items), Interpret the Event as an Emergency (3 items), Accept Responsibility (3 items), Know How to Act (3 items), and Decision to Intervene (4 items). Each item is rated on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Example items include: "I am aware that students at my school are bullied" (Notice), "I think bullying is hurtful and damaging to others"

(Interpret), "I feel personally responsible to intervene and assist in resolving bullying incidents" (Accept), "I have the skills to support a student who is being treated disrespectfully" (Know), and "I would say something to a student who is acting mean or disrespectful to a more vulnerable student" (Intervene). Confirmatory factor analyses support the five-factor structure, and convergent validity analyses using the Defending subscale of the Bullying Participant Behaviors Questionnaire (Summers & Demaray, 2008) has been demonstrated by providing positive correlations ranging from .26 to .35 among middle school students (Jenkins & Nickerson, 2016). Researchers have also demonstrated high internal consistency for the subscales among middle school students, with Cronbach's alpha coefficients ranging from .77 to .87 for the five subscales (Jenkins & Nickerson, 2016). For the current sample, the scales had acceptable internal consistency with Cronbach's alphas ranging from .66 to .71. For the Interpret subscale, we deleted one item (i.e., "It is evident to me that someone who is being bullied needs help") to reach an acceptable level of internal consistency (α = .66) for the scale.

Defending Behavior

We utilized the 3-item Defender subscale of the Participants Roles Questionnaire (PRQ; Salmivalli et al., 2005) to measure defending behaviors students may use to intervene when witnessing bullying. The subscale includes the following items: "I comfort the victim or encourage him/her to tell the teacher about the bullying," "I tell the others to stop bullying," and "I try to make the others stop bullying." Items are rated on a 3-point Likert scale ranging from 0 (*never)* to 2 (*often*). Confirmatory factor analyses support the five-factor structure of the PRQ measure, and construct validity has been demonstrated through significant associations between self-reported roles and sociometric status (e.g., popular, rejected, and average), χ^2 = 117.7–141.6, all *p* values < .001, and peer nominations, χ^2 = 57.9–88.2, all *p* values < .001 (Goossens et al., 2006). Among middle school students, the Defender subscale has good internal reliability ranging from α = .79–.93 (Camodeca & Goossens, 2005; Salmivalli et al., 2005). For the current sample, Cronbach's alpha was high (α = .80).

Bystander Status

We assessed bystander status by asking participants, "Have you seen bullying at school in the past month?" with response choices *Yes* and *No*. The item was developed by the second author, Diana M. Doumas, to assess whether or not students had the opportunity to respond to a bullying incident. Students who reported *Yes* were classified as bystanders (i.e., the student witnessed bullying and had the opportunity to respond) and students who reported *No* were classified as non-bystanders (i.e., students who did not witness bullying and, therefore, did not have the opportunity to respond). The item has face validity and researchers have utilized this item previously to measure bystander status among middle school students (Midgett & Doumas, 2020; Moran et al., 2019). In this study, the 30.4% of students who reported *Yes* to this item at the follow-up assessment (T2) were classified as bystanders, and the 59.6% of students who reported *No* were classified as non-bystanders.

Data Analyses

We conducted all analyses using SPSS version 28.0. We imputed missing data and examined all variables for skew and kurtosis. We used a general linear model (GLM) repeated measures multivariate analyses of covariance (RM-MANCOVA) to examine changes in engagement in the five steps of the Bystander Intervention Model between bystanders and non-bystanders across time for the outcome variables Notice the Event, Interpret the Event as an Emergency, Accept Responsibility, Know How to Act, and Decision to Intervene. The independent variables were Time (baseline [T1]; follow-up [T2]) and Bystander Status (bystander; non-bystander). We also controlled for gender, age, and witnessing bullying at baseline. We conducted post-hoc GLM repeated measures analyses of covariance (RM-ANCOVAs) for each outcome variable. We plotted simple slopes to examine the direction and degree of the significant interactions testing moderator effects (Aiken & West, 1991). We only interpreted

significant main effects in the absence of significant interaction effects. For changes in defending behavior, we used a GLM RM-ANCOVA. The independent variables and control variables paralleled the RM-MANCOVA analysis. We conducted a linear multiple regression to examine engagement of the five steps of the Bystander Intervention Model as predictors of post-training defending behavior. The five steps were entered simultaneously in the regression analysis. We calculated bivariate correlations among the criterion and predictor variables prior to conducting the main regression analyses. We examined the variance inflation factor (VIF) for predictors to assess multicollinearity. We calculated effect size for the ANCOVA models using partial eta squared (η_p^2) with .01 considered small, .06 considered medium, and .14 considered large (Cohen, 1969) and for the regression model using R^2 with .01 considered small, .09 considered medium, and .25 considered large (Cohen, 1969). A *p*-value of < .05 indicated statistical significance.

Results

Preliminary Analyses

Means and standard deviations for the five steps of the Bystander Intervention Model and defending behavior are presented in Tables 1 and 2. Skew and kurtosis were satisfactory and did not substantially deviate from the normal distribution for all variables. Bivariate correlations for the criterion and predictor variables are presented in Table 3. Although several of the correlations between the predictor variables were significant at $p < .01$, the VIF ranged between 1.08–2.69, with corresponding tolerance levels ranging from .37–.93. The VIF is well below the rule of thumb of VIF < 10 (Erford, 2015), suggesting acceptable levels of multicollinearity among the predictor variables.

Changes in the Bystander Intervention Model

Results of the RM-MANCOVA indicated a significant main effect for Time, Wilks' lambda = .86, $F(5, 70) = 2.32$, $p = .05$, $\eta_p^2 = .14$., and a significant interaction effect for Time x Bystander Status, Wilks' lambda = .77, $F(5, 70) = 4.15$, $p = .002$, $\eta_p^2 = .23$. As seen in Table 1, post-hoc RM-ANCOVAs indicated a significant main effect for Time x Know How to Act ($p < .02$) and Decision to Intervene ($p < .01$), as well as significant interaction effects for Time x Bystander Status for Notice the Event ($p < .001$) and Decision to Intervene ($p < .05$). Results indicate that Know How to Act increased from baseline (T1) to the follow-up assessment (T2) for both bystanders and non-bystanders. Examination of the significant Time x Bystander Status interaction effects revealed that bystanders reported an increase in Notice the Event and Decision to Intervene, whereas non-bystanders reported a decrease in engagement in these steps of the Bystander Intervention Model (see Figures 1 and 2).

Changes in Defending Behavior

As seen in Table 2, results of the RM-ANCOVA indicated a significant interaction effect for Time x Bystander Status for defending behavior ($p < .04$). As seen in Figure 3, bystanders reported an increase in defending behavior from T1 to T2, whereas non-bystanders reported a decrease in defending behavior from T1 to T2.

The Relationship Between the Bystander Intervention Model and Defending Behavior

As seen in Table 3, bivariate correlations revealed a positive association between post-training defending behavior and Notice the Event ($p < .01$), Accept Responsibility ($p < .05$), Know How to Act ($p < .05$), and Decision to Intervene ($p < .01$). We next conducted a linear multiple regression analysis to examine the unique effect of each of the five steps on post-training defending behavior. The full regression equation was significant, $R^2 = .18$, $F(53, 7) = 4.39$, $p = .002$. As seen in Table 4, Notice the Event ($p < .01$) and Decision to Intervene ($p < .05$) were significant predictors of post-training defending behavior.

Table 1

Descriptive Statistics and Results of the RM-MANCOVAs for Engagement in the Five Steps of the Bystander Intervention Model by Time and Bystander Status

	Bystander (n = 24)	Non-Bystander (n = 55)	Total (n = 79)	Time			Time x Bystander Status		
	M (SD)	*M (SD)*	*M (SD)*	$F(5, 70)$	p	η_p^2	$F(5, 70)$	p	η_p^2
Notice the Event				1.12	.29	.02	14.10***	.001	.16
Baseline	8.75 (2.21)	7.76 (2.35)	8.06 (2.34)						
Follow-Up	9.50 (2.23)	6.31 (2.36)	7.28 (2.74)						
Interpret as Emergency				1.68	.20	.02	0.08	.78	.001
Baseline	8.98 (1.05)	8.58 (1.47)	8.70 (1.36)						
Follow-Up	8.54 (1.56)	8.36 (1.46)	8.42 (1.48)						
Accept Responsibility				0.81	.37	.01	2.62	.11	.03
Baseline	11.12 (2.26)	11.63 (2.17)	11.49 (2.19)						
Follow-Up	11.38 (1.91)	11.09 (2.25)	11.18 (2.14)						
Know How to Act				5.31*	.02	.07	1.75	.19	.02
Baseline	10.63 (1.81)	10.95 (2.26)	10.85 (2.12)						
Follow-Up	11.63 (2.34)	11.54 (1.78)	11.56 (1.95)						
Decision to Intervene				6.73**	.01	.08	4.12*	.05	.05
Baseline	15.46 (2.47)	16.25 (2.24)	16.01 (2.32)						
Follow-Up	15.71 (2.35)	15.69 (2.43)	15.70 (2.39)						

*p < .05, **p < .01,***p < .001.

Table 2

Descriptive Statistics and Results of the RM-ANCOVA for Defending Behavior by Time and Bystander Status

	Bystander (n = 24)	Non-Bystander (n = 55)	Total (n = 79)	Time			Time x Bystander Status		
	M (SD)	*M (SD)*	*M (SD)*	$F(1, 74)$	p	η_p^2	$F(1, 74)$	p	η_p^2
Defending Behavior				1.36	.25	.02	4.61*	.04	.06
Baseline	3.17 (1.46)	2.84 (1.81)	2.94 (1.71)						
Follow-Up	3.67 (1.66)	2.41 (1.89)	2.79 (1.90)						

*p < .05.

Table 3

Bivariate Correlations for Defending Behavior and the Five Steps of the Bystander Intervention Model

Measure	1	2	3	4	5	6
1. Defending Behavior	__					
2. Notice the Event	.31**	__				
3. Interpret as an Emergency	.04	.09	__			
4. Accept Responsibility	.23*	.11	.30**	__		
5. Know How to Act	.26*	−.07	.01	.67**	__	
6. Decision to Intervene	.38**	.11	.29**	.56**	.63**	__

*$p < .05$, **$p < .01$.

Table 4

Summary of Linear Multiple Regression Analyses for the Five Steps of the Bystander Intervention Model

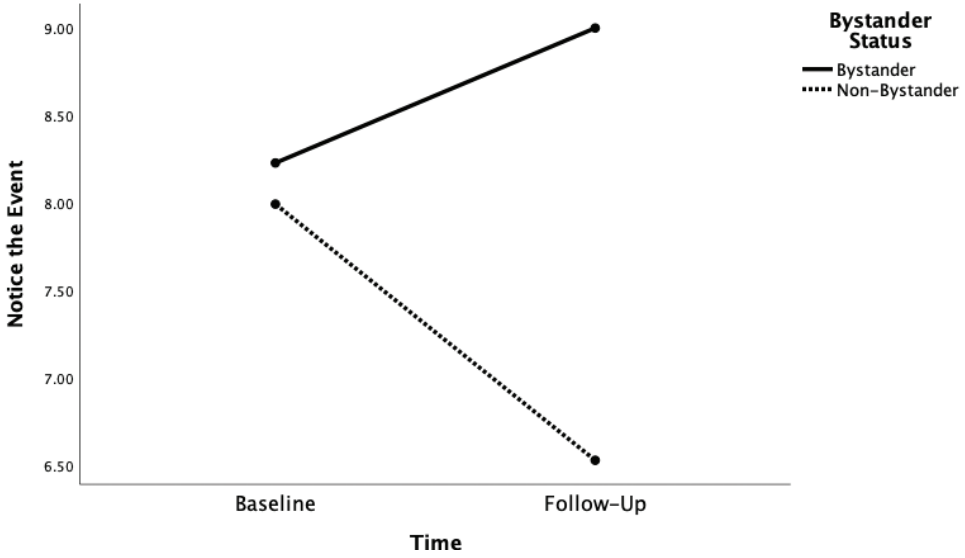
Variable	B	SE B	β	*t*(73)	95% CI
Notice the Event	.20	.07	.29**	2.70	[.05, .35]
Interpret as an Emergency	−.10	.15	−.08	−0.68	[−.40, .20]
Accept Responsibility	−.02	.14	−.02	−0.12	[−.29, .25]
Know How to Act	.08	.16	.08	0.49	[−.25, .41]
Decision to Intervene	.27	.12	.33*	2.30	[.04, .50]

Note. SE = standard error, CI = confidence interval.

*$p < .05$, **$p < .01$.

Figure 1

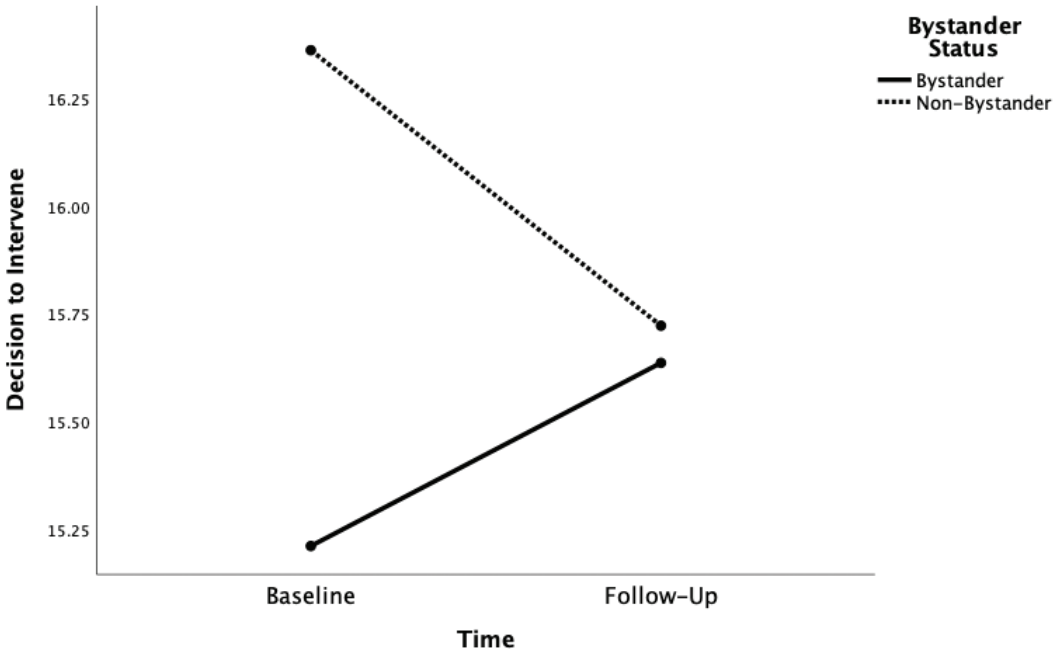
Means for Notice the Event by Time and Bystander Status



Note. Simple slopes are shown depicting the direction and degree of the significant interaction testing moderator effects ($p = .001$). Bystanders reported an increase in Notice the Event and non-bystanders reported a decrease in Notice the Event.

Figure 2

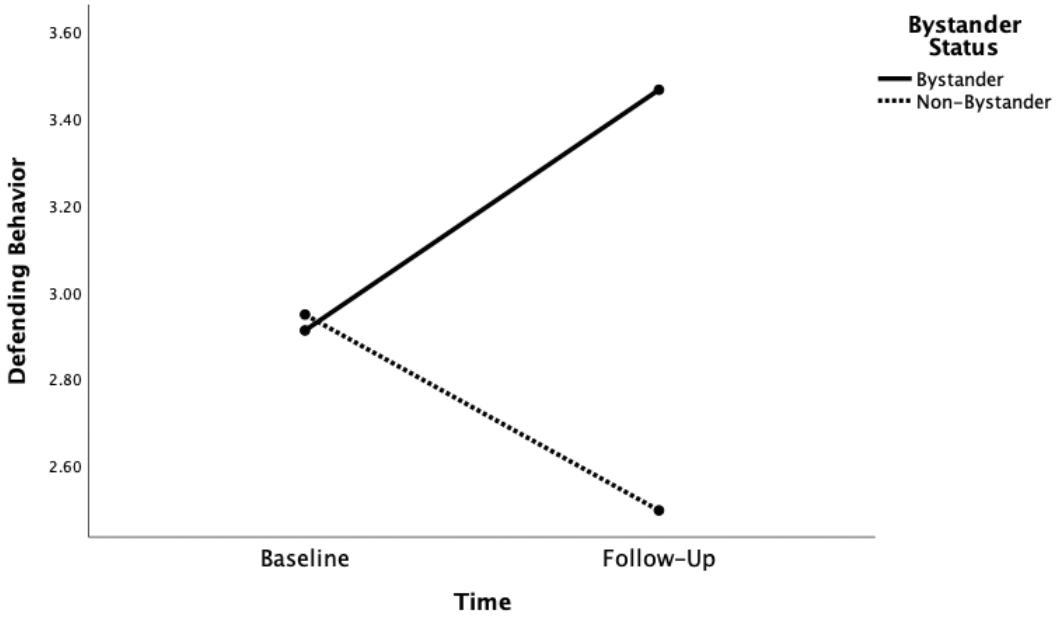
Means for Decision to Intervene by Time and Bystander Status



Note. Simple slopes are shown depicting the direction and degree of the significant interaction testing moderator effects (p = .05). Bystanders reported an increase in Decision to Intervene and non-bystanders reported a decrease in Decision to Intervene.

Figure 3

Means for Defending Behavior by Time and Bystander Status



Note. Simple slopes are shown depicting the direction and degree of the significant interaction testing moderator effects (p = .05). Bystanders reported an increase in defending behavior and non-bystanders reported a decrease in defending behavior.

Discussion

The purpose of this study was to extend the literature on bystander interventions by examining the STAC intervention in the context of the Bystander Intervention Model. This is the first study to identify positive changes in engagement in steps of the Bystander Intervention Model following implementation of a bystander bullying intervention (i.e., STAC) and to illustrate how engagement in the steps of the model relates to post-training defending behavior. Overall, results indicate students trained in STAC reported changes in engagement in three of the five steps of the model and an increase in defending behavior from baseline (T1) to the 6-week follow-up assessment (T2). Further, two of the five steps of the model were uniquely associated with post-training defending behavior.

Findings indicate that there were significant changes in the Bystander Intervention Model steps of Notice the Event, Know How to Act, and Decision to Intervene from baseline (T1) to the 6-week follow-up (T2). For Know How to Act, there was a significant increase for both bystanders and non-bystanders from baseline (T1) to the 6-week follow-up assessment (T2). These findings parallel prior research on the STAC intervention that indicates students trained in the program report an increase in knowledge and confidence to intervene in bullying situations (Midgett et al., 2015; Midgett & Doumas, 2020; Midgett, Moody, et al., 2017; Moran et al., 2019). For Notice the Event and Decision to Intervene, we found differences between bystanders and non-bystanders over time, such that there was an increase in engagement in these steps among students who reported witnessing bullying but a decrease among students who did not report witnessing bullying after training. Findings among bystanders are consistent with previous research demonstrating that students trained in the STAC intervention report an increase in ability to identify bullying (Midgett, Doumas, et al., 2017), awareness of bullying situations (Johnston et al., 2018), and confidence to intervene (Midgett et al., 2015; Midgett & Doumas, 2020; Midgett, Doumas, et al., 2017; Moran et al., 2019). In contrast, non-bystanders may have reported a decrease in these steps because they did not witness bullying after training.

We did not find significant differences from baseline (T1) to the 6-week follow-up (T2) for either group in engagement in the steps Interpret the Event as an Emergency and Accept Responsibility. For Interpret the Event as an Emergency, a possible explanation for this finding is that students reported high scores on this step at baseline. After removing one item on the scale to achieve adequate internal reliability, the maximum score on the scale was 10.00, with a baseline mean of 8.98 for bystanders and 8.58 for non-bystanders. Thus, students in this sample already had a high understanding of the significance of bullying and the importance of helping targets of bullying, which may have been communicated to them prior to our study when the school decided to implement a bullying intervention program. For Accept Responsibility, while the STAC program was designed to provide students with knowledge, skills, and confidence to intervene in bullying situations, the training content is less focused on taking personal responsibility when witnessing bullying. Thus, this may be an important area for future development, emphasizing the importance of each student taking personal responsibility for acting as a "defender" and that by doing that, each student has an important role in reducing bullying and shifting school climate in a positive direction.

Findings also reveal differences in defending behavior from baseline (T1) to the 6-week follow-up (T2) based on bystander status. Specifically, students who witnessed bullying post-training reported an increase in defending behavior, whereas students who did not witness bullying behavior post-training reported a decrease in defending behavior. Findings among the student bystanders are consistent with research demonstrating that more than 90% of middle school students who witness bullying post-training use the STAC strategies to intervene in bullying situations (Midgett & Doumas, 2020;

Moran et al., 2019). The decrease in defending behavior among students who did not witness bullying post-training can likely be explained by the lack of opportunity to utilize defending behavior.

Finally, we examined engagement in the five steps of the Bystander Intervention Model as predictors of post-training defending behavior. Although prior research indicates that engagement in each of the five steps of the Bystander Intervention Model correlate positively with defending behavior among middle school students (Jenkins & Nickerson, 2016), this is the first study to examine the unique effect of engagement in each of the five steps on post–bystander training defending behavior. Results of the regression analysis indicated that Notice the Event and Decision to Intervene were significant predictors of defending behavior. These findings are particularly promising, as engagement in the steps Notice the Event and Decision to Intervene both increased from baseline (T1) to the 6-week follow-up (T2) for students who witnessed bullying after training. Thus, among students who witness bullying as bystanders, the STAC intervention was effective in increasing engagement in the two steps of the bystander model that are uniquely associated with defending behavior.

Limitations and Future Research

Although this study extends research on the Bystander Intervention Model, as it is the first study to examine engagement in the steps of the model in the context of a bystander intervention, there are some limitations. First, the sampling frame included a single recruitment location at a private school in the Northwest, and our final sample was relatively small and composed of English-speaking students who were primarily White. Thus, we cannot generalize our findings to students enrolled in ethnically diverse, public middle schools. Further, because the current study did not include a control group, we cannot make causal attributions about our findings. Future studies with larger, more diverse samples using a randomized controlled design should be conducted to increase generalizability and address causality. Additionally, only one third of students in the current sample reported witnessing bullying post-training. Although prior research indicates 80% of students reported witnessing bullying in the past year, our measure of bystander status was limited to witnessing bullying in the past month, as we aimed to capture witnessing bullying post-training. Future research with a longer follow-up would be useful, as the sample of bystanders would likely be larger with more time between the STAC training and follow-up assessment. Additionally, the item we used to assess bystander status was developed by one of our authors and, although it has face validity, the construct validity of the item has not yet been established. Next, Cronbach's alphas for the Bystander Intervention Model in Bullying Questionnaire scales were lower than found in initial validation research. Additionally, although all Cronbach's alphas were ultimately in the acceptable range, we needed to eliminate an item from the Interpret the Event as an Emergency scale to achieve adequate internal consistency. Finally, our findings were based on self-report data, potentially leading to biased reporting. Thus, including objective measures of observable "defending" behavior would strengthen the findings.

Implications

The current study provides important implications for counselors related to supporting the role of bystanders in bullying prevention. First, findings add to the growing body of literature supporting the STAC intervention as an effective school-based bullying prevention program. Because 28% of middle school students report being bullied (CDC, 2020), and bullying victimization (Moore et al., 2017) and witnessing bullying (Doumas & Midgett, 2021; Midgett & Doumas, 2019) are associated with significant mental health risks, it is imperative that students are equipped with skills they can use to act as "defenders." Middle school counselors can implement STAC as a brief, school-wide intervention through core curriculum classroom lessons as part of a school counseling curriculum.

Second, by focusing on specific steps within the Bystander Intervention Model, counselors can break down the complex process of bullying bystander behavior and have a better understanding of what enables students to intervene when they witness bullying. Notice the Event and Decision to Intervene were both unique predictors of defending behavior among bystanders post-training. Thus, when delivering the STAC intervention, school counselors can increase awareness of bullying by providing education related to the definition of bullying, including what bullying is and is not, as well as the different types of bullying. School counselors can also encourage students to decide to intervene when they witness bullying by providing the skills and confidence needed to intervene using one of the four STAC strategies. Booster sessions may be particularly helpful in promoting the decision to intervene, as school counselors can use this time to reinforce student strategy use.

Next, we did not find changes in engagement in the steps Interpret the Event as an Emergency or Accept Responsibility. The STAC intervention provides education on the negative consequences associated with bullying; this information could be highlighted by counselors within the STAC training to emphasize the magnitude of the problem of bullying and underscore the importance of identifying bullying as an emergency that needs to be addressed. Additionally, when discussing bystander roles, counselors can tie in the concept of why school personnel need students to help address bullying, focusing on the importance of each student taking personal responsibility for making a difference at school by acting as a defender. When conducting the STAC training, it may also be important to engage students who have not witnessed bullying. Although most students witness bullying at some point during adolescence, not all students have witnessed bullying, or witnessed bullying recently. Thus, it may be important to address this in the training, suggesting that even if a student has not witnessed bullying, it is important to learn about bullying and being a "defender," as they may witness bullying in the future.

This study also provides implications for counselors working with youth outside of the school setting. Counselors can conceptualize bystander behavior using the Bystander Intervention Model, assessing engagement in each step of the model and providing education to enhance engagement in each step as needed. Counselors can teach youth about bullying behavior and the different types of bullying, provide information about the consequences of bullying to educate youth on the importance of interpreting bullying as a serious problem, and discuss the importance of taking personal responsibility when witnessing bullying. Consistent with Social Learning Theory (Bandura, 1977), counselors can use the STAC framework to equip youth with skills they can use to intervene when they witness bullying, which can provide opportunities for them to develop and strengthen their self-efficacy through social modeling and mastery experiences to overcome potential challenges. Because self-efficacy influences the decision-making process, the ability to act in the face of difficulty, and the amount of emotional distress experienced while completing a difficult task (Bandura, 2012), self-efficacy can be an important factor in mobilizing youth to engage in the steps of the Bystander Intervention Model. By working with youth on these steps, counselors can empower youth to intervene when they witness bullying and provide youth with prosocial skills they can use to intervene effectively.

Further, this study provides implications for counselor educators. Efforts to reduce bullying and the associated long-standing negative effects on students are widespread in the field, whether working inside schools or in clinical settings. Conversations related to bystander bullying intervention, however, do not seem to have entered counselor education classrooms on a wide scale. Counselor educators can share findings from this study in their courses to educate counseling students on how to provide youth who witness bullying with useful strategies that empower them to confront future instances of school

bullying and cyberbullying. The Bystander Intervention Model and the STAC intervention can be infused into the counselor education curriculum to prepare counselors-in-training to work with youth as allies in the prevention of school bullying.

Conclusion

This was the first study to examine if a bullying bystander intervention increases student engagement in the five steps of the Bystander Intervention Model and if engagement in the five steps of the model is related to post-training defending behavior. Results indicate that from baseline (T1) to the 6-week follow-up (T2), both bystanders and non-bystanders trained in the STAC intervention reported changes in Know How to Act, whereas only bystanders reported increases in Notice the Event, Decision to Intervene, and defending behavior. Further, Notice the Event and Decision to Intervene were uniquely associated with post-training defending behavior. Results underscore the importance of guiding students through the bystander process in bullying prevention and provide additional support for the effectiveness of the STAC intervention.

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

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Centering Social Justice in Counselor Education: How Student Perspectives Can Help

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This mixed methods program evaluation study was designed to assist faculty in better understanding students' multicultural and social justice training experiences, with the goal of improving program curriculum and instruction. It also offers a model for counselor educators to assess student experiences and to make changes that center social justice. A total of 139 first-semester students and advanced practicum students responded to an online survey. The Consensual Qualitative Research-Modified (CQR-M) method was used to analyze brief written narratives. The Multicultural Counseling Competence and Training Survey (MCCTS) and the Advocacy Competencies Self-Assessment Survey (ACSA) were used to triangulate the qualitative data. Qualitative findings revealed student growth in awareness, knowledge, skills, and action, particularly for advanced students, with many students reporting a desire for more social justice instruction. Some students of color reported microaggressions and concerns that training centers White students. Quantitative analyses generally supported the qualitative findings and showed advanced students reporting higher multicultural and advocacy competencies compared to beginning students. Implications for counselor education are discussed.

Keywords: **social justice, program evaluation, training, multicultural counseling, counselor education**

In the midst of the COVID-19 pandemic and the long-standing inequities it brought to light, many universities began examining the ways that injustice unfolds within their institutions (Mull, 2020). Arredondo et al. (2020) noted that counseling and counselor education continue to uphold white supremacy and center the experiences of White people within theories, training, and research. White supremacy culture promotes Whiteness as the norm and standard, intersects with and reinforces other forms of oppression, and shows up in institutions in both overt and covert ways, such as emphasis on individualism, avoidance of conflict, and prioritizing White comfort (Okun, 2021). Arredondo et al. (2020) called for counselor educators to engage in social justice advocacy and to unpack covert White supremacy in training programs. The present study investigated the multicultural and social justice training experiences of students in a Western United States counseling program so that counseling faculty can be empowered to uncover biases and better integrate social justice in the curriculum.

Counselor education programs are products of the larger sociopolitical environment and dominant patriarchal, cis-heteronormative, Eurocentric culture that often fails to "challenge the hegemonic views that marginalize groups of people" which "perpetuate deficit-based ideologies" (Goodman et al., 2015, p. 148). For example, the focus on the individual in traditional counseling theories can reinforce oppression by failing to address the role of systemic oppression in a client's distress (Singh et al., 2020). Counseling theory textbooks usually provide an ancillary section at the end of each chapter focusing on multicultural issues (Cross & Reinhardt, 2017). White supremacy culture is so ubiquitous that it is typically invisible to those immersed within it (DiAngelo, 2018). It is not surprising then that counseling is often viewed as a White, middle-class endeavor, and BIPOC (Black, Indigenous, and People of Color) clients frequently perceive that they should leave their cultural identities and experiences outside

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the counseling session (Turner, 2018). Counselor educators have been encouraged to reflect on how Eurocentric curricula and pedagogy may marginalize students and seek liberatory teaching practices that promote critical consciousness (Sharma & Hipolito-Delgado, 2021).

Students' Perceptions of Their Growth, Learning Process, and Critiques of Their Training

Studies of mostly White graduate students show gains in expanding awareness of their own biases and privilege, knowledge about other cultures and experiences of oppression, as well as the importance of empowering and advocating for clients (Beer et al., 2012; Collins et al., 2015; Sanabria & DeLorenzi, 2019; Singh et al., 2010). Others indicated the benefits of integrating feminist principles in treatment (Hoover & Morrow, 2016; Singh et al., 2010). Consciousness-raising and self-reflection were key parts of multicultural and social justice learning (Collins et al., 2015; Hoover & Morrow, 2016), and could be emotionally challenging. Indeed, Goodman et al. (2018) identified a theme of internal grappling reflecting students' experiences of intellectual and emotional struggle; others noted students' experiences of overwhelm and isolation (Singh et al., 2010), as well as resistance, such as withdrawing or dismissing information that challenged their existing belief system (Seward, 2019). Researchers have also documented student complaints about their social justice training; for example, that social justice is not well integrated or that there was inadequate coverage of skills and action (Collins et al., 2015). Kozan and Blustein (2018) found that even among programs that espouse social justice, there was a lack of training in macro level advocacy skills. Barriers to engaging in advocacy included: lack of time (Field et al., 2019; Singh et al., 2010), emotional exhaustion stemming from observations of the harms caused by systemic inequities (Sanabria & DeLorenzi, 2019), and ill-informed supervisors (Sanabria & DeLorenzi, 2019).

The studies reviewed thus relied on samples of mainly White, cisgender, heterosexual women. Some noted that education on social justice is often centered on helping White students expand their awareness (Haskins & Singh, 2015). In one study focused on challenges faced by students of color, participants expressed frustration with the lack of diversity among their professors, classmates, and curriculum (Seward, 2019). Participants also experienced marginalization and disconnection when professors and students made offensive or culturally uninformed comments and when course content focused on teaching students with privileged identities. Students from marginalized communities also face isolation in academic settings and sometimes question the multicultural competence of their professors (Haskins & Singh, 2015), which in turn contributes to the underrepresentation of students of color in counseling and psychology (Arney et al., 2019).

The Present Study

Counselor educators must critically examine their curriculum, course materials, and overall learning climate for students (Haskins & Singh, 2015). Listening to students' experiences and perceptions of their training offers faculty an opportunity to model cultural humility, gain useful feedback, and make necessary changes. Given the increased recognition of racial trauma and societal inequities, it is critical that counseling programs engage with students of diverse backgrounds as they seek to shift their pedagogy. Historically, academic institutions have responded to student demands with performative action rather than meaningful change (Zetzer, 2021). This mixed methods study is part of a larger process of counseling faculty working to invite student feedback and question internalized assumptions and biases in order to implement real change. The goal of program evaluation is to investigate strengths and weaknesses in order to improve the program (Royse et al., 2010). According to the 2024 Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards, program evaluation is essential to assess and improve the program (CACREP, 2023). Thus, the purpose of this program evaluation study was to understand students' self-assessment and experiences with the

counseling program's curriculum in the area of multicultural and social justice advocacy, with the overarching goal of program curriculum and instruction improvement. This article offers counselor educators a model of how to assess program effectiveness in multicultural and social justice teaching and practical suggestions based on the findings. The research questions were: What are beginning and advanced students' self-perceptions regarding their multicultural and social justice advocacy competencies? What are beginning and advanced students' perceptions of the multicultural and social justice advocacy competencies training they are receiving in their program?

Method

We employed a mixed method, embedded design in which the quantitative data offered a supportive and secondary role to the qualitative results (Creswell et al., 2003). Qualitative and mixed methods research designs are particularly useful in program evaluation (Royse et al., 2010). Mixed method approaches also offer value in research that centers social justice advocacy, as the integration of diverse methodological techniques within a single study fosters the understanding of multiple perspectives and facilitates a deeper comprehension of intricate issues (Ponterotto et al., 2013). We used an online survey to collect written narratives (qualitative) and survey data (quantitative) from two counseling courses: a beginning counseling course in the first semester (beginning students), and an advanced practicum course, taken by those who had completed at least part of their year-long practicum (advanced students).

Participants

Participants were counseling students enrolled in a CACREP-accredited program at a large West Coast public university in the United States that is both a federally designated Hispanic-serving institution and an Asian American and Native American Pacific Islander–serving institution. Responses were collected from two courses, which included 94 beginning students (84% response rate) and 62 advanced students (71% response rate). Twelve percent of the advanced practicum students also completed the survey when they were first-semester (beginning) students. The mean age of the 139 participants was 27.7 (SD = 7.11), ranging from 20 to 58 years. Racial identifications were 40.3% White, 33.1% Latinx, 14.4% Asian, 7.2% Biracial or Multiracial, 2.9% Black, 0.7% Middle Eastern, 0.7% American Indian/Alaska Native, and 0.7% Native Hawaiian/Pacific Islander. The majority identified as women (82.0%), followed by 14.4% as men, and 2.9% as nonbinary/queer. Students self-identified as heterosexual (71.2%), bisexual (11.5%), lesbian/gay (6.5%), queer (4.3%), pansexual (1.4%), and about 1% each as asexual, heteroflexible, and unsure. About 19.4% of students were enrolled in a bilingual/bicultural (Spanish/Latinx) emphasis within the program.

Procedure

After receiving university IRB approval, graduate students enrolled in the first-semester beginning counseling course (fall 2018 and 2019) or the advanced practicum course (summer 2019 and 2020) were asked to complete an online survey through Qualtrics with both quantitative measures and open-ended questions as part of their preparation for class discussion. Students were informed that this homework would not be graded and was not intended to "test" their knowledge but rather would serve as an opportunity to reflect on their experience of the program's multicultural and social justice training. Students were also given the option to participate in the current study by giving permission for their answers to be used. Those who consented were asked to continue to complete the demographic questionnaire. In accordance with the American Counseling Association *Code of Ethics* (2014), students were informed that there would be no repercussions for not participating. A faculty member outside the counseling program managed the collection of and access to the raw data in order to protect the identities of the students and ensure that their participation or lack of participation in the study could

not affect their grade for the course or standing in the program. All students, regardless of participation status, were given the option to enter an opportunity drawing for a small cash prize ($20 for data collection in 2018 and 2019, $25 for 2020) through a separate link not connected to their survey responses.

Data Collection

We collected brief written qualitative data and responses to two quantitative measures from both beginning and advanced students.

Qualitative Data

The faculty developed open-ended questions that would elicit student feedback on their multicultural and social justice training. Prior to beginning the counseling program, first-semester students were asked two questions about their experiences and impressions: How would you describe your knowledge about and interest in multiculturalism/diversity and social justice from a personal and/or academic perspective? and How would you describe your initial impressions or experience of the focus on multicultural and social justice in the program so far? They were also asked, if it was relevant, to include their experience in the Latinx counseling emphasis program component. Advanced students, who were seeing clients, were asked the same questions and also asked to: Consider/describe how this experience of multiculturalism and social justice in the program may impact you personally and professionally (particularly in work with clients) in the future.

Quantitative Data

Two instruments were selected to quantitatively assess students' perceptions of their own multicultural and advocacy competencies. The Multicultural Counseling Competence and Training Survey (MCCTS; Holcomb-McCoy & Myers, 1999) is designed to assess counselors' perceptions of their multicultural competence and the effectiveness of their training. The survey contains 32 statements for which participants answer on a 4-point Likert scale (*not competent*, *somewhat competent*, *competent*, *extremely competent*). Sample items include: "I can discuss family therapy from a cultural/ethnic perspective" and "I am able to discuss how my culture has influenced the way I think." The reliability coefficients for each of the five components of the MCCTS ranged from .66 to .92: Multicultural Knowledge (.92), Multicultural Awareness (.92), Definitions of Terms (.79), Knowledge of Racial Identity Development Theories (.66), and Multicultural Skills (.91; Holcomb-McCoy & Myers, 1999). In this study, the Cronbach's alpha coefficients ranged from .75 to .96.

The Advocacy Competencies Self-Assessment Survey (ACSA; Ratts & Ford, 2010) assesses for competency and effectiveness across six domains: (a) client/student empowerment, (b) community collaboration, (c) public information, (d) client/student advocacy, (e) systems advocacy, and (f) social/political advocacy. It contains 30 statements that ask participants to respond with "almost always," "sometimes," or "almost never." Sample questions include "I help clients identify external barriers that affect their development" and "I lobby legislators and policy makers to create social change." Although Ratts and Ford (2010) did not provide psychometrics of the original ACSA, it was validated with mental health counselors (Bvunzawabaya, 2012), suggesting an adequate internal consistency for the overall measure, but not the specific domains. In this study, the Cronbach's alpha coefficients ranged from .69 to.79 for the six domains, and .94 for the overall scale. For the purposes of this study, we were not interested in specific domains and used the overall scale to assess students' overall social justice/advocacy competencies.

Data Analysis

Qualitative Data Analysis

To analyze the qualitative data, we used Consensual Qualitative Research-Modified (CQR-M; Spangler et al., 2012), which was based on Hill et al.'s (2005) CQR but modified for larger numbers of participants with briefer responses. In contrast to the in-depth analysis of a small number of interviews, CQR-M was ideal for our data, which consisted of brief written responses from 139 participants. CQR-M involves a consensus process rather than interrater reliability among judges, who discuss and code the narratives, and relies on a bottom-up approach, in which categories (i.e., themes) are derived directly from the data rather than using a pre-existing thematic structure. Frequencies (i.e., how many participants were represented in each category) are then calculated. We analyzed the beginning and advanced students' responses separately, as the questions were adjusted for their time spent in the program.

After immersing themselves in the data, the first two authors, Sapna B. Chopra and Rebekah Smart, met to outline a preliminary coding structure, then met repeatedly to revise the coding into more abstract categories and subcategories. The computer program NVivo was used to organize the coding process and determine frequencies. After all data were coded, the fifth author, Eric W. Price, served as auditor and provided feedback on the overall coding structure. Both the consensus process and use of an auditor are helpful in countering biases and preconceptions. Brief quantitative data, as used in this study, can be used effectively as a means of triangulation (Spangler et al., 2012).

Quantitative Data Analysis

To examine for significant differences in the self-perceptions of multicultural competencies and advocacy competencies between White and BIPOC students as well as between beginning and advanced students, a two-way (2x2) ANOVA was conducted with the overall MCCT as the criterion variable and student levels (beginning, advanced) and race (White, BIPOC) as the two independent variables. In addition, two (5x2) multivariate analyses of variances (MANOVAs) were conducted with the five factors of multicultural competencies (knowledge, awareness, definition of terms, racial identity, and skills) as criterion variables and with student levels (beginning, advanced) and student races (White, BIPOC) as independent variables in each analysis. Data for beginning and advanced students were analyzed separately to assess whether time in the counseling program helped to expand their interest and commitment to social justice.

Research Team

We were intentional in examining our own social identities and potential biases throughout the research process. Chopra is a second-generation South Asian American, heterosexual, cisgender woman. Smart is a White European American, heterosexual, cisgender woman. Yuying Tsong identifies as a genderqueer first-generation Taiwanese and Chinese American immigrant. Olga L. Mejía is an Indigenous-identified Mexican immigrant, bisexual, cisgender woman. Price is a White, gay, cisgender male. All have experience as counselor educators and in qualitative research methods, and all have been actively engaged in decolonizing their syllabi and incorporating multicultural and social justice into their pedagogy.

Results

The research process was guided by the overarching question: What are beginning and advanced counseling students' perceptions of their multicultural and social justice competencies and training and how can their feedback be used to improve their counselor education program? We explore the qualitative findings first, as the primary data for the study, followed by the quantitative data.

Qualitative Findings for Beginning Counseling Students

Two higher-order categories emerged from the beginning students' narratives: developing competencies and learning process so far.

Developing Competencies

Students' descriptions of the competencies they were developing included themes of awareness, knowledge, and skills and action. Some students entered the program with an already heightened awareness, while others were making new discoveries. Awareness included subthemes of humility (24.5%), awareness of own privilege (6.4%), and awareness of bias (3.2%). "There's a lot to learn" was a typical sentiment, particularly from White students. One White female student wrote: "I definitely need more and I believe that open discussions, even hard ones would be some of the best ways to go about this." A large group expressed knowledge of oppression and systemic inequities (33%); a smaller group referenced intersectionality (3.2%). Within skills and action, some students expressed specific intentions in allyship (11.7%); a number of students expressed commitment to social action but felt unsure how to engage in social justice (11.7%).

Learning Process So Far

Central themes in this category were support for growth, concerns in training, and internal challenges. Some students felt excited and supported, while some were cautiously optimistic or concerned. Support for growth was a strong theme that reflected excited and enthusiastic to learn (22.3%); appreciation for the Latinx emphasis (18.1%); and receiving support from professors and program (17.0%). For example, one Mexican student in the Latinx emphasis who noted that mental health was rarely discussed in her family shared: "For me to see that there is a program that teaches students how to communicate to individuals who are unsure of what counseling is about, gave me a sense of happiness and relief."

A few students were adopting a wait-and-see attitude and expressed some concerns about their training. Although the percentage for these subthemes is low, they provide an important experience that we want to amplify. This theme had multiple subthemes. The subtheme concerns from students of color included centering White students (3.2%), microaggressions (3.2%), and lack of representation (1.1%). A student who identified as a Mexican immigrant shared experiences of microaggressions, including classmates using a hurtful derogatory phrase referring to immigrants with no comment from the professor until the student raised the issue. Concerns in training also included the subtheme concerns with how material is presented in classes (7.0%). For some, the concern related to the potential for harm in classes in which White and BIPOC students were encouraged to process issues of privilege and oppression. For example, one Asian Pacific Islander student wrote that although they appreciated the emphasis on social justice, "Time always runs out and I believe it's careless and dangerous to cut off these types of conversations in a rushed manner." A small minority seemed to suggest a backlash to the emphasis on social justice, stating that the content was presented in ways that were too "politically correct," "biased," or "repetitive."

Multiple subthemes emerged from the theme of internal challenges. Both BIPOC and White students shared feeling afraid to speak up (5.3%). BIPOC students expressed struggling with confidence or wanting to avoid conflict, while White students' fear of speaking up was also connected to discomfort and uncertainty as a White person (2.1%). A small minority of White students did not express explicit discomfort but seemed to engage in a color-blind strategy, as indicated in the theme of people are people (2.1%): "I find people are people, regardless of any differences, and love hearing the good and bad about everybody's experiences." Some students of color expressed limited knowledge about cultures other than one's own (4.3%). For example, an Asian American student stated that they had gravitated to "those who were most similar to me" growing up. Lastly, a few students shared feeling overwhelmed and exhausted (3.2%).

Qualitative Findings for Advanced Counseling Students

Four higher-order themes emerged: competencies in process, multiculturalism and diversity in the program, social justice in the program, and the learning process.

Competencies in Process

Similar to beginning students, advanced students described growing self-awareness, knowledge and awareness of others, skills, and action. Their disclosures often related to clinical work, now that they had been seeing clients. Self-awareness included strong subthemes of: humility and desire to keep learning (25.8%); increased open-mindedness, acceptance of others, and compassion (22.6%); awareness of personal privilege and oppression (17.7%); awareness of personal bias and value systems (17.7%); and awareness of personal cultural identity (14.5%). One Mexican American student wrote: "I have also gained an increased awareness of how my prejudices can impact my work with clients and learned about how to check-in with myself."

Knowledge and awareness of others had subthemes of privilege and oppression (19.4%) and increased knowledge of culture (14.5%), with awareness of the potential impact on clients. The advanced students also had more to say about skills, which included subthemes of diversity considerations in conceptualization (29%), and in treatment (12.9%), and cultural conversations in the therapy room (21%). One White student wrote: "I have been able to have difficult conversations that once were unheard of. I have also been able to bring culture, ethnicity, and oppression into the room so that my clients can feel understood and safe." Within the theme of action, 52% wrote about their commitment to social justice and intention to advocate. Although this strongest subtheme suggested action was still more aspirational than currently enacted, a smaller group also wrote about the experiences that they have already had with client advocacy (12.9%), community and/or political action (12.9%), and unspecified action (11.3%).

Multiculturalism and Diversity in the Program

Many students (44%) indicated that they appreciated that multicultural issues were integrated or addressed well within the program. However, with more time spent in the program, 26% felt that there was more nuance, depth, or scope needed. Some wanted more attention to specific issues, such as disability, gender identity, and religion/spirituality. One Asian American student wrote that the focus had been "basic and surface-level," adding "I feel like it has also generally catered to the protection of White feelings and voices, which is inherently complicit in the system of White supremacy, especially in higher ed." Others (9.7%) said more training in clinical application was needed.

Social Justice in the Program

Students expressed a variety of opinions. The largest number (29%) were satisfied that social justice issues were well integrated into the program. Although more students were satisfied than not, many (24%) noted that social justice is addressed but not demonstrated. Similarly, 24% noted minimal attention, specifically that social justice was not addressed much beyond the one course focused on culture, and 24% noted a desire for more opportunities within the program to engage in advocacy. Some suggested requiring social justice work rather than leaving it as an optional activity. Others (13%), mostly from 2020, noted the relevance of current events and sociopolitical climate. One White student shared about a presentation on Black Lives Matter: "This project opened my eyes to my limited knowledge of systemic oppression in the U.S. and impacted me in ways that I will NEVER be the same." A small number of students (3%) reported that there was no need or room for more training in social justice. One White student wrote that they felt "frustrated" and that the social justice "agenda is so in my face all the time," adding "sometimes I feel like I am being trained to be an advocate and an activist, which is/are a different job."

The Learning Process

Three central themes emerged: enrichment experienced, challenges, and suggestions for change. Many students were appreciative of their experience. A strong subtheme within enrichment experienced was professors' encouragement and modeling (24%). Others commented on how much came from learning from peers (21%). Some shared feeling personally empowered (14.5%). For example, a student who identified as coming from an Asian culture wrote about the hesitancy to be an activist, stating, "There is an underlying belief that our voices will not really ever be heard which is strongly tied to systemic oppression and racism throughout history. Consequently, I appreciate this challenge to grow more in social justice issues." Others shared ways that the program prompted them to engage in social justice outside the classroom (11.3%). For example, one student wrote: "This program gave me the knowledge and education I needed to make sure that when I did speak out I wasn't just talking to talk. I would actually have facts, stats, evidence-based research to back up my argument." A number of students noted the unique benefits of the Latinx program (9.7%). One Mexican American student reflected that they had learned about diversity within Latinx cultures, and that, "As a result, I feel more confident in being able to serve clients from various Latinx cultures or at least know where to obtain relevant information when needed." Many students expressed a sense of belonging (8.1%).

Challenges. Nearly 10% wrote about struggling to make time [for social justice] and 6.5% noted the emotional impact. For example, one White student wrote: "It was a rude and brutal awakening, to say the least. It was riddled with emotion and heartache but was worth the process." A few had conflicted or mixed feelings (8.1%)—they felt appreciative but wanted more. A few noted possible harm to marginalized students (6.5%). One Asian American student wrote that faculty should be "calling out microaggressions . . . otherwise, their stance on social justice feels more performative and about protecting their own liability rather than caring for their students of color." A smaller number (4.8%) struggled with peers and colleagues who seemed uninformed.

Suggestions for Change. Students offered suggestions for improvement, with a strong theme to develop more diverse representation (16.1%), including more representation in faculty, students, case examples, and class discussions. Some comments were specifically about needed attention to Black experiences; one concerned teaching about resiliencies and strengths in the face of oppression. Almost 15% suggested making changes to courses or curriculum. One White student wrote: "If it were me running the program (lol) I would . . . remove the culture class and have all those topics embedded into the fabric of each class because culture and diversity are in all those topics." A few suggested that

faculty require social justice assignments (8.1%), adding that many students will not act unless required. A few also suggested that the program provide more education of White students (8.1%).

Quantitative Findings

Quantitative analyses were conducted to provide triangulation for the qualitative findings and a different view of the data, including possible differences between BIPOC and White students and beginning and advanced students. Table 1 includes descriptive statistics providing an overview of beginning and advanced students' self-perception of their multicultural and social justice competencies.

Table 1

Descriptive Statistics of Competencies

			Multicultural		Social Justice/Advocacy	
		N	Mean	*SD*	Mean	*SD*
White	Beginning	35	2.58	.50	62.97	24.23
	Advanced	27	3.09	.38	76.07	19.11
	Total	62	2.80	.52	68.68	22.93
BIPOC	Beginning	59	2.66	.56	63.05	29.30
	Advanced	35	3.01	.30	77.14	20.71
	Total	94	2.79	.51	68.30	27.19
Total	Beginning	94	2.63	.54	63.02	27.39
	Advanced	62	3.05	.34	76.68	19.87
	Total	156	2.80	.51	68.45	25.51

To examine if there were discernable differences between the beginning and advanced students' perceptions of their competencies, and if there were differences between White and BIPOC students, a two-way (2x2) ANOVA was conducted with the overall MCCT as the criterion variable and student levels (beginning, advanced) and race (White, BIPOC) as the two independent variables. Results indicated that although there were no interaction effects between race and student levels, there were significant differences in overall multicultural competencies between beginning and advanced students, $F(1, 152) = 30.54$, $p < .001$, indicating that advanced practicum students reported significantly higher overall multicultural competencies than beginning students. There were no statistically significant differences between White and BIPOC students in their overall multicultural competencies. Two (5x2) MANOVAs were conducted with the five factors of multicultural competencies as criterion variables (knowledge, awareness, definition of terms, racial identity, and skills). Student levels (beginning, advanced) and student race (White, BIPOC) were independent variables. Results indicated that there were significant differences between beginning and advanced students in at least one of the multicultural competencies components, Wilks' Lambda = .72, $F(5, 150) = 11.97$, $p < .001$. More specifically, follow-up univariate ANOVAs indicated that advanced students reported significantly higher multicultural competencies in their knowledge, $F(1, 154) = 43.74$, $p < .001$, $\mu^2 = .22$; awareness, $F(1, 154) = 6.20$, $p = .014$, $\mu^2 = .04$; and racial identity, $F(1, 154) = 43.17$, $p < .001$, $\mu^2 = .21$. However, there were no significant differences in definitions of terms or skills. Even though there were no significant

differences between White and BIPOC students in their overall multicultural competencies, the results of the 5x2 MANOVA indicated that there were significant differences in at least one of the components, Wilks' Lambda = .87, $F(5, 150) = 4.49$, $p = .001$. Follow-up univariate ANOVAs indicated that White students reported higher multicultural competencies in racial identity than BIPOC students in this study, $F(1, 154) = 4.51$, $p = .035$, $\mu^2 = .03$. There were no differences in the other areas.

A two-way (2x2) ANOVA was conducted with the overall ACSA as the criterion variable and student levels (beginning, advanced) and race (White, BIPOC) as the two independent variables. Results indicated that while there were no interaction effects between race and student levels, there were significant differences in overall advocacy competencies between beginning and advanced students, $F(1, 152) = 10.78$, $p = .001$, indicating that advanced students reported significantly higher overall advocacy competencies ($M = 76.68$) than beginning students ($M = 63.02$). There were no statistically significant differences between White and BIPOC students in their overall advocacy competencies.

Discussion

This study was designed to examine students' experiences of their multicultural and social justice training as an aspect of program evaluation, specifically to assist faculty in improving curriculum and instruction with regard to multicultural and advocacy competencies; the study also offers a unique contribution to existing literature by including a more racially diverse (60% BIPOC) sample. Students reported growth in the core areas of multicultural and social justice competency as outlined by Ratts et al. (2016): awareness, knowledge, skills, and action. Consistent with Field et al.'s (2019) findings, students reported more growth in awareness and knowledge than in social justice action, with some differences as students moved through the program. Although beginning students identified personal biases, the theme of self-awareness was more complex for them later in the program. This suggests that a longer time spent in the program contributed to personal growth; although this seems expected, these outcomes have not necessarily been examined before and confirm that the programs' increasing effort on multiculturalism and social justice are showing gains. The advanced students wrote about clinical application as well and made overt statements of their commitment to social justice. The quantitative results supported these qualitative findings, with advanced students reporting higher multicultural competencies in knowledge, awareness, and racial identity and higher overall advocacy competencies compared to beginning students. With one exception, there were no significant differences between White and BIPOC students in their self-assessment of multicultural or advocacy competencies. Across racial groups, students expressed humility and desire to learn more.

Although students expressed mixed opinions about their experience of the multicultural and social justice training, a greater number of advanced students reported that they thought multicultural (44%) and social justice issues (30%) were well integrated into the program compared to the number of students with critiques. Students reported that support from faculty and peers facilitated their growth and learning, consistent with previous research (e.g., Beer et al., 2012; Keum & Miller, 2020). Some students noted a sense of belonging, particularly those in the Latinx emphasis.

Similar to other researchers, we found that many students wanted social justice issues to be integrated across the curriculum rather than into one course (Beer et al., 2012; Collins et al., 2015); they also wanted more focus on skills and action (Collins et al., 2015; Kozan & Blustein, 2018). Students' scores on the ACSA advocacy competencies scale reflect this gap in training as well. Though fewer students offered critiques of their training, these responses are important to amplify because some of these concerns are rarely solicited or acknowledged. For example, BIPOC students echoed the challenges faced by students

in Seward's (2019) study, including lack of representation in their faculty, classmates, and curriculum as well as feelings of marginalization when microaggressions in the classroom went unchecked and when instruction centered the needs of White students. Additionally, a few advanced students from 2020, during a time of significant racial-sociopolitical uprising in the United States, expressed concern that class discussions potentially caused harm to students from marginalized communities. Though more students expressed a desire for greater in-depth training, a small minority of mostly White students indicated that they did not want more social justice training and would rather focus solely on traditional counseling skills. These different student perspectives point to the challenges of teaching social justice amidst diverse political and ideological backgrounds and the need to increase community and collaboration.

Listening to Student Feedback and Implications for Decolonizing Program Curriculum

This study's findings support the benefits of listening to students' voices related to multicultural and social justice to inform counselor educators on program strengths and areas for growth. Although student feedback was not the sole impetus for making program changes, accessing this more detailed response was helpful in refining our purpose and direction, as well as highlighting weaknesses. Perhaps more important was the faculty's willingness to engage in this self-reflective process and to take necessary actions. Rather than waiting for exit interview feedback from graduating students, counselor educators can conduct ongoing program evaluations through anonymous online surveys as well as town hall meetings that invite students to share their process of learning, perceptions of the cultural climate, and experiences of microaggressions. We have a growing understanding that during such evaluations great care needs to be taken for building safety, so as not to retraumatize students from marginalized communities. Based on the results and a series of Zoom town hall meetings, we have implemented changes, such as more consistent integration of social justice across the curriculum; training and day-long retreats focused on increasing faculty competence; faculty participation in Academics for Black Survival and Wellness, an intensive training led by Dr. Della Mosely and Pearis Bellamy; accountability support groups in social justice work; and decolonizing syllabi and class content (e.g., including BIPOC voices and non–APA-style writing assignments). Faculty have also made significant modifications to course materials. For example, beginning students complete weekly modules that include readings and exercises from *The Racial Healing Handbook* (Singh, 2019), and students study Liberation Psychology during the first week of theories class so they can consider ways to decolonize more traditional models throughout the semester. These strategies have been helpful in preparing students for more difficult conversations surrounding anti-racism in more advanced courses throughout the program. Forming faculty accountability partners or small groups is helpful so that faculty can support each other as a part of their ongoing development in addressing internalized White supremacy and avoiding harm to students.

Student feedback also called attention to the need for self-care, which our program continues to explore. Consistent with previous research (Collins et al., 2015; L. A. Goodman et al., 2018; Hoover & Morrow, 2016; Singh et al., 2010), students reported that their multicultural and social justice learning was often accompanied by moments of overwhelm, hopelessness, and despair. Without tools to manage these emotions, some students may retreat into defensiveness and withdrawal (Seward, 2019), and some may experience activist burnout (Gorski, 2019). Sustainability is necessary for effective social change efforts (Toporek & Ahluwalia, 2021). Counseling programs can offer resources and guidance for students to practice self-care with counselor educators modeling self-care behavior. For example, the Psychology of Radical Healing Collective (Chen et al., 2019) offered strategies to practice radical self-care, including making space for one's own healing, finding joy and a sense of belonging, and engaging in advocacy at the local community level. Mindfulness practices can be integrated into social justice

education to help students and counselor educators manage difficult emotions, increase their ability to be present, and strengthen compassion and curiosity (Berila, 2016). In addition to individual self-care practices, counselor educators can advocate for community care by tending to the community's needs and drawing on collective experience and wisdom (Gorski, 2019).

The findings point to the need for counselor educators to better address Whiteness and White supremacy, as well as to center the experiences of students from marginalized communities. Counselor educators may be able to mobilize and direct White students' feelings of guilt into racial consciousness and action by helping them explore Whiteness, White privilege, and what it means to them while allowing and confronting feelings that arise (Grzanka et al., 2019). It may be helpful for educators to read and assign books on White fragility and ways to address it (DiAngelo, 2018; Helms, 2020; Saad, 2020), so that they can assist White students in managing these emotions. It is important that educators explicitly name and recognize White supremacy as it shows up in counseling theory and practice, and to include a shift from the primary focus on the individual to understanding and dismantling oppressive systems. Counselor educators must also attend to the ways in which they center the comfort of White students over the needs of BIPOC students, so that they do not perpetuate harm and trauma (Galán et al., 2021). Although students with privileged identities may learn powerful lessons about oppression from their classmates, it is important that such learning does not occur at the expense of students with marginalized identities. Offering spaces for White students, especially those who are new to conversations about race and racism, to process their feelings may be helpful to avoid harm to BIPOC students who have experienced racial trauma. Similarly, BIPOC students may benefit from spaces in which they can talk freely and support each other as they unpack their own experiences of microaggressions and trauma (Galán et al., 2021).

Based on the finding that support from faculty was important in facilitating student growth and learning, counselor educators may benefit from implementing strategies informed by relational pedagogy and relational–cultural theory (Dorn-Medeiros et al., 2020). Relational pedagogy centers the relationship between teachers and students and posits that all learning takes place in relationships. Relational–cultural theory emphasizes mutual empathy and empowerment and is rooted in feminist multicultural principles. Practices grounded in these approaches include professors' use of self-disclosure to model openness, vulnerability, and self-reflection; and their work to reduce power imbalances and invite student feedback at multiple points in time through anonymous surveys and one-on-one meetings. Counselor educators can uplift students as the experts of their experience (Sharma & Hipolito-Delgado, 2021).

Limitations and Future Research

The results of this study must be considered in light of a number of limitations. The use of the online survey meant that we were not able to follow up with students for further discussion or clarification of their responses. Adding focus groups or interviews to this methodology would likely provide a more thorough picture. In spite of assurances to the contrary, some students may have been hesitant to be honest out of concern that their own professors would be reading their feedback. It is possible that different themes would have emerged if all students had participated. In addition, 12% of the advanced students had participated as beginning students and therefore were previously exposed to the survey materials. Although this could have impacted their later responses, we suspect that given the nearly 2-year time lapse this may not have been meaningful. Nevertheless, future research and program evaluation would be strengthened with longitudinal analyses. Lastly, the reliability for the ACSA was relatively low, so conclusions are tentative; however, the results support the qualitative data. Despite these limitations, this study offers a model for assessing students' learning and experiences with the

goal of program improvement. The process of counselor educators humbling themselves and inviting and integrating student feedback is an important step in decolonizing counselor education and better serving students and the clients and communities that they will serve.

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Adverse Childhood Experiences of Professional School Counselors as Predictors of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

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School counselors work closely with students and are often the first point of contact regarding traumatic experiences. It is generally understood that exposure to other individuals' trauma may lead to a reduction in compassion satisfaction and an increase in secondary traumatic stress, while long-term exposure may result in professional burnout. This study examined the role of school counselors' (*N* = 240) own adverse childhood experiences (ACEs) as related to compassion satisfaction, secondary traumatic stress, and burnout. Results indicated that 50% of the professional school counselors in this convenience sample had personal histories of four or more ACEs, which is significantly higher than the general public and passes the threshold for significant risk. Results indicated that the ACEs of school counselors in the present study, as well as some demographic variables, significantly correlated with rates of compassion satisfaction, secondary traumatic stress, and burnout.

Keywords: **school counselors, compassion satisfaction, secondary traumatic stress, burnout, adverse childhood experiences**

As counselors in PK–12 settings, professional school counselors (PSCs) are uniquely positioned to deliver comprehensive school counseling programs that attend to all students' academic and social/emotional needs (American School Counselor Association [ASCA], 2019). Providing these comprehensive services may lead to burnout and secondary traumatic stress, which can adversely impact PSCs' ability to meet students' academic and social/emotional needs (Mullen & Gutierrez, 2016). Although research has examined various factors that may contribute to burnout such as caseload, lack of administrative support, and tasks unrelated to school counseling (Bardhoshi et al., 2014; Fye, Bergen, & Baltrinic, 2020; Fye, Cook, et al., 2020), few studies have examined whether personal historical factors such as childhood adversity may be related to burnout and secondary traumatic stress. Though self-care is often encouraged in counselor education programs and promoted among practitioners (American Counseling Association [ACA], 2014; Council for the Accreditation of Counseling and Related Educational Programs [CACREP], 2015), we lack knowledge of which PSCs may be more vulnerable to burnout or secondary traumatic stress (Coaston, 2017). Therefore, it is important that we better understand whether a PSC's own historical experiences of adversity or trauma may make them more susceptible to burnout and secondary traumatic stress, as this may impact their ability to meet students' needs.

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) encompass 10 maladaptive childhood experiences, including physical abuse, emotional abuse, sexual abuse, substance abuse, physical neglect, emotional neglect, divorce, incarcerated family member, household mental illness, and domestic abuse (Crandall et al.,

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2020; Felitti et al., 1998). Researchers have found that ACEs have the propensity to shape life beyond childhood, often playing a pivotal role in adult development. Several studies have outlined the dangers of multiple ACEs and negative outcomes in adulthood (Crandall et al., 2020; Felitti et al., 1998). Felitti and colleagues' (1998) seminal study found that ACEs are common, 55.4% of the population having at least one ACE, and 6.2% reporting four or more ACEs. A growing number of subsequent studies have found that ACEs have a dose–response effect, in which a 1-point increase (using a 10-point scale) in one's ACE score significantly increases the chance of deleterious mental and physical effects in adulthood (Boullier & Blair, 2018; Felitti et al., 1998; Merrick et al., 2017).

Scholars have found that those with four or more ACEs have a 4- to 12-fold increase in deleterious mental and physical outcomes such as depression, anxiety, addiction, and suicide attempts (Crandall et al., 2020; Crandall et al., 2019; Felitti et al., 1998). Researchers have investigated both the dose–response effect and the pervasive nature of ACEs, suggesting that they may be predictive of long-term mental health impacts. Broadly, adults who were exposed to multiple ACEs were more likely to have three or more mental health disorders such as depression, anxiety, substance addiction, suicidality, and PTSD (Atzl et al., 2019; Fellitti et al., 1998). This is especially detrimental for minoritized persons, as two large U.S. samples of over 200,000 adults have shown that Black and Latine persons, sexually minoritized individuals, and those coming from lower socioeconomic status (SES) had significantly higher levels of ACEs than White persons, heterosexual individuals, and those coming from middle- to upper-class SES backgrounds (Giano et al., 2020; Merrick et al., 2017). Giano et al. (2020) also found that women had significantly higher rates of ACEs as compared to men. Given that childhood experiences may be a critical determinant of mental health in adulthood, individuals with marginalized identities may be at greater risk for negative long-term mental health outcomes (Giano et al., 2020).

ACEs can also impact job function and satisfaction, financial stability, and increased absences (Anda et al., 2004). Of all the helping professions, researchers note that mental health professionals have some of the highest recorded rates of ACEs (Redford, 2016; Thomas, 2016); however, it is unknown how this relates specifically to the school counseling profession. PSCs serve students in a variety of ways to help students fulfill their academic and social/emotional needs (ASCA, 2019). This ability to provide services may be impacted by professional functioning. The *ASCA Ethical Standards for School Counselors* require PSCs to monitor their emotional and physical health while maintaining wellness to ensure effectiveness (ASCA, 2022). However, researchers note that many counselors do not routinely prioritize their own wellness (Coaston, 2017). Therefore, it is important to understand the effect ACEs have on PSCs to ensure that PSCs can meet student needs.

Burnout

Burnout can occur when a PSC feels depleted of their capacity to perform at a high level due to feelings of incompetence, fatigue, or extreme pressures from their work environment (Mullen & Gutierrez, 2016). Due to high student-to-counselor ratios, diminished counselor self-efficacy, job dissatisfaction, and non-counseling duties, PSCs run the risk of experiencing counselor burnout (Holman et al., 2019; Mullen et al., 2017; Rumsey et al., 2020). Bardhoshi et al. (2014) reported organizational factors such as lack of administrator support, the incapability to meet designated annual goals, and non-counseling duties were associated with burnout, whereas Fye, Bergen, and Baltrinic (2020) found that PSCs with fewer years of counseling experience are more prone to burnout.

Identity factors such as gender, race, and SES have been examined in relation to burnout (Fye et al., 2022); however, these factors have not been evaluated within the context of PSCs' own personal historical experiences, such as their ACEs. Fye et al. (2022) examined demographic and organizational factors on a multidimensional model of wellness, revealing that there were no large systemic differences

in wellness due to gender and race/ethnicity; however, individual elements of the wellness model were significant. One study has shown that male BIPOC counseling students report higher levels of exhaustion compared to female BIPOC counseling students (Basma et al., 2021).

Secondary Traumatic Stress

As students continue to experience traumatic events happening in and outside of school, PSCs are often immersed in the traumatic experiences of their students. This consistent exposure could have an impact on school counselors professionally. Indirect exposure to trauma stemming from students' trauma, witnessing others' trauma, or being exposed to graphic material is considered secondary exposure (Fye, Cook, et al., 2020; Padmanabhanunni, 2020). When PSCs attend to student trauma and become fixated, overwhelmed, or burdened, they can experience burnout and secondary traumatic stress (Rumsey et al., 2020). Yet, similar to Fye, Cook, et al.'s (2020) study on burnout, Rumsey et al. (2020) found that years of school counseling experience is negatively correlated with secondary exposure and secondary traumatic stress. School counselors with more years of experience are less likely to be affected by secondary traumatic stress (Rumsey et al., 2020). As PSCs are often the first point of contact regarding PK–12 students' mental health in the aftermath of a traumatic event, additional research is needed regarding PSCs' experiences of secondary traumatic stress. Presently, there is a gap in the literature regarding how demographic factors and PSCs' own ACEs scores predict positive and negative job-related outcomes; therefore, it would be advantageous to learn how ACEs and demographic factors, such as gender, race, or SES, might influence compassion satisfaction, burnout, and secondary traumatic stress.

Compassion Satisfaction

Since the original ACEs study, researchers have turned toward identifying protective factors that may mitigate the effects of harmful childhood experiences. Firstly, compassion satisfaction, while studied limitedly, may serve as a protective factor against burnout and secondary traumatic stress (Stamm, 2010). Compassion satisfaction is defined as a psychological benefit derived from working effectively with clients/students to produce meaningful and positive change in their lives (Stamm, 2010). Researchers note the dearth of literature surrounding gender, race/ethnicity, and PSC wellness, as well as systemic gender and race/ethnicity-related barriers to wellness that exist for PSCs (Bryant & Constantine, 2006; Fye et al., 2022). Currently, the relationship between burnout, secondary traumatic stress, and compassion satisfaction in PSCs with ACEs is unclear.

Brown et al. (2022) conducted a study on ACEs, positive childhood experiences (PCEs), and compassion satisfaction, burnout, and secondary traumatic stress with a diverse national sample of 140 clinical mental health counselors (CMHCs). They found that 43% of participants had four or more ACEs and over 70% had five or more PCEs (Brown et al., 2022). Results from this study found that higher ACEs scores predicted lower compassion satisfaction, but racially minoritized CMHCs, those coming from lower childhood SES, and female CMHCs had higher rates of compassion satisfaction as compared to CMHCs who identified as White, coming from middle- or upper-class SES backgrounds, or male. Furthermore, higher ACEs scores predicted higher rates of burnout, and higher PCEs predicted less burnout (Brown et al., 2022). The relationship between PSCs' own identity factors (e.g., gender, race/ethnicity, and childhood SES) and childhood experiences on job-related outcomes (e.g., compassion satisfaction, burnout, and secondary traumatic stress) remains unstudied.

The purpose of this study was to examine the effects of early childhood experiences on the professional quality of life of PSCs. We focused on the rates of ACEs and demographic variables of PSCs and their relationship to burnout, secondary traumatic stress, and compassion satisfaction. We aimed to answer the following research questions (RQs): 1) What are the mean rates of ACEs, compassion

satisfaction, burnout, and secondary traumatic stress among PSCs? 2) To what extent do PSCs' ACEs and demographic variables predict compassion satisfaction, burnout, and secondary traumatic stress? and 3) After separating the participants into two groups (PSCs with three or fewer ACEs and those with four or more ACEs), to what extent do PSCs' ACEs and demographic variables predict compassion satisfaction, burnout, and secondary traumatic stress?

Method

Using a cross-sectional, non-experimental correlational design, we reported descriptive statistics (means; RQ 1) and multiple regression models (predictive relationships; RQs 2 and 3). Using G*Power 3.1.9.6, we calculated an a priori power analysis with a .05 alpha level (Cohen, 1988; 1992), a medium effect size for multiple R^2 of .09 (Cohen, 1988), and a power of .80 (Cohen, 1992). This power analysis revealed a target number of participants (N = 138).

Participants

An invitation letter and informed consent document through Qualtrics outlined criteria for school counselors to participate in the study: age 18 and up who work 30 hours or more a week in the field of school counseling. Authors Eric M. Brown, Melanie Burgess, and Kristy L. Carlisle sent Qualtrics invitations to the study through social media, such as X (formerly Twitter), Facebook, and Instagram. We recruited 240 school counselors who met criteria. We could not calculate a response rate because it was impossible to track responses through social media. The majority (62.9%; n = 151) of participants identified as White. The mean age of the participants in the sample was 35 with a range of 23 to 55. Gender was split almost evenly with 50.8% (n = 122) male and 48.3% (n = 116) female. More than half (60%; n = 144) reported a childhood SES of lower or working class, while only 2.9% (n = 7) reported current lower class, and the majority (56.7%; n = 136) reported current middle class. More demographic information is included in Table 1.

Table 1

Participant Demographics

Characteristic	% (n)
Sex	
Male	50.8 (122)
Female	48.3 (22)
Transgender or Other Gender	0.8 (2)
Race/Ethnicity[a]	
African American or Black	7.9 (19)
American Indian/Native American	2.1 (3)
Arab American/Middle Eastern	1.7 (4)
Asian/Asian American	1.7 (4)
Asian Indian	3.3 (8)
Hispanic/Latinx	23.3 (56)
Pacific Islander	0.4 (1)
White	62.9 (151)
Childhood Socioeconomic Status	
Lower or Working Class	60.0 (144)
Middle Class	33.8 (81)
Upper Middle/Upper Class	5.0 (12)

Note. N = 240.
[a] For statistical purposes in SPSS, we grouped PSCs as Minoritized and White.

Instrumentation

In addition to a demographic questionnaire, we used instruments with strong psychometrics to measure ACEs, compassion satisfaction, burnout, and secondary traumatic stress.

Adverse Childhood Experiences (ACEs) Questionnaire

Felitti et al. (1998) developed the ACEs Questionnaire to identify instances of abuse and neglect in childhood. The 10-item questionnaire has good test–retest reliability (Dube et al., 2004) and Cronbach's alpha coefficient of .78 in one study (Ford et al., 2014) and .90 (Mei et al., 2022) in another. Its structural validity passed invariance tests across demographics, exceeding all thresholds (CFI = .986, TLI = .985, RMSEA = .021, SRMR = .066; Mei et al., 2022). Participants self-report instances of ACEs from 0 to 10, with higher scores indicating higher risk for mental and physical ailments and prohibited quality of life. Serious risk is indicated by a score of 4 or higher (Dube et al., 2004).

Professional Quality of Life Scale (ProQOL)

Stamm (2010) created a 30-item questionnaire measuring compassion satisfaction, burnout, and secondary traumatic stress and reported Cronbach's alpha scores of .88 for compassion satisfaction, .75 for burnout, and .81 for secondary traumatic stress. Heritage et al. (2018) found good item fit and invariance across demographics in demonstration of construct validity. The ProQOL subscales are described as being low (22 or less), moderate (23–41), or high (42 or higher). Positive feelings about helping ability (compassion satisfaction) are measured with scores of 22 or lower indicating problems. Exhaustion, frustration, and depression (burnout) are measured with scores 42 and higher showing impairment at work. Fear and trauma from work (secondary traumatic stress) are measured with scores 42 and higher indicating fear resulting from work.

As a widely used instrument, recent researchers have offered several critiques, including a four-factor structure with burnout as two latent subscales, traditional burnout and emotional well-being (Sprang & Craig, 2015), or interpreting compassion fatigue and compassion satisfaction to be on opposite ends of one spectrum (Geoffrion et al., 2019). Fleckman et al. (2022) used the ProQOL in their sample of PK–12 teachers and did not achieve a sufficient model fit; therefore, they posited that the ProQOL may be more appropriate for human service and mental health professionals compared to educators. Because PSCs are mental health professionals working in education settings, we used the instrument as it was originally designed with the three separate constructs of compassion satisfaction, burnout, and secondary traumatic stress.

Procedure

Our Institutional Review Board approved the current study. Purposeful sample methods included use of a purchased data set of 6,000 counselors' emails as well as postings on Facebook groups for PSCs. All potential participants received an informed consent document and a Qualtrics link to the three instruments and demographic questionnaire. After data cleaning (i.e., removal of cases with incomplete responses on the instruments) produced 240 usable cases, we computed scores from the instruments and checked assumptions for multiple regression using SPSS 28. Reliability for each instrument showed Cronbach's alpha score of .86 and an omega score of .87 for the ACEs Questionnaire and .81 Cronbach's alpha and .82 omega scores for the ProQOL.

Data Analysis and Results

RQ 1 asked for mean scores of ACEs, compassion satisfaction, burnout, and secondary traumatic stress. We calculated a mean ACEs score of 3.68, 95% CI [3.2854, 4.0330] for PSCs, lower than the threshold of 4 and thus just below the range for significant risk. However, 50.42% of participants

(*N* = 121) reported an ACEs score of 4 or more. Minoritized PSCs had a particularly higher ACEs score (4.9) than White PSCs (2.96). Females had a higher ACEs score (4.14) than males (3.23). Finally, participants with lower childhood SES (low or working) had slightly lower ACEs scores (3.41) than those with higher SES (middle and upper; 3.82 and 5.04). Then we investigated mean scores of PSCs' compassion satisfaction, burnout, and secondary traumatic stress. For compassion satisfaction, they scored 30.93, 95% CI [30.1798, 31.6785]. When we explored burnout, they scored 27.58, 95% CI [26.2399, 28.2184]. Finally, they showed a mean secondary traumatic stress score of 31.49, 95% CI [30.6610, 32.3223]. PSCs on average have moderate levels of compassion satisfaction, burnout, and secondary traumatic stress.

RQ 2 asked about predictive relationships of ACEs, gender, race/ethnicity, and SES on compassion satisfaction, burnout, and secondary traumatic stress. Three linear regression models, one for each subscale, all produced significant results. Model 1 ran a regression of compassion satisfaction on ACEs, gender, race/ethnicity, and childhood SES, explaining 27.7% of the variance in compassion satisfaction, $F(5, 225) = 17.214$, $p < .001$. Gender ($\beta = -0.331$), race/ethnicity ($\beta = -0.125$), and childhood SES ($\beta = 0.180$) significantly predicted compassion satisfaction. ACEs showed nonsignificant results in this model. Being female, being racially minoritized, and having higher childhood SES predicted higher compassion satisfaction (see Table 2).

Table 2

Regression Results: Coefficients (compassion satisfaction, burnout, secondary traumatic stress)

	β	*Std. Error*	*Beta*	*T*	*Sig*
Compassion Satisfaction (Constant)	26.298	1.682	--	15.631	< .001
ACE	0.010	0.121	.006	0.086	= .931
Gender[a]	-3.859	0.704	-.331*	-5.483	< .001*
Race[b]	-1.514	0.746	-.125*	-2.029	= .044*
Childhood SES[c]	2.149	0.711	.180*	-3.021	= .003*
$R^2 = .277$ ($p < .001$)					
Burnout (Constant)	27.052	1.583	--	17.089	< .001
ACE	0.176	0.114	.107	1.544	= .124
Gender[a]	1.714	0.662	.169*	2.588	= .010*
Race[b]	2.940	0.702	.279*	4.189	< .001*
Childhood SES[c]	-0.175	0.669	-.017	-0.261	= .795
$R^2 = .152$ ($p < .001$)					
Secondary Traumatic Stress (Constant)	28.695	2.139	--	13.413	< .001
ACE	0.166	0.154	.079	1.081	= .281
Gender[a]	-2.068	0.895	-.159*	-2.311	= .022*
Race[b]	0.502	0.948	.037	0.530	= .597
Childhood SES[c]	2.171	0.904	.163*	2.401	= .017*
$R^2 = .059$ ($p = .017$)					

Note. ACE = Adverse Childhood Experiences; SES = socioeconomic status.
[a]For statistical purposes in SPSS, we grouped gender as female, male, and transgender or other gender.
[b]For race, we grouped PSCs as Minoritized and White.
[c]For Childhood SES, we grouped PSCs as lower or working class, middle-class, or upper middle/upper class.

Model 2 ran a regression of burnout on ACEs, gender, race/ethnicity, and childhood SES, explaining 15.2% of the variance in compassion satisfaction, $F(5, 225) = 8.062$, $p < .001$. Gender ($\beta = 0.169$) and race/ethnicity ($\beta = 0.279$) significantly predicted burnout. ACEs and childhood SES showed nonsignificant results in this model. Being male and being White predicted higher burnout (see Table 2).

Model 3 ran a regression of secondary traumatic stress on ACEs, gender, race/ethnicity, and childhood SES, explaining 5.9% of the variance in secondary traumatic stress, $F(5, 225) = 2.862$, $p = .017$. Only gender ($\beta = -0.159$) and childhood SES ($\beta = 0.163$) significantly predicted secondary traumatic stress. ACEs and race/ethnicity showed nonsignificant results in this model. Being female and having higher childhood SES predicted higher secondary traumatic stress (see Table 2).

RQ 3 asked about the predictive relationship of ACEs, gender, race/ethnicity, and SES to compassion satisfaction, burnout, and secondary traumatic stress after dividing the sample into two groups: PSCs with three or fewer ACEs ($n = 119$) and those with four or more ACEs ($n = 121$). Three linear regression models for each group all produced significant results. Model 1 ran a regression of compassion satisfaction on ACEs, gender, race/ethnicity, and childhood SES. For Group 1 (three or fewer ACEs) the model explained 41.7% of the variance in compassion satisfaction, $F(5, 109)$ 15.599, $p < .001$. Gender ($\beta = -0.369$), and childhood SES ($\beta = 0.194$) significantly predicted compassion satisfaction. ACEs and race/ethnicity showed nonsignificant results. Being female and having higher childhood SES predicted higher compassion satisfaction for those with three or fewer ACEs. For Group 2 (four or more ACEs), the model explained 26.6% of the variance in compassion satisfaction, $F(5, 110) = 7.975$, $p < .001$. Gender ($\beta = -0.277$) and race/ethnicity ($\beta = -0.342$) significantly predicted compassion satisfaction. ACEs and childhood SES showed nonsignificant results. Being female and being a racially minoritized person predicted higher compassion satisfaction for those with four or more ACEs (see Table 3).

Table 3

Regression Results: Coefficients (compassion satisfaction)

	β	*Std. Error*	*Beta*	*T*	*Sig*
ACE < 4 (Constant)	20.214	2.846	--	7.102	< .001
ACE	-0.070	0.545	.006	-0.012	= .897
Gender[a]	-5.046	1.040	-.369*	-4.852	< .001*
Race[b]	0.820	1.165	.194	2.307	= .524
Childhood SES[c]	2.688	1.165	.194*	2.307	= .023*
$R^2 = .417$ ($p < .001$)					
ACE > 4 (Constant)	29.897	1.990	--	15.024	< .001
ACE	0.286	0.228	.106	1.253	= .213
Gender[a]	-2.702	0.855	-.277*	-3.161	= .002*
Race[b]	-3.296	0.821	-.342*	-4.017	< .001*
Childhood SES[c]	0.443	0.866	.045	0.511	= .610
$R^2 = .266$ ($p < .001$)					

Note. ACE = Adverse Childhood Experiences; SES = socioeconomic status.
[a]For statistical purposes in SPSS, we grouped gender as female, male, and transgender or other gender.
[b]For race, we grouped PSCs as Minoritized and White.
[c]For Childhood SES, we grouped PSCs as lower or working class, middle-class, or upper middle/upper class.

Model 2 ran a regression of burnout on ACEs gender, race/ethnicity, and childhood SES. For Group 1 (three or fewer ACEs), the model explained 14.5% of the variance in burnout, $F(5, 109) = 3.692$, $p = .004$. ACEs ($\beta = 0.249$) significantly predicted burnout. Gender, race/ethnicity, and childhood SES showed nonsignificant results. Having higher ACEs predicted higher burnout. For Group 2 (four or more ACEs), the model explained 35.9% of the variance in burnout, $F(5, 110) = 12.336$, $p < .001$. ACEs ($\beta = 0.158$), gender ($\beta = 0.277$), and race/ethnicity ($\beta = 0.461$) significantly predicted burnout. Childhood SES showed nonsignificant results. Having higher ACEs, being male, and being White predicted higher burnout (see Table 4).

Table 4

Regression Results: Coefficients (burnout)

	β	*Std. Error*	*Beta*	*T*	*Sig*
ACE < 4 (Constant)	31.882	2.448	--	13.025	< .001
ACE	1.061	0.469	.249*	2.264	= .026*
Gender[a]	0.197	0.895	.020	0.220	= .827
Race[b]	-0.806	1.104	-.067	-0.730	= .467
Childhood SES[c]	-1.543	1.002	-.157	-1.539	= .127
$R^2 = .145$ ($p = .004$)					
ACE > 4 (Constant)	20.916	2.085	--	10.103	< .001
ACE	0.471	0.237	.158*	1.989	= .049*
Gender[a]	2.999	0.887	.277*	3.382	= .001*
Race[b]	4.939	0.852	.461*	5.601	< .001*
Childhood SES[c]	0.877	0.899	.081	0.975	= .332
$R^2 = .359$ ($p < .001$)					

Note. ACE = Adverse Childhood Experiences; SES = socioeconomic status.
[a]For statistical purposes in SPSS, we grouped gender as female, male, and transgender or other gender.
[b]For race, we grouped PSCs as Minoritized and White.
[c]For Childhood SES, we grouped PSCs as lower or working class, middle-class, or upper middle/upper class.

Model 3 ran a regression of secondary traumatic stress on ACEs, gender, race/ethnicity, and childhood SES. For Group 1 (three or fewer ACEs), the model explained 16.4% of the variance in secondary traumatic stress, $F(5, 109) = 4.267$, $p = .001$. Gender ($\beta = -0.303$) significantly predicted secondary traumatic stress. ACEs, race/ethnicity, and childhood SES showed nonsignificant results. Being female predicted higher secondary traumatic stress. For Group 2 (four or more ACEs), the model explained 14.5% of the variance in secondary traumatic stress, $F(5.110) = 3.745$, $p = .004$. ACEs ($\beta = 0.288$) significantly predicted secondary traumatic stress. Gender, race/ethnicity, and childhood SES showed nonsignificant results. Having higher ACEs predicted higher secondary traumatic stress (see Table 5).

Table 5

Regression Results: Coefficients (secondary traumatic stress)

	β	*Std. Error*	*Beta*	*T*	*Sig*
ACE < 4 (Constant)	26.661	3.813	--	6.992	< .001
ACE	0.678	0.730	.101	0.929	= .355
Gender[a]	-4.640	1.394	-.303*	-3.330	= .001*
Race[b]	-1.187	1.719	-.062	-0.691	= .491
Childhood SES[c]	1.068	1.561	.069	0.684	= .495
R^2 = .164 (p = .001)					
ACE > 4 (Constant)	26.189	2.378	--	11.015	< .001
ACE	0.858	0.273	.288*	3.146	= .002*
Gender[a]	0.268	1.021	.025	0.252	= .794
Race[b]	0.916	0.980	.086	0.934	= .352
Childhood SES[c]	1.765	1.035	.163	1.705	= .091
R^2 = .145 (p = .004)					

Note. ACE = Adverse Childhood Experiences; SES = socioeconomic status.
[a]For statistical purposes in SPSS, we grouped gender as female, male, and transgender or other gender.
[b]For race, we grouped PSCs as Minoritized and White.
[c]For Childhood SES, we grouped PSCs as lower or working class, middle-class, or upper middle/upper class.

Discussion

The purpose of this study was to establish the average rates of ACEs, compassion satisfaction, burnout, and secondary traumatic stress in PSCs as well as determine the extent to which PSCs' own ACEs might predict compassion satisfaction, burnout, and secondary traumatic stress in a U.S. sample of school counselors. This study is unique in that it is the first to explore PSCs' personal historical predictors and their relationship with job-related variables, both establishing the present rates of ACEs while also examining their potential to be risk factors for PSCs. As professional organizations (ASCA, 2022) and previous literature (Padmanabhanunni, 2020) noted the importance of having PSCs monitor their own wellness to ensure that their own trauma does not influence their work, this study provides a deeper understanding of how personal adversity may influence professional responsibilities.

Minoritized PSCs in our convenience sample had significantly more ACEs than White PSCs, which is congruent with previous studies (Giano et al., 2020; Merrick et al., 2017). While Brown et al. (2022) established racial differences in ACEs for CMHCs for its sample, noting that racially minoritized CMHCs had higher ACEs scores than White CMHCs, in this study we established gender differences, in which female PSCs had higher rates of ACEs compared to male PSCs in the present study's sample. This extends previous literature, which reported ACEs scores in aggregate for pediatric and adult populations (Boullier & Blair, 2018; Merrick et al., 2017). The most striking finding in our study was that 50.42% of PSCs in our convenience sample had four or more ACEs, which was slightly higher than the 43% that Brown et al. (2022) found in CMHCs, and significantly higher than the approximately 6% found in large U.S. and Austrian samples (Felitti et al., 1998; Riedl et al., 2020), suggesting PSCs may have a personal history that includes more ACEs than the general population. This is consistent with previous studies that have shown that those within mental health fields may tend to have higher

rates of childhood adversity and trauma (Brown et al., 2022; McKim & Smith-Adcock, 2014; Thomas, 2016). Yet, despite having higher rates of ACEs, participants in our sample reported moderate levels of compassion satisfaction, burnout, and secondary traumatic stress on average, which is supported by previous research and theory related to these constructs, as PSCs' stress and job satisfaction are mediated by burnout (Mullen et al., 2017).

Our examination of the compassion satisfaction of PSCs showed that as a whole, those who identified as female, racially minoritized persons, and those who came from higher childhood SES were more likely to experience higher compassion satisfaction. For PSCs having three or fewer ACEs, being female and having higher childhood SES predicted higher compassion satisfaction. For PSCs with four or more ACEs, being female and being racially minoritized predicted higher compassion satisfaction. We found these results, which were also congruent with Brown et al.'s (2022) study with CMHCs, to be notable. It may be expected that coming from a higher childhood SES would result in higher compassion satisfaction as higher SES may be a protective factor. Yet, female and racially minoritized PSCs reporting higher rates of compassion satisfaction despite having higher ACEs scores on average is worth noting, as this builds upon recent findings that BIPOC PSCs have elevated essential wellness (i.e., meaning and purpose) compared to White PSCs (Fye et al., 2022).

In terms of who is more likely to suffer from burnout, in the total sample, we found that being male and being White predicted higher levels of burnout compared to PSCs who identified as being female and racially minoritized. Previous literature has shown that years of experience is negatively correlated with burnout (Fye, Cook, et al., 2020); however, our data extends this to other demographic variables. For those with fewer than three ACEs, having higher ACEs predicted higher burnout, suggesting that regardless of the ACEs threshold, as the number of ACEs increases, PSCs are more susceptible to burnout. For those with four or more ACEs, having higher rates of ACEs, being male, and being White predicted higher burnout scores. This lends further support to research showing that male counseling graduate students experience heightened levels of exhaustion compared to their female peers (Basma et al., 2021). Considering the higher rates of ACEs in the female and racially minoritized groups, it is notable that these two groups of PSCs experienced burnout less than male and White counselors.

Implications for School Counselors and Counselor Education

The results of the present study contribute to scholarship regarding PSC wellness, highlighting potential identity-related and personal historical predictors of positive and negative job-related outcomes that can impact PSCs and their work with students. These results are noteworthy for practicing school counselors, as well as counselor education programs dedicated to the continued health and longevity of the school counseling profession. Given that our sample was split in half, with PSCs self-reporting above and below the threshold for ACEs, we acknowledge that this may be reflective of those presently working in the field. This split presents two distinct profiles for PSCs, those who have ACEs scores above the threshold of four or more, and those who had ACEs scores of three or fewer. Regardless of profile, any increase in ACEs score puts a PSC at risk for being more susceptible to burnout. In monitoring their wellness, PSCs can reflect on how these risk factors could subsequently impact their professional functioning. Similarly, counselor educators can build reflective practices into their programs to increase pre-service school counselors' self-awareness regarding their wellness.

PSCs-in-training need to be made aware of the effects of ACEs, not only due to the effects on students, but also the effects they may have on their own professional well-being. Counselor educators and supervisors may advise PSCs-in-training to seek counseling to process their ACEs prior to entering the field fully after graduation. There are several evidence-based counseling modalities that aid in

the processing of trauma and acute stress (e.g., EMDR, cognitive process therapy, STAIR Narrative Therapy). Though childhood adversity is not synonymous with trauma, the high rates of ACEs of counselors as evidenced in this study and that of Brown and colleagues (2022) indicate that trauma-informed education may be necessary. The 2024 CACREP standards (CACREP, 2023) say relatively little regarding requirements to educate about trauma, yet it will be important for counselor educators to equip counselors-in-training with knowledge concerning both how to care for traumatized students and also to care for themselves.

Limitations

This study is limited by the nature of survey research such as self-reporting bias and inability to assess all factors that may be influencing the relationship, specifically external factors that previous studies have explored. It is important to note that this study did not examine organizational factors that previous research has shown to be impactful regarding PSCs' burnout, such as school counselor caseload, PSCs' supportive relationships (e.g., supervision, mentorship), and the role of school climate (Holman et al., 2019; Mullen et al., 2017; Rumsey et al., 2020). Research has indicated that years of experience (Rumsey et al., 2020) and organizational variables (e.g., non-counseling duties, role ambiguity, supervisor support; Fye, Bergen, & Baltrinic, 2020; Holman et al., 2019) are mitigating factors in PSCs' experience of secondary traumatic stress. Qualitative research may provide a richer understanding of the phenomena of these outcomes for school counselors. For example, why do PSCs with higher childhood SES have higher levels of secondary traumatic stress?

Splitting the sample in half (PSCs with three or fewer ACEs and PSCs with four or more) produced two groups ($n = 119$ and $n = 121$), which individually did not meet our required power analysis ($N = 138$). While we believe in the potential of the results to shed light on the issue of PSCs' compassion satisfaction, burnout, and secondary traumatic stress, further research may confirm or elaborate upon the findings. Furthermore, because the sample in the current study did not match previous samples' reporting rate of reported ACEs scores (e.g., Felitti et al., 1998; Riedl et al., 2020), this study may be replicated on a different sample to contribute to trends in ACEs scores among the PSC population.

A significant limitation to our study included our lack of racially minoritized counselors. As a result, we combined racially minoritized counselors and compared them to White counselors, which limited our ability to distinguish between the unique strengths and struggles that may exist within a given racial group. More research needs to be conducted on counselors from various ethnic and cultural groups both within the U.S. and globally. It would be helpful to know what protective factors may exist for school counselors from racially or ethnically marginalized backgrounds around the world. We believe that the results of this study should not draw attention away from numerous studies that have shown that systemic and organizational factors such as school work environment and school counselor caseload have a significant impact on the professional resilience of PSCs (Bardhoshi et al., 2014; Holman et al., 2019; Mullen et al., 2017; Rumsey et al., 2020). The results of this study do not suggest that the problem of burnout is solely or primarily a result of the personal history of PSCs.

Future Research

Exploring more demographic variables, personal variables, and work characteristics may be beneficial in understanding the relationship between these factors and the presence of compassion satisfaction, burnout, and secondary traumatic stress. In addition to investigating the aforementioned variables, future research may focus on an experimental pre-/post-test design providing a group of school counselors training regarding secondary traumatic stress, burnout, and wellness practices. This may be particularly helpful for those who have experienced four or more ACEs due to the research that childhood trauma is

linked to poor health in adulthood (Anda et al., 2002, 2004; Dube et al., 2004; Frewen et al., 2019; Gondek et al., 2021; Merrick et al., 2017; Mwachofi et al., 2020). Future research may also include an examination of PSCs' rates of ACEs and the types of schools served. For example, scholars may examine whether PSCs with higher ACEs tend to work in schools where the rates of ACEs are higher for children. Furthermore, considering the timing of the current study with data collection occurring prior to the COVID-19 pandemic, assessing the roles of the pandemic, current economic uncertainty, and ongoing racial injustices on these variables would be informative as to how they may be related.

Conclusion

We sought to examine the rates of ACEs of PSCs and learn whether ACEs are correlated with higher rates of compassion satisfaction, burnout, and secondary traumatic stress. We found that an unusually high rate of PSCs in our sample had four or more ACEs and are therefore susceptible to factors such as burnout and secondary traumatic stress. As a result of these findings, we believe that in conjunction with calls for structural change to PSCs' work environment (e.g., student caseload), greater attention needs to be given to ways that PSCs' own history may factor into their susceptibility to burnout and secondary traumatic stress.

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

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Black People's Reasons for Becoming Professional Counselors: A Grounded Theory

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Drawing from the concepts of Critical Race Theory and the Theory of Nigrescence, we report the results of a grounded theory study to explain why a sample of 28 Black counselors chose their profession. Findings suggest that the contributors to this study were motivated to become counselors because of their inspiration to challenge cultural mandates (i.e., grounding motivator), to disrupt Black underrepresentation (i.e., secondary motivator), and to live out their personal and professional convictions (i.e., secondary motivator). Recommendations for counselor education, counseling practice, and counseling research are included.

Keywords: **Black counselors, Black underrepresentation, grounded theory, Theory of Nigrescence, Critical Race Theory**

Accredited counseling programs enroll White students and hire White faculty at significantly higher rates than they enroll Black students and hire Black faculty (Council for the Accreditation of Counseling and Related Educational Programs [CACREP], 2022). Black students and faculty in counseling programs have described their program climates as unsupportive and hostile (Bradley & Holcomb-McCoy, 2004; Brooks & Steen, 2010; Haskins et al., 2013). Given the overwhelming representation of White counselors (U.S. Bureau of Labor Statistics, 2023), this perception has a bearing on Black participation in the professional counseling workforce. To date, the counseling knowledge base offers little on the factors, motivators, and/or reasons that inspire people to become counselors, regardless of their racial and/or ethnic identities. These motivators, factors, and reasons are important, given the value professional counseling places on understanding individuals' career development and trajectory.

Exploring constructs associated with the choices that Black counselors make about becoming counselors is uniquely important given the historical exclusion of Black counselors from the profession (National Center for Education Statistics [NCES], 2021; U.S. Bureau of Labor Statistics, 2023). Simultaneously, Black clients are seeking mental health support in record numbers and actively indicating that they want treatment from Black counselors (Substance Abuse and Mental Health Services Administration, 2018). The goal of this study was to develop a grounded theory of what motivates Black people to become professional counselors.

Review of the Literature and Theoretical Framework

Developing a theory that explains the reasons why Black people become counselors can benefit the counseling profession in at least three ways. First, it centers the voices, experiences, and insights of Black counselors. Centering them and their experiences is a critical and disruptive act that provides

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direct and unfiltered insights about factors that have contributed to their engagement and factors that inhibit that engagement, given how their specific experiences and insights are not significantly reflected in counseling research. Second, the results can provide counselors at all levels (e.g., counselor education program faculty and staff, counseling leaders, practicing counselors, and counseling students) an introductory evidence base that can inform more innovative ways to both recruit Black counselors and make counselor preparation programs more inclusive, supportive, and affirming. Third, the findings also provide counselor preparation programs and the agencies and institutions that employ graduates with an introductory evidence base that contributes to increasing the number of Black counselors, which has been documented to encourage more Black and other marginalized people to seek mental health support (Cook et al., 2017; Moreno et al., 2020; Noonan et al., 2016; Primm et al., 2010).

The reasons for the historical exclusion and ongoing underrepresentation of Black counselors are simple. We assert that Black counselors' exclusion and underrepresentation are a direct consequence of systemic racism. Different forms of systemic racism are evidenced in at least two specific contexts: 1) systemic racism in counseling programs evidenced by limited enrollment of Black counseling students and hiring of Black faculty and 2) systemic racism in counseling journals evidenced by underreported research about career development for Black counselors.

Systemic Racism in Counseling Programs

In its most recent report on counseling program racial demographics, CACREP (2022) noted that approximately 55% of all students in counseling programs were White, while just over 16% were Black. In 2017 CACREP reported approximately 60% of students in counseling programs were White, while less than 20% were Black. So, while there is more representation of other students of color in accredited counseling programs, the number of Black students has decreased. These trends continue in graduate education at institutions across the United States with respect to Black student enrollment. The NCES (2023) reported that Black students comprised 14% of the approximately 3 million students enrolled in U.S. postbaccalaureate programs, as compared to 62% of White students enrolled in 2019. Likewise, the NCES (2021) reported that of the approximately 810,000 full-time faculty at degree-granting institutions in 2018, 75% were White and 6% were Black. The recent Supreme Court ruling striking down race-based affirmative action in college admissions (*Students for Fair Admissions, Inc. v. President and Fellows of Harvard College*, 2023), along with assessments found to be culturally biased and inconsistent in predicting students' success (e.g., Graduate Record Examination; Sullivan et al., 2022) have the potential to be barriers to Black student enrollment. These factors have clear implications for the counseling workforce, evidenced by White counselors comprising anywhere between 70% and 76% of the counseling workforce (U.S. Bureau of Labor Statistics, 2023). Unfortunately, Black counseling students and faculty have reported counseling program climates to be isolating, hostile, and tokenizing (Bradley & Holcomb-McCoy, 2004; Brooks & Steen, 2010; Haskins et al., 2013).

Career Development Among Black People in Helping Professions

The research on the impact of race and racial identity on career development among Black people is consistent, indicating Black people consider their race in their career choices (Bell, 2018; Byars-Winston, 2010; Byars-Winston & Fouad, 2006; Chung, 2002; Fouad & Byars-Winston, 2005; Hackett & Byers, 1996; Rollins & Valdez, 2006). Unfortunately, very little research explicitly reports on Black people's motivation to join helping professions, including counseling. June and Pringle (1977) offered a constructive critique of career theorists (i.e., Roe, Super, and Holland) whose research anchors career development theory in many counselor preparation programs, writing that "None of the three writers incorporated the influence of race in any significant manner in their theories" (June & Pringle, 1977, pp. 22–23). June and Pringle's insights from more than 35 years ago are telling, given the

absence of research that attempts to acknowledge the ways race and racism influence career choices among people who are not White. What follows is a review of the research reporting on influencing factors of Black people who choose to enter helping professions such as social work, family and consumer sciences, and nursing, which can potentially offer insights about why some Black people might choose to become professional counselors. Also included is research about how race influences the career counseling process for Black students and new professionals as they seek to identify viable career options.

Creative Nursing published an article in 2008 (Anonymous, 2008) that provided readers with firsthand accounts of why a group of over 20 nurses chose to enter that profession. They overwhelmingly cited being called to the profession, suggesting that their career choice went beyond typical considerations such as financial stability or convenience. Social work researchers have similarly investigated this topic and have reported that Black social workers most frequently chose the profession because they wanted opportunities to work with people (Gockel, 1966) or had the desire to open a private practice (Butler & Butler, 1990). In their study of 120 social workers, Bowie and Hancock (2000) reported that the social workers chose gaining more social work education in order to advance their careers and learning new social work skills as among the most important reasons to enroll in graduate-level social work courses. Similarly, Burdette-Williamson and O'Neal (1998) reported undergraduates who chose family and consumer sciences as a major were most motivated by influential people, including but not limited to college advisors, parents, and/or college friends. These motivating factors to join helping professions align with Branch's (2018) dissertation that reported on Black men's reasons for becoming counselors. Branch cited prior experiences with therapy and Black male counseling mentors as reasons why Black men chose their career path leading to counseling.

Other researchers have centered Black people in the context of career development. The cultural formulation approach with Black clients (Byars-Winston, 2010; Byars-Winston & Fouad, 2006; Fouad & Byars-Winston, 2005) focuses on racial differences in variables related to career choice. Fouad and Byars-Winston (2005) reported differences among racial/ethnic groups in perceptions of career opportunities and barriers to those opportunities; they concluded that the career aspirations of Black and other people of color are similar, but their dreams differ by racial groups. Byars-Winston (2010) recommended the cultural formulation approach in career counseling with Black clients as a descriptive guide to inform counselors' consideration, documentation, and influence of culture in the counseling relationship by integrating four cultural formulation dimensions (i.e., self and cultural identity, self and cultural conceptions of career problems, self in context, and cultural dynamics in counseling relationships) with the three functions of Black cultural identity (i.e., bonding, buffering, and bridging).

Research about career development among Black students in educational settings (pre-K through higher education) and interventions support using the cultural formulation approach. Rollins and Valdez (2006) sampled 85 Black high school students and found that students who experienced a higher degree of racism reported significantly higher career decision-making self-efficacy (i.e., belief in one's ability to make a good career decision) but not career task self-efficacy (i.e., belief in one's ability to successfully complete a career-related task). Rollins and Valdez found that higher ethnic identity achievement, parental socioeconomic status, and being female were related to higher levels of career self-efficacy. Similarly, Duffy and Klingamen (2009) reported in a study of 2,300 racially diverse first-year college students a series of statistically significant, positive correlations between higher levels of ethnic identity achievement and career decidedness. Ethnic identity was found to play little, if any, role in the career development progress of White students. However, for Black

and Asian American students, after controlling for race, ethnic identity was found to significantly moderate the relationship between ethnic identity achievement and career decidedness. Duffy and Klingamen (2009) urged counselors to be cognizant of the role ethnic identity plays in students' career development. The literature reminds us that there are unique considerations for the career development of Black people that explicitly focus on racial identities in general. The research also suggests that there is useful information to be gleaned from how Black people in other helping professions make their career choices, but comparatively little exists about Black counselors.

The literature reviewed here elucidates the challenges Black people confront as counseling clients, counseling students, counseling professionals, and counseling faculty. Researchers continue to document the ways that Black clients experience negative outcomes in counseling, as well as their desires to have counselors who share their racial identity. Barriers exist that exclude Black people from graduate programs, thus creating a shortage of counseling professionals. Similarly, Black faculty are also underrepresented in counseling programs. Still, the importance and value of more Black counselors exist, and the goal of this study was to provide a theoretical grounding to explain Black counselors' motivation to join the profession.

Integrated Theoretical Framework

Our research team drew on Critical Race Theory (CRT) and the Theory of Nigrescence for an integrated theoretical framework. CRT posits that racism and White supremacy is embedded in everyday structures and systems and impacts the lived experiences of people of color (Garcia & Romero, 2022). Delgado and Stefancic (2001) articulated that race is a socially constructed concept and there is no biological superiority of one racial group over another. Secondarily, several groups are vested in maintaining the current racial hierarchy that esteems Whiteness as superior. Finally, racism is ordinary, common, and an intrusive force in and on Black and other people of color (McGee & Stovall, 2015). For these reasons, CRT provides an appropriate lens for investigation.

Cross et al.'s Theory of Nigrescence (1991) posits that a healthy racial identity is the result of a developmental process during the life span. During this process (i.e., pre-encounter, encounter, immersion/emersion, internalization, and internalization/commitment), Black people transition from not understanding how race affects their experiences to experiencing agency in their own understanding of racial identity of self and others. We believe that race is inextricably tied to Black people deciding to become counselors as they are aware of the deleterious effect of racism on their lives. We further contend that Black people who choose to become professional counselors are further along in their racial identity development, per Nigrescence Theory. These two theories provided us with a fitting and culturally relevant framework with which to administer this study. Our focus on the intersections of race and racism, racial identity development, and career development are congruent with the aims of CRT (Delgado & Stefancic, 2001) and Cross and colleagues' (1991) Theory of Nigrescence.

Methods

Our goal with this study was to develop an introductory evidence base that identifies what motivates Black counselors to join the counseling profession. There has been a limited amount of research on the intersection of Black peoples' racial identity and their career motivations. There has also been little research that reports on what motivates Black people to become counselors or how their experiences influence their decision to join the profession. Consequently, we chose a grounded theory design for this study because it is used to help answer complex research questions wherein data are collected

and extensively analyzed to create a theory (Mills & Gay, 2019; Singh et al., 2010). To generate a grounded theory, we endeavored to collect data and identify patterns therein to learn what motivated a specific sample of Black people to become counselors (Corbin & Strauss, 1990; Creswell & Poth, 2016) by drawing on the causal conditions, the context(s), and the intervening variables that influence the phenomenon being studied (Vollstedt & Rezat, 2019). Our central research question for the study was: What motivates Black people to become professional counselors?

Researchers' Positionality Statement

Our research team consisted of six members at varying points in our counseling and counselor education careers. We all share a commitment to resisting and disrupting all forms of oppression. Michael D. Hannon is a Black, male, cisgender counselor educator and counselor whose clinical and research interests are Black men's mental health and confronting anti-Black racism in professional counseling. LaShawn M. Adams is a Black, cisgender woman whose research focuses on Black women in higher education and feminist ideology. Natalie Nieves and Estefanie Ceballo are Latine cisgender women whose research interests focus on Latine culture from a relational–cultural theory perspective. Adams, Nieves, and Ceballo are doctoral candidates. David Julius Ford, Jr. is a Black, male, queer counselor educator and counselor whose research and clinical interests include Black men in higher education; career counseling; queer and trans Black, Indigenous, and people of color (BIPOC); and persons living with HIV/AIDS. Linwood G. Vereen is a Black, male, cisgender counselor educator and counselor whose research and clinical interests include Black people's mental health, humanistic existentialism, Black existentialism, and humor in counseling. We affirm and celebrate our diverse range of salient and intersectional identities. Our diverse identities also informed the choice of our integrated theoretical framework, given we are all people of color at various points in our racial identity development and who have a shared professional identity.

Contributor Recruitment and Profile

We used two sampling methods, criterion and snowball sampling (Mills & Gay, 2019; Patton, 2014), to recruit potential contributors. Criterion sampling (Patton, 2014) requires that contributors to a study meet a very prominent criteria for eligibility. Mills and Gay (2019) described snowball sampling as the process when researchers invite contributors to recommend additional eligible contributors. All contributors (i.e., participants) were required to meet the following four inclusion criteria: 1) identify as Black (i.e., continental African, Black American, Afro-Caribbean, Afro-Latine, and/or a member of the African Diaspora); 2) be a member of the counseling profession, evidenced by being a counseling student (i.e., enrolled in a counseling master's, post-master's, and/or doctoral program), a practicing counselor, and/or being a counselor educator/supervisor; 3) speak and understand American English; 4) be at least 18 years old. All 28 contributors received $40 gift cards for their participation.

Upon receiving IRB approval, our research team began recruiting by inviting potential contributors with flyers and descriptions via counseling and counselor education email distribution lists and various social media platforms (e.g., X/Twitter, Instagram, Facebook, LinkedIn). Our recruitment efforts yielded over 51 responses from diverse Black counselors, and our final sample included 28 contributors. Twenty-three potential contributors were excluded due to either not fully meeting eligibility criteria and/or interview scheduling conflicts. Each contributor chose their own alias to protect their identity. Basic demographic data about the contributors is listed in Table 1.

Table 1

Contributor Demographics

Alias	Age	Yrs. of Counseling Exp.	Gender Identity	Ethnicity	Professional Role
Ada	28	0–5 years	Cisgender woman	Black American	Doctoral student; practicing counselor
Aisha S.	46	15+ years	Female	Afro-Caribbean	Practicing counselor
Andrea	24	0–5 years	Female	Afro-Caribbean	Practicing counselor
Bianca	25	0–5 years	Female	Mixed race (Black/Hispanic)	Practicing counselor
Capt. Ingenuity	37	0–5 years	Male	Black American	Practicing counselor
Carlos	41	11–15 years	Male	Black American	Doctoral student
Cheeta	39	0–5 years	Female	Black American	Master's student
Denise	42	15+ years	Female	Black American	Doctoral student; practicing counselor
Destiny	33	11–15 years	Female	Black American	Counselor educator/ supervisor; practicing counselor
Dorothy	45	6–10 years	Female	Mixed race (Black American & White American)	Practicing counselor
Erykah	28	0–5 years	Female	Afro-Caribbean	Doctoral student; practicing counselor
Franchon	38	11–15 years	Female	Mixed race (Native and African American)	Retired/former counselor
Grayson	45	0–5 years	Female	Black American	Practicing counselor
Jacques	68	15+ years	Male	Mixed race (Creole Chamorro)	Practicing counselor
Jalen	40	15+ years	Male	Black American	Practicing counselor
Jena Six	55	0–5 years	Female	Did not reply	Practicing counselor
Jesika	41	6–10 years	Female	Afro-Caribbean	Master's student; school counselor
Jo	63	0–5 years	Female	Black American	Practicing counselor
Marie J.	31	0–5 years	Female	Black American	Doctoral student
Matt	60	15+ years	Male	Black American	Doctoral student
Michelle	26	0–5 years	Female	Black American	Master's student
Mildred P.	51	0–5 years	Female	Black American	Master's student
Morris	22	0–5 years	Female	Black American	Master's student
Rene	29	6–10 years	Female	Black American	Practicing resident in counseling
Sasha	41	0–5 years	Female	Black American	Doctoral student
Serena	26	0–5 years	Female	Black American	Academic advisor
Trey	32	6–10 years	Male	Black American	Doctoral student
Victor	33	0–5 years	Male	Black American	Practicing counselor

Data Collection and Analysis

Our sole data collection method was one-time, individual, semi-structured interviews with 28 contributors. We all participated in the data collection process, conducting individual interviews lasting on average 45 minutes each. Each interview was conducted using web conferencing technology (i.e., Zoom), was audio recorded, and was professionally transcribed. We developed an interview protocol to address our overall research question, informed by our review of the literature and specifically inquiring about the reasons contributors chose to become professional counselors. The interview protocol can be found in the Appendix.

Our data analysis process was consistent with general grounded theory analysis methods (Miles & Huberman, 1994; Vollstedt & Rezat, 2019) and those identified by counseling researchers who have conducted and published grounded theory research studies (Hannon & Hannon, 2017; Singh et al., 2010), which included an interactive, three-step process of open coding, axial coding, and selective coding. Our open coding process began after the completion of the fifth interview, wherein members of our team conducted a detailed review of the interviews to find discrete ideas, events, or experiences (i.e., codes) that communicated the reasons why the contributors decided to become professional counselors (Corbin & Strauss, 1990; Singh et al., 2010). Open codes from the first five interviews helped us to develop a codebook as a basis for comparison for the remaining 23 interviews. Our team reached consensus on a list of open codes present in the 28 interviews and then began the axial coding process. Axial coding is a process in which "categories are related to their sub-categories, and the relationships tested against the data" (Corbin & Strauss, 1990, p. 13). In essence, our research team worked together to categorize the open codes, describing them more summatively as we considered the causal conditions, contexts, and intervening variables that explained why these contributors chose to become counselors (Corbin & Strauss, 1990). Finally, we engaged in selective coding of the interview data, which required us to identify a core category that described the central phenomenon (i.e., decision to become counselors) around which all other categories are integrated (Vollstedt & Rezat, 2019).

Trustworthiness

To validate our discoveries, our research team employed a number of trustworthiness strategies. One strategy was member checking (Hannon & Hannon, 2017; Lincoln, 1995) at three different times: 1) during interviews (i.e., asking clarifying questions of contributors during interviews); 2) after interviews (i.e., forwarding transcribed interviews to contributors for additional information and/or corrections); and 3) after our agreement of findings (i.e., providing an executive summary of findings to contributors). No contributors requested content changes. A second trustworthiness strategy we leveraged was investigator triangulation (Denzin & Lincoln, 2000), or when a study includes multiple researchers to assist with accuracy and confirmability of analysis. The investigator triangulation was facilitated through activities such as team meetings to discuss our relationship to the research topic, our individual interpretations of the data, and the subsequent consensus coding that allowed us to intentionally monitor and address the influences of any potential biases. This investigator triangulation provided our team the opportunity to bracket any potential biases we had in our analysis process. A third strategy we used was individual journaling (Giorgi, 1985) to help inform our analysis meetings and determine the ways in which contributors' accounts affected us emotionally and/or intellectually.

Findings

We endeavored to learn, and develop a grounded theory about, why a group of Black people decided to become counselors through this study. What we identified, grounded in the contributors' responses, was a set of interacting and influencing factors that inspired them to become counselors.

These Black counselors were motivated to join the profession based on their inspiration to challenge cultural mandates (i.e., grounding motivator), to disrupt Black underrepresentation (i.e., secondary motivator), and to live out their personal and professional convictions (i.e., secondary motivator). A visual representation of our grounded theory can be found in Figure 1. What follows is a description of our grounded theory.

Figure 1

Grounded Theory Diagram

Challenging Cultural Mandates (Grounding Motivator)

Contributors' responses indicated they were all motivated to join the profession, in part, to challenge cultural mandates imposed on them by both Black people and people from other racial and/or ethnic groups. These mandates were articulated by implying specific societal and/or career expectations for Black people and communicated ideas and stereotypes like, "Black people don't do counseling" or professional counseling is not a financially viable career. There was variance in contributors' answers about this, potentially influenced by their role and years in the profession (e.g., master's student, practicing counselor, counselor educator/supervisor). The data suggested that the more years in the profession, the more explicit, unapologetic, and clear their rationale was to challenge these cultural mandates. For example, Sasha, a 41-year-old counseling doctoral student, discussed challenging stereotypes about the benefit of counseling for Black people: "In the Black

community, they're like, 'Oh, I don't need help, I don't have mental issues.' And that was part of my motivation to let them know it's okay to get counseling." Ada, a 28-year-old counselor and counseling doctoral student, described her experience receiving mixed messages about working in mental health from people with whom she attended her Black church, saying, "I remember expressing that interest . . . and most people were like, 'That's, like really needed, especially in our community.' But this one older woman was just like, 'You want to work with people who are like, messed up in the mind?'" Jalen, a 40-year-old counselor, spoke about the strategies he used to make his counseling career financially viable, noting, "In-home counseling led me into . . . people talking about how you can make more money by getting more credentials."

Black (Under)Representation (Secondary Motivator)

All of the contributors to this study explicitly spoke about being motivated to become counselors for more representation in the profession. We learned from the contributors that this motivator was influenced by two variables: 1) having an adult/senior influence, and 2) having negative personal counseling experiences. Many shared compelling stories of an adult/senior influence (e.g., a family member, a professor) who encouraged them to consider professional counseling as a career option. Additionally, many shared negative experiences as clients. Mildred P., a 51-year-old professional counselor, shared the importance of having a counselor that has a shared racial and/or ethnic identity, noting, "I've not seen counselors that look like me. And I feel like . . . if you can relate on the surface, then there's a level of comfort." Jo, a 63-year-old counselor who works with college students, addressed the need for more Black counselors who work with college students to increase representation and to amend negative counseling experiences she and Black student clients have had:

> There was only one Black counselor there, and she can't see everybody in the 48,000 population at [redacted university]. She can't see everyone. And so, they [Black students] didn't want to go. Or, they've gone before and their experiences weren't the best. And they don't go back. We know that that happens all the time. It's even happened to myself. So, when I was thinking about what I can do, because I can complain, you know, and say, 'Oh, we don't have counselors, we don't have counselors,' or I can do something about it in my little area of the world.

The experience of having an adult/senior influence on these contributors' motivation to become professional counselors and increase Black representation was salient. Denise, a 42-year-old counselor educator, shared the profound impact of having a Black mentor who was a professional counselor. She shared, "What really was beneficial was seeing . . . a Black man willing to show someone the ropes. . . . I emailed that person, and they responded the same day. That just spoke so much to me of their integrity." Serena, a 26-year-old Black counselor, recalled the importance of adult/senior influences in her desire to join the profession, noting,

> ACA did a mentoring program and . . . I kind of forgotten I'd signed up. And then I got an email saying you're connected to a mentor and it was great. She had two mentees and she was a counselor of color from [university redacted] and very passionate about empowering people of color, and she was the one, she was the first person to ask me, 'Why do you want a doctorate?' In all my—since undergrad—no one asked me that. . . . She was awesome. She introduced me to one of her doctoral students, another Black woman. We met a couple times over Zoom as well.

Finally, Rene and Dorothy provided examples of the ways that negative counseling experiences inspired them to become counselors to increase Black representation in the field. Rene, a 29-year-old female counselor, shared, "In my own journey, I saw how difficult it is to find counselors who had similar identities. And that furthered my already very strong desire to be in the helping profession . . . be a part of that as well." Dorothy, a 45-year-old counselor, offered a similar sentiment:

> I had experiences growing up that led me to therapy personally. And it was really difficult to find a therapist who I could identify with, who I didn't have to explain in detail about why something was upsetting to me. And I had some experiences that were so difficult that I didn't return to counseling for several years. And so that was a real driving force in me deciding to enter this profession a little bit later in my life. Because I wanted to be able to offer that to people in similar situations.

Personal and Professional Convictions (Secondary Motivator)

The responses from the contributors in our study indicated that they had personal and professional convictions that motivated them to become professional counselors. Throughout their stories, it was clear to our team that the contributors possessed personal and professional values that inspired them to take action (i.e., become counselors) which allowed them to experience personal and professional congruence. We interpreted the contributors' personal and professional convictions as a consequence of two factors: 1) they all possessed altruistic dispositions, and 2) they all possessed values of justice and equity.

Evidence of the influence of altruistic dispositions on the contributors' convictions and ultimate choice to become counselors were present in the following ways. Michelle, a 26-year-old counseling student, simply stated, "You know . . . it's also just wanting to help people and wanting to show people compassion. And teach them that compassion for themselves. That's big for me." Likewise, Morris, a 22-year-old master's student, shared,

> Most of the time, my friends didn't want to go to the counselors either. So we ended up just being there for each other and just trying to solve each other's problems or give each other advice. So I just realized maybe I should seek this in a professional way.

Destiny, a 33-year-old counselor educator, supervisor, and clinician, reiterated this point, noting that she had "this compulsion to kind of really help people, to really just talk, and recognizing that . . . my empathy was so innate, and just other effective qualities that you would consider to be associated with a counselor."

The contributors to this study also clearly valued equity and justice for individuals and communities, which guided their personal and professional convictions and ultimate decisions to become counselors. One example of this is from Aisha S., a 36-year-old counselor educator and supervisor. She described her motivation to be a counselor as being connected to a greater purpose, sharing, "What else stood out for me from those experiences that made me consider professional counseling . . . was being able to . . . think about how I can engage in advocacy efforts at the local level, at the grassroots level."

Ada, a 28-year-old counselor and counseling doctoral student, shared a similar narrative that centered justice and equity as salient forces among her personal and professional convictions:

> I think because I've been in that situation where . . . I've had to deal with microaggressions or . . . just flat out . . . ignorance, I think that those experiences, along with my own personal therapy, have helped me to pause and think about areas that I am privileged. . . . I don't have to worry about being deported. I don't have any disabilities. So, like, I don't have to constantly think about things like, does this place have an elevator? Or, does this place, like, have a ramp or something like that?

This presentation of a grounded theory explaining why a sample of Black people chose to become professional counselors illustrates the complex and interacting variables that influenced their career choice. It provides our profession insight into how we might continue to attract, retain, and support more diverse people entering the profession and hopefully experiencing career satisfaction.

Discussion

Our study sought to answer a critical question: What motivates Black people to become professional counselors? The findings of the study suggest a confluence of experiences, influences, and variables that led this group of Black people to ultimately join the profession. By leveraging concepts from two theories (i.e., CRT and Theory of Nigrescence), we discovered the salient reasons for 28 Black people to become professional counselors. Three explicit factors lent themselves to the development of a grounded theory that will hopefully engender further study. We offer an account of the ways the findings complement and/or challenge past findings on this issue, and present potentially new insights.

The *challenging cultural mandates* and *Black (under)representation* factors specifically address how our research base has informed counselors about Black people's experiences with counseling and allied mental health professions. The contributors shared the ways systemic, individual, and/or internalized racism has influenced their experiences in and with counseling. Their responses explicitly align with tenets of CRT (Delgado & Stefancic, 2001). The contributors' various accounts of experiences with racism in several forms (e.g., microaggressions, being tokenized, being excluded) reiterate all the ways in which racism is an intrusive force in the lives of Black and other people of color in the United States (McGee & Stovall, 2015). The counseling profession is at a crossroads with determining training standards and the ways that those training standards will prepare counseling students to meet the needs of diverse clients (CACREP, 2023; Hannon et al., 2023). The sociopolitical climate in the United States continues to be tenuous given anti-Black legislation in states like Florida and North Carolina that is outlawing teaching courses about Black people's history and diversity, equity, inclusion, and belonging for university faculty and staff.

The *personal and professional convictions* factor offers potentially new insight about how salient the contributors' values are for deciding to become counselors. The contributors' decision to become counselors was a result of their altruistic dispositions and their commitment to justice and equity, factors that may assist professional counselors to inspire others to envision counseling as a catalyst for justice for Black people and people from other marginalized groups. These values are congruent with our various codes of ethics (American Counseling Association, 2014; National Board for Certified Counselors, 2023) and the Multicultural and Social Justice Counseling Competencies (Ratts et al., 2016). These specific motivations align closely with what has been reported about why some Black people chose to become nurses, citing a calling (Anonymous, 2008). Further, we tentatively assert the connection of this finding with Cross and colleagues' (1991) Theory of Nigrescence. We believe that there may be a connection between what stage of racial identity development Black people are functioning from (i.e., pre-encounter, encounter, immersion/emersion, internalization) and their willingness to make choices that reflect their

altruistic dispositions and justice values. There are two points of inference worth raising here. First, the contributors to this study explicitly and implicitly made mention of their own racial identity development being closer to the internalization stage when deciding to become a counselor, and we associate that with their inclination to advocate for and pursue justice for themselves and their communities. We wonder if a more mature racial identity development is a predictor of choosing to become a counselor among Black people. Second, the contributors discussed various forms of racism that they experienced in their preparation programs and how, at times, it prompted them to assess where they were in their racial identity development (e.g., operating from an internalization paradigm and moving to an immersion/emersion paradigm depending on the type or form of racism experienced).

The findings also complement prior studies about the career development of Black people in general (Bell, 2018; Byars-Winston, 2010; Byars-Winston & Fouad, 2006), and specifically about counselors (Branch, 2018). It also aligns with the salience of race in career choice and decision-making. The contributors to this study explicitly mentioned that race was an influence (e.g., Black [under]representation) and that their experiences in and with counseling were influenced by their racial identity, illuminating the relevance of CRT (Delgado & Stefancic, 2001; McGee & Stovall, 2015) and Cross et al.'s (1991) Theory of Nigrescence. Branch (2018) indicated that the most salient reason why a sample of Black men became counselors was because of prior positive experiences with Black male counselors (e.g., informal relationships, mentoring relationships, treatment). The study contributors' negative counseling experiences and their relationships with their adult senior influencer demonstrated how their racial identity significantly impacted their career choices and overall professional development.

Implications

We believe the results from our study can inform the ways that our profession engages with, attracts, supports, retains, and invests in Black counselors. What follows is a presentation of the implications of these findings within two specific contexts: 1) counselor education programs and 2) counseling practice. Counselor education programs must commit to increasing Black representation in their programs by taking explicit steps to challenge admission requirements found to be culturally biased and engage in bolder and more innovative recruitment and retention/support efforts (e.g., agreements with historically Black colleges and universities, predominantly Black colleges and universities, and/or minority-serving institutions) for Black students enrolled in their programs. Counselor education programs can intentionally engage with undergraduate student organizations to further orient potential Black applicants to the counseling profession at large. This research indicates that Black representation is essential in encouraging and promoting mental health services and wellness for Black people. Black representation also encourages Black people to join the profession, a factor that counseling institutions should acknowledge and utilize. An increase in Black representation in counseling programs provides the rationale to engage counseling students in the reflective work that helps them become clearer about their own racial identity development, their own assertions about the influence of race and racism on their own and clients' lives, and their own career development trajectory. This can be exceptionally helpful in didactic instruction and individual and group supervision.

Finally, the results of our study affirm the need for the counseling profession to continue acknowledging the importance of collaboration between counseling organizations that have different but complementary roles. For example, professional counseling organizations composed of primarily White members should prioritize endorsing and collaborating with professional counseling organizations whose missions and membership are primarily Black (e.g., National Association of Black Counselors, African American Counseling Association, Black Mental Health Symposium). These demonstrations of

solidarity, partnership, and membership communicate clear support for such organizations and reiterates the importance of Black counselors identifying pathways for Black clients to culturally affirming and culturally relevant mental health care. Further, the relationships between counselor preparation programs and professional counselors must continue to be mutually beneficial. Practicing counselors are best positioned to inform and advise on community and client needs, given their important role in rendering services. Leveraging the insights of professional counselors to inform counselor education and research is paramount to treating clients in culturally relevant and responsive ways.

Limitations

We acknowledge the privilege that we have in conducting this study and the responsibility of sharing the results for the professional counseling readership. Likewise, we assume responsibility for sharing how the study is limited. One way is in the homogeneity of the sample. We recruited professional counselors who were Black, and the overwhelming majority of them were Black American, female, monolingual counselors. Although our contributors' voices and experiences are critical for this discourse, a more diverse sample of Black counselors (e.g., Afro-Latine, continental African, Afro-Caribbean, bilingual and/or multilingual Black counselors) could possibly enrich the findings. This translates into another study limitation, which is the limited extent to which findings are transferable, given both the sample size and lack of ethnic diversity (Creswell & Poth, 2016). A third potential limitation is researcher bias. Although we attended to potential bias through trustworthiness strategies such as member checking, investigator triangulation, consensus coding, and research team debriefs, we acknowledge the intimate relationship we all have with this topic and the potential for our biases to influence our interpretations.

Future Research

Counseling researchers should invest more time in learning and sharing about why people choose counseling as a profession, particularly those people who have been historically excluded from the profession for a variety of reasons. Additional studies about why a wider range of people with intersecting and/or other marginalized identities choose to become counselors can enrich our literature and counseling profession at all levels (e.g., students, practicing counselors, counselor educators). For example, Black counselors who are multiracial, are immigrants, and/or speak multiple languages might have very different reasons for joining the profession than Black American counselors. The results from such studies will assist the profession to work from an evidence base to develop programs, interventions, and other forms of support to attract a more racially diverse workforce. Results from these types of studies will allow our profession to develop applicable career development theories that specifically study the lived experiences of Black people and people from other marginalized groups and address their career needs.

Conclusion

This study and its results can continue to assist our profession to exist as the just, inclusive, and affirming profession we aspire for it to be. Actualizing the courage to empirically investigate the reasons Black and other socially, economically, and linguistically diverse people choose to become professional counselors can only benefit our preparation programs, our practicing counselors, and our ever-evolving research base. We maintain hope for the profession's future to live out our code of ethics (ACA, 2014) in this regard. This is just one step in our effort to sound the clarion call for professional counseling to understand the impact of Black counselors in the field and the importance of institutions (e.g., colleges, universities, professional organizations) having social, cultural, economic, linguistic, and gender diversity among their staff. We trust this contribution moves us to even more action.

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The authors reported no conflict of interest.
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Appendix

Interview Protocol

Individual Interview Questions/Script

Thank you for agreeing to participate in this important study. If you remember, this study is designed to begin providing an empirical base for what factors motivate Black people to become professional counselors. Please note these interviews will be audio recorded. Do you have any questions before we begin? Please take your time in answering the following questions and please be reminded that you can skip any question and withdraw at any time.

All participants should be asked these questions:

- Would you share with me what motivated you to become a counselor?
- What about those experiences convinced you that professional counseling was a good fit for your career?
- What did/do you find most helpful in your counselor training?
- What did/do you find most challenging in your counselor training?
- Are/were you one of few Black students in your counselor training program?
    - If so, what is/was that experience like for you?
    - If not, what is/was that experience like for you?
- Do you believe you experienced/are experiencing anti-Black racism in your counselor training program?
    - If so, in what ways is this happening/did this happen?

If participant is/was a practicing counselor, please ask:

- What is most rewarding for you as a Black practicing counselor?
- What role, if any, do Black counselors have in helping increase Black representation in counseling?
- Do you believe anti-Black racism exists in professional counseling? If so, in what ways?
- Are you one of few Black counselors where you practice?
    - If so, what is that experience like for you?
    - If not, what is that experience like for you?

If participant is a counselor educator, please ask:

- How long have you been a counselor educator?
- What motivated you to become a counselor educator?
- What role, if any, do Black counselor educators have in helping increase Black representation in counseling?
- Do you believe anti-Black racism exists in counselor education? If so, in what ways?
- Are you one of few Black counselor educators where you teach?
    - If so, what is that experience like for you?
    - If not, what is that experience like for you?

Please conclude all individual interviews with this question and information:

- Is there anything else you'd like to share about your motivations to become a professional counselor that we haven't discussed to this point?
- *Thank you for participating in this interview. Your insights are valuable. What you can expect now is for our research team to transcribe this interview, de-identify it, and send it to you for your review to confirm its accuracy. Our team will then begin our analysis and send you updates on our interpretations of what participants have shared. If you have any questions, please do not hesitate to be in touch with Dr. Hannon at hannonmi@montclair.edu.*

A Phenomenological Exploration of Counselors' Experiences in Personal Therapy

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Professional counselors may choose to increase self-awareness and/or engage in self-care through the use of personal therapy. Some counselors may feel reluctant to pursue personal therapy due to stigma related to their professional identity. To date, researchers have paid limited attention to the unique concerns of counselors in personal therapy. The purpose of this descriptive phenomenological study was to explore counselors' experiences and decision-making in seeking personal therapy. Participants included 13 licensed professional counselors who had attended personal therapy with a licensed mental health professional within the previous 3 years. We identified six emergent themes through adapted classic phenomenological analysis: presenting concerns, therapist attributes, intrapersonal growth, interpersonal growth, therapeutic factors, and challenges. Findings inform mental health professionals and the field about the personal and professional needs of counselors. Limitations and future research directions are discussed.

Keywords: **professional counselors, self-awareness, self-care, personal therapy, phenomenological**

Self-awareness is a fundamental part of the counseling profession. Not only do professional counselors seek to increase the self-awareness and personal growth of their clients, but counselor educators call upon counselor trainees to increase their own self-awareness before entering the field (Council for the Accreditation of Counseling and Related Educational Programs [CACREP], 2023, Section 3A11). Additionally, counselor educators often recommend self-growth experiences such as personal counseling to increase counselor trainees' self-awareness in preparation for professional practice (Remley & Herlihy, 2020). Several scholars define counselor self-awareness as the mindfulness of thoughts, feelings, and behaviors in the self and in the counseling relationship (Fulton & Cashwell, 2015; Merriman, 2015; Rosin, 2015). Pompeo and Levitt (2014) asserted that self-awareness parallels awareness of personal values and enables counselors to explore best practices in counseling. However, after training, it becomes less clear how, if at all, counselors access their own counseling for self-growth and self-awareness; therefore, we designed the current study to explore how practicing counselors utilize personal therapy.

Correlates of Self-Awareness Among Counselors

Counselor self-awareness relates to awareness of the counseling relationship, which is helpful to client satisfaction and growth (Pompeo & Levitt, 2014); as such, several researchers have examined the clinical implications of counselor self-awareness, including professional competence, client treatment outcomes, and wellness. For example, Rake and Paley (2009) found that the therapists in their study reported modeling themselves after their own therapist as well as learning about technical aspects of a therapeutic approach. In regard to wellness, Gleason and Hays (2019) found that counselor self-awareness helped identify stressors and needs regarding personal wellness in doctoral-level counselor trainees. Similarly, Merriman (2015) discussed how self-awareness can help prevent burnout or compassion fatigue. Many researchers have investigated the importance of self-awareness as a characteristic of counselors who can competently work with culturally diverse clients (Ivers et al., 2016; Sue et al., 2022). Thus, some evidence of the clinical impact of counselor self-awareness already exists in the literature.

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Expanding upon the impacts of self-awareness on the therapeutic relationship, Anderson and Levitt (2015) articulated the importance of self-awareness in how counselors' social influence impacts the working alliance. Additionally, Tufekcioglu and Muran (2015) described how the working alliance provides a laboratory wherein the client can focus on and more clearly delineate their experience in relation to the therapist's experience. Thus, the counseling goal of cultivating mindfulness in clients with respect to the details of their own experience involves counselors becoming mindful of the corresponding details of their own experience. Tufekcioglu and Muran argued that every encounter with a client demands the counselor's self-reflection in the form of greater self-awareness in relation to the working alliance, and maintained that the therapeutic process should involve change for both participants.

Counselors Seeking Mental Health Care

Counselors can gain self-awareness in a variety of ways, including personal therapy. Mearns and Cooper (2017) stated that the term *therapy* loosely signifies the receiving of mental health services from any mental health professional who holds a license to practice. We use the word *therapist* in reference to researchers who did not specify the type of mental health professional (e.g., counselor, psychologist, social worker) who provided therapy to the participants in their study. Several scholars have suggested that therapists who participated in their own personal therapy experienced increased professional development as well as positive client outcomes. For example, VanderWal (2015) found that clients of counselor trainees with personal therapy experience demonstrated reduced rates of distress more quickly than clients of counselor trainees without personal therapy experience. Other researchers have noted the impact of therapy on therapists' personal growth. Although not specific to professional counselors, Moe and Thimm (2021) conducted a systematic review of the literature regarding mental health professionals' experiences in personal therapy and discovered benefits related to genuineness, empathy, and creation of a working alliance. Outcomes of this previous research support the positive impact of personal therapy for therapists.

Some counselors may seek personal therapy due to mental health concerns. Therefore, it is worth exploring the needs of this unique population. In one study, Orlinsky (2013) reported that therapists' most frequently cited presenting concerns were resolving personal problems. Additionally, Moore et al. (2020) reported that counselors experienced interpersonal stress as a response to threatening situations in their clinical work and, in order to cope, neglected their own personal needs. Other investigators found a relationship between higher rates of ethical dilemmas in clinical practice and increased stress and burnout among counselors (Mullen et al., 2017). Robino (2019) introduced the concept of *global compassion fatigue*, a phenomenon wherein counselors experience "extreme preoccupation and tension as a result of concern for those affected by global events without direct exposure to their traumas through clinical intervention" (p. 274). In this conceptual piece, Robino summarized the literature findings on how indirect exposure of distressing events impact the mental well-being of professional helpers and advocated for the role of self-awareness as an important coping skill. Furthermore, Prosek et al. (2013) found that counselor trainees presented with elevated levels of anxiety and depression, providing further evidence that counselors are at risk for mental health concerns related to occupational and personal stressors.

Purpose of the Study

The psychological needs of counselors coupled with the emphasis on gaining self-awareness highlight the necessity for counselors' personal therapy. Self-awareness is an important component of counselor development due to the personal nature of the profession (Pompeo & Levitt, 2014; Remley & Herlihy, 2020). Personal therapy is one way to enhance counselor self-awareness (Mearns & Cooper, 2017). Additionally, counselors may experience a variety of mental health concerns, including compassion fatigue, interpersonal conflict, depression, and anxiety (Moore et al., 2020; Mullen et al., 2017; Orlinsky,

2013; Prosek et al., 2013; Robino, 2019). Researchers have primarily focused on the perceived outcomes of personal therapy, including personal growth, professional development, and positive client outcomes (Moe & Thimm, 2021; VanderWal, 2015). However, scarce research exists regarding counselors' decision-making processes in seeking personal therapy. Thus, if counselors could benefit from personal therapy, and if little knowledge exists regarding how counselors decide to seek personal therapy, professional counselors, counselor educators, counselor supervisors, and other mental health providers have limited information regarding how to facilitate that decision-making process.

Researchers employing qualitative investigation typically seek to holistically understand meaning. More specifically, the goal of a phenomenological approach is to capture the experiences and meaning-making from the participants' perspectives (Creswell & Creswell, 2017). We want to illuminate how professional counselors make meaning of their experiences in personal therapy, as much of the existing literature focuses on trainees, clinical outcomes, or quantitative data. We believe describing the lived experiences, or essence (Moustakas, 1994), of counselors receiving personal therapy may lead to a deeper body of research regarding the perceptions, emotions, and behaviors of this population. The following questions guided our inquiry:

1. What contributes to counselors' decisions to seek personal therapy?
2. How do professional counselors make meaning of their experiences in utilizing personal therapy?

Method

Phenomenologists seek to understand the distinctive characteristics of human behavior and first-person experience (Hays & Singh, 2023). Based on an existentialist research paradigm, we wanted to understand how counselors make meaning of their experiences in personal therapy. Because we aimed to describe the lived experiences of counselors receiving personal therapy, descriptive phenomenology answers the research questions appropriately (Prosek & Gibson, 2021). Consistent with descriptive phenomenology, we used Miles et al.'s (2019) adaptation of classic data analysis, an inductive–deductive approach.

Research Team and Reflexivity

At the time of data collection (pre–COVID pandemic), Dax Bevly, who identifies as a White, Latina cisgender woman in her late 20s, was completing a doctoral degree in counseling. Elizabeth A. Prosek, who identifies as a White, cisgender woman, brought experience in conducting, teaching, and mentoring qualitative research studies. Bevly utilized a research team for data analysis that included four women in their early 20s completing master's degrees in counseling; three identified as White and one identified as Asian. As instruments in the research themselves, the team needed to embrace their potential influence and impact (Hays & Singh, 2023); therefore, Bevly and Prosek participated in research reflexivity meetings several times during data collection and analysis, where they discussed thoughts and emotions evoked through their participation in the study. Descriptive phenomenology requires researchers to establish epoche, an exchange of assumptions that can be held accountable to bracket or identify throughout the process. Our research team demonstrated epoche by journaling and discussing biases and assumptions regarding the present study throughout the data analysis process. Bevly in particular was especially aware of her own personal biases due to long-term participation in personal therapy, believing it to have highly influenced her personal and professional development in a positive way. Bevly consulted with the research team as we examined experiences, reactions, and any assumptions or biases that could interfere with the coding process during data analysis.

The research team members held Bevly accountable for her responses to the research process (Creswell & Creswell, 2017). The four other members of the research team also engaged in the examination of their experiences, reactions, and assumptions or biases during analysis, reporting assumed benefits including increased awareness, higher functioning in relationships, and increased self-esteem. Bevly also utilized the research team for the purpose of engaging in critical discussion during the analysis process in order to develop a trustworthy study. Furthermore, Bevly and Prosek kept a journal in order to document the research team members' bracketing throughout the study. The journal also noted the connection and validation that Bevly experienced in interviewing participants and the care and mindfulness to not insert her personal experiences, especially regarding the overlapping roles of client and counselor as well as feelings of vulnerability.

Procedure

We obtained IRB approval before participant recruitment. Eligibility for the study included identifying as a licensed professional counselor (LPC) aged 18 or older who utilized counseling services with a licensed mental health therapist either currently or within the previous 3 years (similar criteria to Yaites, 2015). We used purposive sampling to select participants for this phenomenological study (Hays & Singh, 2023), recruiting participants through email, word of mouth, and networking with LPCs in a 50-mile radius of our institution, which is located in a large state in the Southwestern United States. This radius allowed us to intentionally reach more diverse areas of the geographical region. We also recruited participants through personal contacts and professional counseling organizations. Potential participants completed an eligibility online survey via Qualtrics. We contacted them via phone or email to explain the study and confirm their eligibility. We excluded participants who reported holding expired LPC licenses, experienced therapy more than 3 years ago, or described personal therapy from an individual without a license in a mental health profession. We scheduled face-to-face meetings with participants in their professional counseling office at their convenience. Although participants read and acknowledged the informed consent before meeting face-to-face, we readdressed informed consent before proceeding. Bevly conducted and audio recorded 60-minute interviews with each participant. At the conclusion of each interview, Bevly also facilitated a sand tray activity with the participant.

Participants

We recruited participants based on gaining depth with adequate sampling (Prosek & Gibson, 2021). Participants ($N = 13$) identified mostly as White, cisgender women with an average age of 37.23; see Table 1 for complete demographics. Although we sought to recruit participants with diverse social identities, geographic limitations presented a challenge. Thus, our findings should be interpreted with caution, as the external validity, or generalizability, of the findings to other populations or different contexts is impacted by the limited diversity among our participant demographics. Lastly, we asked participants to choose pseudonyms in an effort to protect their anonymity and confidentiality.

Data Sources

Demographic Form

In order to determine eligibility and collect demographic information, we asked potential participants to complete a Qualtrics survey, an online initial screening tool that included questions about age, gender, racial and ethnic identification, sexual orientation, religious/spiritual identity, number of personal therapy sessions completed, length of time since termination of personal therapy (if applicable), number of years as an LPC, disability status, licensure of therapist, therapist demographic information, and whether or not their counseling training program required personal therapy. The online demographic survey also included information about informed consent and confidentiality. Although it was not required for the study, all participants reported that therapy took place face-to-face.

Table 1

Participants of the Study

Participant	Age	Race/Ethnicity	Gender	Religious/Spiritual Affiliation	Sexual Orientation
Alma	37	Latina	Woman	Christian	Heterosexual
Amy	30	Latina	Woman	Christian	Heterosexual
Ashley	29	Multiracial	Woman	Spiritual	Heterosexual
Betty	55	White	Woman	None	Heterosexual
Elenore	30	Multiracial	Woman	Christian	Queer
Felicity	44	White	Woman	Christian	Heterosexual
Jennifer	40	White	Woman	Christian	Heterosexual
Liz	35	White	Woman	Pagan	Bisexual
Lynn	48	White	Woman	Christian	Heterosexual
Michelle	37	White	Woman	Christian	Heterosexual
Rose	30	White	Woman	Christian	Heterosexual
Sophia	35	White	Woman	None	Heterosexual
Thomas	34	White	Man	None	Heterosexual

Semi-Structured Interview Protocol

We developed a semi-structured interview protocol to guide the interviews. We drafted the questions based on existing literature concerning counselors and personal therapy. The protocol consisted of six open-ended questions and follow-up prompts to understand the experiences of professional counselors who have engaged in personal therapy (see Table 2).

Table 2

Interview Protocol

Grand tour question:
Please tell me about your experience in personal therapy in as much detail as you feel comfortable sharing. Follow-up: - What motivated you to seek personal therapy? - What was happening in your life at the time? - How did you go about selecting a therapist? - Can you tell me about what your internal process (thoughts/feelings) was like leading up to your decision to seek personal therapy?
What outcomes did you experience as a result of personal therapy?
How, if at all, has personal therapy affected your personal growth?
How, if at all, has personal therapy affected your own clinical work?
Describe the experience of being both a client and a counselor. - Some literature suggests that counselors feel stigmatized when seeking personal therapy. What do you make of this? How is that similar or different for you?
Is there anything else that you would like to share?

Sand Tray Activity

Hays and Singh (2023) stated that "visual methods in general provide participants the opportunity to express themselves in a nonverbal manner that may access deeper aspects of their understanding and/or experience of a phenomenon" (p. 332). After the semi-structured interview, Bevly invited participants to create their personal therapy experience in a sand tray using the figures and materials provided. This method is consistent with Measham and Rousseau (2010), who used sand trays as a method of data collection for understanding the experiences of children with trauma. The sand trays were documented by digital photos (see Appendix), and participants' discussions about their creations are part of the audio recordings.

Data Analysis

We sent the audio recordings to a professional transcriptionist for transcription of each interview and sand tray session. We reviewed transcripts while listening to the recordings for participants' tone and to verify accuracy. Consistent with phenomenological procedures, the research team conducted data analysis according to an adaptation of classic analysis (Miles et al., 2019), in which three main activities take place: data reduction, data presentation, and conclusion or verification.

Prior to initial coding, the research team completed several tasks in order to develop the preliminary coding manual: taking notes, summarizing notes, playing with words, and making comparisons (Miles et al., 2019). Taking notes involved the research team as well as Bevly's own independent analysis of a subset of the first three interviews and sand tray explanation transcripts. We divided the transcripts into 10-line segments and wrote notes in the margins. The research team noted our initial reactions to the material.

Summarizing notes involved discussion between the team regarding our reactions to the interview material. We compared and contrasted our margin notes and highlighted shared perspectives and inconsistent viewpoints in a summary sheet. To play with words, we generated metaphors based on our summary sheet. We developed phrases that represented our interpretation of the participants' interview responses.

During the making comparisons task, we compared and contrasted the key phrases developed in the previous step and grouped them into categories. The team then facilitated reduction of the data as we combined similar phrases and merged overlapping categories. Hays and Singh (2023) asserted the importance of sieving the data to eliminate redundancy. We continued to merge categories and reformat the category headings. From this process, we developed preliminary themes based on the data. To develop initial codes, we established agreement by independently applying the preliminary codes to a subset of three interviews. The research team met weekly to discuss inconsistencies and points of agreement, adjust the preliminary codes, and reapply them to the data subset. We continued to discuss any remaining discrepancies and concerns until we reached a mean agreement of 86% to 90% (Creswell & Creswell, 2017). We reached a mean agreement of 95.1% and then finalized the codes to use in our coding manual.

It is important to note that the research team sensed that we had reached saturation during the final coding process once we began to read the same comments repeatedly in the participant transcripts. In final coding, we applied the final coding manual to each of the interviews and sand

tray explanations. We used the same coding manual for both the interviews and the sand tray explanations. The same research team member coded both the interview and sand tray explanation for the same participant. Bevly coded all 13 interviews and sand tray explanations; all four research team members coded the first three interviews and sand tray explanations. Two research team members coded interviews and sand tray explanations 4 through 8, and the other two research team members coded interviews and sand tray explanations 9 through 13. The research team's finalized codes included the meaning and depth of participants' experiences in personal therapy. However, if necessary, researchers could still recode during final coding to maintain consistency with the revised definitions (Creswell & Creswell, 2017). When recoding occurred, we reviewed previously analyzed transcripts with the updated codebook on four occasions. Once we completed final coding, Bevly performed member checks with the participants.

Establishing Trustworthiness

To develop trustworthiness in qualitative research, Lincoln and Guba (1985) presented four criteria: credibility, transferability, dependability, and confirmability. We established credibility in this study through the use of research partners in debriefing, researcher reflexivity, and participant checks. Participant checks occurred after we completed final coding. In this process, we emailed all participants a summary of the identified themes and inquired if the summary portrayed an accurate representation of the experience. Nine out of 13 participants responded and informed Bevly that no adjustments were necessary because the summary adequately captured their experiences. The remaining four participants did not respond to the follow-up email. Additionally, we utilized researcher partners in debriefing and data analysis steps to strengthen the development of the coding manual. In relation to researcher reflexivity, we bracketed our experiences by reflecting on biases and assumptions as counselors who experienced personal therapy through journaling and discussing assumptions with each other, particularly those related to positive personal experience in our own counseling. We demonstrated transferability by openly and honestly providing information about the researchers, the proposed study's context, the participants, and study methods. This transparency allows readers to have a sense of the context when interpreting findings. We achieved dependability through documenting each task that we completed for the study by keeping an audit trail, allowing for replication. Additionally, the use of multiple data sources, including the demographic survey, interviews, and sand trays, increased the complexity of analysis (i.e., dependability). Also, we provided an in-depth description of our methodology to increase dependability of the study, including information about sample size, data collection, and data analysis that the research team used. Lastly, confirmability was based on an acknowledgement that we, as the primary researchers, cannot be truly objective (Cope, 2014). However, we triangulated the findings using participant checks, consultation with colleagues, and research team consensus to facilitate confirmability.

Findings

The research team identified six major themes and 11 subthemes (see Table 3). The six major themes were: (a) presenting concerns, (b) therapist attributes, (c) intrapersonal growth, (d) interpersonal growth, (e) therapeutic factors, and (f) challenges. We present the subthemes in more detail in the following sections using participant data as supporting evidence.

Table 3

Themes and Subthemes

Themes	Subthemes
Theme 1: Presenting concerns	Subtheme 1a: Mental health Subtheme 2a: Life transitions
Theme 2: Therapist attributes	Subtheme 2a: Practicality Subtheme 2b: Quality
Theme 3: Intrapersonal growth	Subtheme 3a: Cognitive Subtheme 3b: Emotional
Theme 4: Interpersonal growth	Subtheme 4a: Personal Subtheme 4b: Professional
Theme 5: Therapeutic factors	Subtheme 5a: Nurturing Subtheme 5b: Normalization Subtheme 5c: Vulnerability Subtheme 5d: Transference
Theme 6: Challenges	Subtheme 6a: Finances Subtheme 6b: Stigma Subtheme 6c: Role adjustment

Theme 1: Presenting Concerns

Presenting concerns included participants' thoughts and feelings prior to engaging in personal therapy. Participants shared their decision-making processes and motivations leading to the initiation of personal therapy. Participants described two subthemes that captured their motivation to engage: mental health concerns and life transitions. Mental health concerns represented grief, trauma, anxiety, depression, emotional dysregulation, and relational stressors. For example, Michelle shared:

> I would say those were the times when it was like I was pulled to my end, and so the depression, it was like I needed something else more than just the regular support from family and friends and then the miscarriages. It was like I felt so isolated, and then with my dad dying it was like I, gosh, this is . . . it was like both of them dying so close together.

Participants also described life transitions that served as motivation to engage in personal therapy, such as changes in relationships, careers, and living arrangements. As Lynn represented,

> some of that was related to like, as a result of the divorce. I've moved three times in the past, like sold a house and moved out of it or kind of moved into storage while in that house in order to be able to stage it and sell it. Then out of the house into an apartment, out the apartment into a rent house. And so there's been a lot of upheaval for me and for my child.

Presenting concerns may also be interactional in nature. For some participants (n = 10), life transitions overlapped with their mental health concerns, such as a career change triggering anxiety. However, the remaining three participants cited either mental health concerns or life transitions as a reason for initiating personal therapy. All participants differentiated their experience of internal mental health distress and external life stressors.

Theme 2: Therapist Attributes

As participants reflected on the different feelings and thought processes they experienced during the initiation of personal therapy, they also shared different attributes they looked for in a therapist. Two subthemes emerged: practicality and quality. Practicality involved factors such as location and affordability. Quality consisted of therapist credentials, training, experience, and specialty areas. All participants shared factors related to both subthemes, including Liz and Alma:

> So I was like, "Okay. Well I know this person, I know this person, I know this one. Oh. I don't know this person, okay. Let's see if they have an opening." I wanted someone that was close to my work because it's easier for me just to go straight from work considering working at a hospital, I can work ridiculously long hours. Sometimes, you know, 12-hour days . . . so I needed someone in [city withheld], and I needed someone I didn't know. (Laughs) And they took my insurance. (Liz)

> I really wanted somebody who was not an intern and not a grad student. I need somebody who was fully licensed. I was looking for somebody who'd done their own work. I wouldn't really know, but I can kind of tell. I was looking for somebody who had done their own work, their own process, and somebody who'd work with therapists. And so the first therapist that I found, she'd been a therapist for about 12 years. She had a successful private practice on her own. (Alma)

Some participants (n = 8) prioritized affordability and location over other attributes, while other participants (n = 5) emphasized education, specialty area, and recommendations as their way of selecting therapists. Each participant highlighted their need for accessibility and a good fit into their hectic schedules and personal lives. Participants described these factors as a method of narrowing down the pool of possible therapists.

Theme 3: Intrapersonal Growth

All participants expressed changes in thoughts related to self that were associated with increased perspective represented by the theme of intrapersonal growth and narrowed into subthemes of cognitive and emotional. Participants specifically reported cognitive intrapersonal growth through internal changes such as awareness, mindfulness, and a sense of purpose as outcomes of receiving personal therapy. Twelve participants described these cognitive changes as a positive experience. Jennifer described the experience as distressing due to the increased awareness of unpleasant knowledge of self and others:

> I think a lot of self-awareness in the sense of why I function the way I function and an understanding of why, not only the why, but what I was needing and what I was seeking. And so, just a greater understanding of those pieces that I really had no awareness of before that. . . . I had a little awareness of it, I should say. I probably knew a little bit, but I don't think I trusted myself in seeing that, trust in myself, trust in my intuition, and trust in my decision-making.

All participants described emotional intrapersonal growth within themselves related to regulation, stability, and expression as a result of personal therapy. Participants reported a decrease in distressing emotion, increased attunement to their emotional well-being, and an increased ability to express emotions in a healthier manner. Additionally, participants experienced fewer negative feelings toward themselves,

including Thomas, who shared, "Back then I was just hiding from a lot of pain. I was hiding a lot of pain. So now I've been able to work through that in therapy, I'm just more emotionally attuned in general."

All participants expressed the overlap between cognitive and emotional intrapersonal growth; furthermore, participants explained how this intrapersonal growth that occurred as a result of personal therapy carried over into other relationships. Participants shared that these internal benefits influenced external factors in their lives. Thus, the theme of intrapersonal growth led directly into the fourth theme, interpersonal growth.

Theme 4: Interpersonal Growth

All participants shared interpersonal growth, changes in relationships, and depth of social connection, both in their personal relationships and their professional relationships with clients. Participants reflected on how their growth affected relationships with romantic partners, family, friends, and clients. As a result, the two subthemes of personal relationships and professional relationships arose in the data, as expressed by Betty and Thomas:

> I believe that it helped me connect with people on a deeper level. Because it's hard to empathize or connect with someone if you can't feel yourself. 'Cause if you can't feel yourself, you can't feel what they're feeling either. So, with my kids, I would be able to first of all, set firmer boundaries with them. And they would take me more seriously. And I'll then also be able to connect more. And in another area, I was able to learn to ask for help. . . . instead of trying to always take care of things and handle things by myself, and to actually feel safe enough to ask for help. (Betty)

> I could empathize. I could play the role of counselor and do my job, but I wasn't doing it, like "for real for real" . . . I was falling out of what I really needed to be doing, and now I'm able to sit with clients, and every now and then my mind wanders to "oh, I gotta do this or that," but I'm quick, I become aware of it more quickly, and I'm able to feel deeply with clients. . . . I have sessions all the time now where I'm tearing up with my clients and just feeling so moved by them. And also, I cry more in my personal life and professional life. (Thomas)

Twelve participants experienced their interpersonal growth as helpful in alleviating their presenting concerns. The remaining participant described the interpersonal growth as tense and uncomfortable. All participants explained that their interpersonal growth in personal relationships was connected to interpersonal growth in professional relationships with their clients. For example, increased boundaries with family extended to increased boundaries with clients. Participants shared that the relationship with their therapist acted as a surrogate for relationships with other people in their lives, which emerged in the therapeutic factors theme.

Theme 5: Therapeutic Factors

All participants reported avenues of healing within the context of the therapeutic alliance that led to the changes in self and in relationships. Participants reflected on how engaging in the relationship with their therapist facilitated their intrapersonal and interpersonal growth. This theme included four subthemes: nurturing, normalization, vulnerability, and transference. Seven participants described their therapist as nurturing or felt nurtured throughout the process of personal therapy. Participants reported that nurturing meant feeling safe with, trusting of, and cared for by their therapist. This atmosphere of nurturing helped participants foster the courage to take risks without fear of judgment or criticism, as expressed by Jennifer:

> I felt prized, and loved, and 100% accepted. And nothing was abnormal or weird, like, what I shared. . . . her response was always super supportive. . . . My schedule was really odd, and so she made it work for my schedule. So, sometimes we met at 7:30 in the morning. Which I really appreciate. Sometimes we met at 8:00, sometimes we met at 2:00 in the afternoon . . . and I never felt like that was a burden . . . she never made it sound like I was burdening her . . . and I'm super appreciative for that.

All participants reported that their therapist, in different ways, normalized their experience. Many participants (n = 12) believed something was atypical or flawed about their personhood for needing personal therapy. Receiving help triggered feelings of stigma, self-rejection, or self-criticism. Thus, a large part of participants' healing process was feeling normalized by the therapist. Thomas shared:

> There's even been times when I've asked her, like, "do I fit a diagnosis? Like, what's wrong with me?" You know, there's even been times when I've kind of demanded from her, like "what, what's the deal? I've been seeing you for 2 years, tell me what's wrong with me." And she won't do it. She will not do it, and she's just like, "No, that's not what I do." And so that's helped me immensely. She's like "everything you've told me, every, everything fits." And it's helped me to see it that way.

Participants also reported feeling vulnerable as the client and described the feeling of opening themselves to the presence and feedback of another as uncomfortable but also inducing growth. Participants described this level of vulnerability as it related to their counselor identity; they explained that they were most accustomed to structuring the session and managing the time and felt more comfortable in the therapeutic relationship in the role of counselor. As the client, participants experienced a new kind of vulnerability that led to intrapersonal and interpersonal growth due to the reversed power differential, as described by Betty:

> When I'm the client, it's like, "I don't know where we're going, I don't know what's gonna come up." It's kind of scary sometimes. Like you know? He's the guy with the flashlight, and I don't know where he's, what's gonna happen sometimes. Like what's going to get uncovered, [what] I'm suddenly gonna become aware of or feel, or something. So it's a little scary.

Several participants (n = 9) shared that healing occurred as a result of therapeutic transference in the relationship with their therapist. Participants reported perceiving the therapist as a significant relationship in their life, sometimes describing their therapists as a parental presence. At times, the therapists themselves were the healing catalyst, acting as a substitute for redirecting emotional wounds. This subtheme also encompassed feelings of attachment. In many cases, participants' early attachment figures were either emotionally or physically unavailable or harmful. Participants explained that their therapists acted as a healthy attachment figure and described this aspect of the relationship as reparative. Some participants shared feeling re-parented by their therapist, like Michelle:

> She probably was the age of my mom at the time, and so I felt very nurtured by her in a way that, like I always wanted to be nurtured by mom but it hadn't happened like that. . . . I mean, there was that transference kind of feeling that was happening, but it was very positive and she was very warm, and I feel like that relationship was so healing and allowed me to process through more things, feeling supported and encouraged by someone who is kinda like my mom but not my mom, almost like it was like a reparative thing within the relationship.

Theme 6: Challenges

Two participants shared that personal therapy was a purely positive experience without negative or uncomfortable feelings. However, 11 participants reported challenges during the course of therapy that inhibited their healing processes. These challenges included three subthemes: finances, stigma, and role adjustment, as explained by Felicity, Michelle, and Rose:

> Um and then I kind of thought I was done and then I realized it was like, okay I have to add the money aspect, because every time I'm just like ugh, because I am perpetually broke. And so, I added the money like off to the side just like it's not really part of the process but it's this thing that exists that I can't erase. (Felicity)

> There is a stigma like that if you need to go see someone that you're somehow like inadequate to deal with your own stuff, or that you're crazy or that you're really far gone, like only people who are really far gone need to do that, but I still think it's a pride thing, you know? (Michelle)

> It's weird and it's distracting as a client because . . . I know what she's doing. Why is she doing that? Huh. Like it's a good place to run to if you don't want to go where they're trying to take you; you can go into your analytical, left brain, logical mode. Oh, I know exactly, and you feel like an expert. You know what they're doing. They're not pulling it over on you. (Rose)

Five participants discussed the idea of stigma related to their counselor status. The remaining participants (n = 9) explained that they did not personally feel stigmatized, but were aware of the stigma that existed with regard to counselors who receive personal therapy. All participants shared that they would attend personal therapy longer or more frequently if not for financial barriers. Additionally, each participant described the difficulty of experiencing the identity of both client and counselor.

Discussion

We aimed to answer two overarching research questions: 1) What contributes to counselors' decisions to seek personal therapy? and 2) How do professional counselors make meaning of their experiences in utilizing personal therapy? The results of the current study are both similar and contradictory to previous literature. For example, many researchers have demonstrated evidence of counselor burnout and compassion fatigue (Moore et al., 2020; Robino, 2019; Thompson et al., 2014). Participants described feeling burned out and lacking in empathy as motivations to seek personal therapy. Additionally, Day and colleagues (2017) outlined behavioral symptoms of burnout and compassion fatigue, including mood changes, sleep disturbances, becoming easily distracted, and increased difficulty concentrating. Many participants shared similar symptoms when discussing thoughts and feelings in their decision-making processes to initiate personal therapy, as well as when describing their mental health concerns. Therefore, it is important to assess counselors for levels of burnout and compassion fatigue in addition to raising awareness of their signs and symptoms.

The subtheme of stigma in participant voices within the current study is consistent with the existing literature. Kalkbrenner et al. (2019) found that stigma was one of three primary barriers to counseling among practicing counselors and human service professionals. Participants in our study described the general stigma and personal shame in seeking mental health treatment. Furthermore, participants

differentiated between general stigma regarding mental health and stigma specific to counselors. Based on this finding, counselors may experience greater stigma than the general population when seeking personal therapy due to their professional identity. We would also like to note the research team's personal reactions of feeling affirmed and normalized, as we had all experienced some level of stigma in seeking our own therapy—hearing and reading the participants' experience of stigma created increased feelings of universality among our team.

With regard to theories about the working alliance, Mearns and Cooper (2017) described the notion of working at the intimate edge of the ever-shifting interface between client and counselor, referring to both the boundary between self and other and the boundary of self-awareness. Most notably in our study, the subtheme of professional interpersonal growth illuminates how the self-awareness gained in therapy impacted participants' clinical work, supporting the working alliance theory, outlined by Mearns and Cooper (2017), which posits that expanding self-discovery and becoming more intimate with one's own experience through the evolving relationship with the other increases intimacy in interpersonal relationships as one becomes more attuned to the self.

Aligned with the concept of professional growth, many researchers have emphasized that personal therapy was an educational or training experience for therapists and added to their professional repertoire of knowledge and skills (Anderson & Levitt, 2015; Moe & Thimm, 2021). However, these findings are not congruent with the experiences of participants in the present study. Although participants reported enhanced professional growth in terms of boundaries with clients and professional advocacy outside of the therapeutic relationship, participants shared that the intellectual aspect of personal therapy within the relationship served as a barrier to the healing process. All participants expressed a desire or intent to release themselves of their counselor identity while experiencing the client role. Thus, some counselors may not see personal therapy as a means for education or professional role modeling and instead find those aspects as distracting to the experience. It is also interesting to note that our research team's perspectives mirrored this varied experience; through our journaling and discussion, we acknowledged that some research team members shared the experience of participants in our study, while other members felt more similarly to the preexisting literature's conclusions.

Limitations and Future Research

The current study includes many strengths, such as the rigor we followed and trustworthiness we demonstrated. However, some limitations exist. Firstly, we collected data prior to the pandemic; a replication study post–COVID-19 could shed light on specific factors related to how the pandemic has impacted counselors' experiences in personal therapy. Additionally, we used a single interview design, which limits the amount of extended field experience with participants. Participants may have offered more intimate and sensitive information after spending more time in the interviewing process. Due to the sensitive nature of the topic of the study, we worked to establish trust and build rapport with the participants by using introductory questions at the beginning of the interview. Researchers may collect richer data through the use of longitudinal studies that examine participants' experiences in personal therapy over time and with other data sources. Despite plans to recruit a sample that was diverse in terms of age, gender, ethnic identification, sexual orientation, and religious/spiritual orientation, participants in this study were similar to each other. Only one participant identified as a man, and the majority of participants ($n = 9$) were White. We attempted to rectify the above limitations through networking with licensed professional counselors who worked in a variety of counseling settings. However, future researchers could examine the experience of counselors who identify as men or non-binary, as well as counselors of color.

Implications for Counselors

The knowledge gained from our study offers both suggestions for how clinicians can approach counselors in personal therapy and broader advocacy for the profession to increase engagement in counseling. In terms of clinical practice, participants often emphasized the struggle in assuming the client role, as they were most comfortable with the typical power differential in their professional work. This phenomenon was especially salient in the participant voices of this study; vulnerability and role adjustment were crucial themes of their experience. Therefore, it may behoove clinicians to maintain awareness of this possibility or discuss it within personal therapy. For example, Moore et al. (2020) suggested engaging in conversations about interpersonal stress, self-care, and burnout within the supervision relationship; however, we purport that clinicians of clients who are also counselors could facilitate intentional space to address these issues in counseling. That being said, mental health professionals may find benefit in balancing attending to the person of the counselor with focus on professional identity due to the barrier of role adjustment presented in this study. Neswald-Potter and colleagues (2013) suggested the use of the Wheel of Wellness Model developed by Witmer and Sweeney (1992) to facilitate an integrated approach in promoting wellness in counselors: spirituality, self-direction, work and leisure, friendship, and love. Finding meaning in all life tasks could assist clinicians in balancing professional and personal concerns in working with counselors as clients. Wellness is often associated with self-care practices in counseling.

Self-care is not a novel topic of discussion in counselor training or professional practice. However, in light of this study's findings, we aim to describe therapeutic interventions for mental health professionals who may have counselors as clients. Coaston (2017) summarized much of the literature on self-care for counselors and recommended several strategies for interventions in three main areas: mind, body, and spirit. Concretely, interventions may include mindfulness, boundary setting, time management, cognitive reappraisal writing activities, stretching, moral inventory, and listing life principles (Coaston, 2017; Posluns & Gall, 2020). Finally, Bradley et al. (2013) outlined a variety of creative approaches to counselor self-care, as well as facilitative questions that may lend well to opening dialogue in a therapy session. Example questions include: (a) What are the indications that you are doing well and healthy? (b) Which things in the environment can be changed to help you continue to grow? and (c) Do you experience this emotion or pattern of emotions frequently? How did you respond? These suggested self-care interventions are only useful if counselors attend personal therapy, and in the results of our study, participants described how stigma remained a barrier.

Clinicians may consider normalizing thoughts and feelings related to stigma in order to encourage engagement in counseling. Sommers-Flanagan and Sommers-Flanagan (2018) defined normalization as the therapist's use of indirect or direct statements that reframe client problems as contextual responses to the difficulties of life. Therapists use normalization to depathologize client concerns and convey implicit acceptance of the person of the client. Varying degrees of normalization skills include psychoeducation, reframing, and self-disclosure (Sommers-Flanagan & Sommers-Flanagan, 2018). Reducing the stigma of accessing counseling as a counselor may need to begin with normalizing it during training. Knaak et al. (2014) reported that the most effective anti-stigma interventions incorporate social contact, education, personal testimonies, teaching skills, and myth-busting. Therefore, creating space for anti-stigma interventions in professional development activities (e.g., conference presentations, continuing education sessions) as well as incorporating these strategies into counselor training (e.g., class or group supervision) may advocate for engagement in counseling across the counselor profession spectrum. Additionally, a follow-up study examining counselors seeking therapy to improve their own clinical efficacy with clients may also serve as a way to decrease stigma.

Lastly, we believe that the findings of our study support the need for and advocacy of personal therapy after graduate training. Unlike counselor trainee program requirements that often mandate a certain number of hours in personal therapy, fully licensed professional counselors are not regulated by licensing boards with regard to continuing personal therapy. Policy changes that include a personal therapy requirement in a similar vein as continuing education credits may positively impact counselor stigma and wellness.

Conclusion

Counselors face many challenges in their clinical work, including occupational stressors and the need for self-awareness (Moore et al., 2020; Mullen et al., 2017; Prosek et al., 2013; Robino, 2019; Thompson et al., 2014). The current descriptive phenomenological study serves to provide an understanding of the lived experiences of counselors who utilize personal therapy, including their motives to engage and meaning made while engaged. We offer clinical suggestions within the counseling relationship, steps to reduce stigma, and recommendations for facilitating self-care strategies among counselor trainees and professional counselors directly from voices of counselors who have accessed personal therapy.

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Appendix

Factorial Invariance of Scores on the Inner Wealth Inventory: A Nationwide Sample of Adults in the United States

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The Inner Wealth Inventory (IWI) is a screening tool for measuring inner wealth (IW), a wellness-based construct centered on empowering clients to inherently value themselves for being who they are. The initial IWI score validation study was conducted with samples of child welfare professionals. If the IWI's psychometric properties are confirmed with a normative sample of U.S. adults, it has potential to offer professional counselors a tool for measuring IW. The purpose of the present study was to test the factorial invariance and convergent validity evidence of scores on the IWI with a national sample (N = 840) of U.S. adults, stratified by the census data for gender, ethnoracial identity, geographic location, and age. The results of factorial invariance and convergent validity testing revealed strong support for the psychometric properties of a sample of U.S. adults' scores on the unidimensional IWI, including equivalence in the meaning of IW across gender, ethnoracial identity, help-seeking history, education, and income in our sample.

Keywords: **Inner Wealth Inventory, professional counselors, U.S. adults, psychometric properties, equivalence**

Promoting wellness with an emphasis on development and prevention is a core focus in the discipline of professional counseling (Long et al., 2022; Myers, 1992; Myers & Sweeney, 2014). Measuring and promoting wellness is an especially important issue when considering the ubiquitous and comorbid nature of mental and physical health issues among adults living in the United States (World Health Organization [WHO], n.d., 2021). Wellness-based screening tools with rigorously validated scores have a lot of utility in professional counseling settings for monitoring clients' health and wellness (Mason et al., 2023).

Consistent with the wellness orientation of the counseling profession, The Inner Wealth Inventory (IWI) is a wellness-based screening tool for measuring inner wealth, which is defined as:

> A growing, accruing, and deepening sense of internal enrichment, which can be enhanced by external or internal self-narrated recognitions, that empowers a person to navigate the world in relation to one's unfolding of who they really are as a person who is meaningful, valued, and who has great things to contribute by being simply true to oneself. (Bennett et al., 2023, p. 123)

The initial IWI score validation study was conducted with two large samples of child welfare professionals (Bennett et al., 2023). The psychometric properties of screening tools can fluctuate over time or with different normative samples (American Educational Research Association [AERA] et al., 2014). Professional counselors have an ethical duty to make sure that screening tools have valid and reliable scores with untested samples to confirm that they are used properly (Lenz et al., 2022; National Board for Certified Counselors, 2023). Accordingly, the primary aim of the present investigation was to test the

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factorial invariance (equivalence in meaning) of IWI scores with a national sample of U.S. adults. Pending evidence of factorial validity, we will test the convergent validity of IWI scores with established measures.

The State of Mental and Physical Health Among U.S. Adults

The comorbid nature of mental and physical health issues among U.S. adults has increased in severity and complexity since the COVID-19 pandemic (Clarke et al., 2020). Anxiety and depression are two of the most prevalent mental health issues among U.S. adults (National Alliance on Mental Illness [NAMI], 2022). Anxiety and depressive disorders tend to co-occur with a number of physical health issues, including heart disease and pain disorders (Winkler et al., 2015). In fact, heart diseases were the number one killer of adults over 18 in the United States from 1999–2020, with intentional self-harm (including suicide), and essential hypertension also in the top 15 (Centers for Disease Control and Prevention [CDC], n.d.). The pervasive and concurrent nature of anxiety, depression, and non-communicable physical diseases is further exacerbated by sociodemographic factors.

Sociodemographic Factors

Past investigators documented a number of sociodemographic health disparities among adults in the United States by gender identity, ethnoracial identity, help-seeking history, income, and education (Kalkbrenner, 2022; Kobayashi et al., 2021; Patrick et al., 2020). Specifically, differences in power, privilege, and biological factors between females and males contribute to inequitable health outcomes (Pan American Health Organization & WHO, n.d.). Specifically, women reported higher rates of negative health outcomes and reduced health care access than men (Connor et al., 2020; Talevi et al., 2020). In terms of ethnoracial differences, U.S. adults who identified as racial minorities/non-White reported higher rates of both mental health concerns (i.e., any mental, behavioral, or emotional disorder) and physical concerns (e.g., heart disease, hypertension, asthma or emphysema) in comparison with their White counterparts (National Institute of Mental Health, 2023; Ramraj et al., 2016). Similarly, lower levels of education are a risk factor for poorer health conditions (van der Heide et al., 2013). In comparison to individuals with less than a high school degree, those with a degree higher than a high school degree reported better health conditions (Johnson-Lawrence et al., 2017). Moreover, individuals with college degrees reported better health in general in comparison to their counterparts with less education (Lawrence, 2017). Income is another sociodemographic factor that impacts wellness in a multifaceted manner (Beech et al., 2021). For instance, adults living under the poverty line are at risk for food insecurities and exposure to hazardous working environments (Laska et al., 2021; Mikati et al., 2018). Additionally, individuals living with a lower socioeconomic status are more at risk for COVID-19 and its aftermath (J. A. Patel et al., 2020).

Help-seeking history is a relatively new demographic variable in the extant literature that is related to attitudes about counseling and utilization of counseling services (Kalkbrenner, 2023; Cheng et al., 2018). In the context of a demographic variable, help-seeking history is not intended to quantify a latent trait representing a comprehensive representation of one's engagement in counseling. Rather in terms of a demographic variable, help-seeking history is quantified categorically as either 1 (attended at least one session of personal counseling) or 2 (never attended counseling; Cheng et al., 2018). A help-seeking history is a predictor of more positive attitudes about accessing mental health support services (Cheng et al., 2018). However, Kalkbrenner (2023) found that adults in the United States with a help-seeking history reported lower levels of mental and physical health than those without a help-seeking history. Accordingly, help-seeking history and other sociodemographic variables are important considerations when calibrating wellness-based screening tools (e.g., the IWI).

The initial IWI score validation study (Bennett et al., 2023) established the IWI's overall internal structure (exploratory factor analysis [EFA] and confirmatory factor analysis [CFA]) and validity based

on relations with other variables. Factorial invariance testing is an extension of CFA and a method for enhancing the precision of internal structure validity. Factorial invariance testing (psychometric equivalence across subgroups of the larger sample) is an especially important next step in this line of research, as findings in the extant literature (e.g., Kalkbrenner, 2022; Kobayashi et al., 2021; Patrick et al., 2020) have evidenced differences in wellness by sociodemographic variables.

Inner Wealth and the Inner Wealth Inventory

Inner wealth (IW) is a latent construct consisting of internal enrichment and empowerment (Bennett et al., 2023; Glasser & Lowenstein, 2016). This internal enrichment can be furthered by external factors such as meaningful social connections. This enrichment acts by empowering individuals to view themselves as a meaningful and valued person who contributes things to the world by being their true self (Bennett et al., 2023). The Nurtured Heart Approach (NHA) is a framework used to help individuals in growing their IW (Glasser & Lowenstein, 2016). The NHA and IW have been implemented for decades (Glasser & Easley, 1998); however, there is a dearth of empirical NHA studies in the extant literature, as a screening tool for measuring IW (the primary outcome variable in NHA) did not exist until recently. Bennett et al. (2023) developed and validated scores on the IWI with two large samples of child welfare professionals. Bennett et al. (2023) also found that IWI scores were significant negative predictors (with large effect size estimates) of lower levels of burnout and compassion fatigue as well as significantly higher levels of resilience. One of the next steps in this line of research is to test the generalizability of IWI scores with a national sample of U.S. adults, as professional counselors need wellness-based inventories with valid scores.

Purpose Statement and Research Questions

The purpose of the current study was to test the factorial invariance and convergent validity evidence of IWI scores with a national sample of adults in the United States. If scores are validated, the IWI has potential to contribute a wellness-based screening tool with utility for appraising IW in clinical and in research settings. The following research questions (RQs) guided the present study:

Research Question 1: Is the dimensionality of scores on the IWI confirmed with a national sample of adults in the United States?

Research Question 2: Are scores on the IWI from a national sample of adults in the United States invariant across extant sociodemographic variables?

Research Question 3: What is the convergence of scores on the IWI with established measures among a national sample of adults in the United States?

Method

A quantitative cross-sectional research design was employed to answer the research questions. Specifically, we used a psychometric design based on internal structure validity, convergent validity, and internal consistency reliability. This study is part of a larger grant-funded project with an aim to increase the generalizability of scores on wellness-based measures.

Participants and Procedures

Following IRB approval, grant funding was used to hire Qualtrics Sample Services (2023), an online research panel and sampling pool for survey research. Mike Kalkbrenner, the first author, entered the instrumentation into the Qualtrics secure online survey tool and sent the distribution link to the Qualtrics Research Services Account Executive. Working with a team of analysts, the Research Services

Account Executive launched a national sampling procedure (stratified by the U.S. Census Bureau [2022] data for gender, age, ethnoracial identity, and geographic location) among adults living in the United States. The present study included two eligibility criteria. First, prospective participants had to be 18 years old or older. Second, they had to be permanent residents of the United States at the time of data collection. The team of Qualtrics analysts completed a quality check on the data by identifying and removing random response patterns, speeders, and unrealistic answers.

A raw sample of $N = 850$ responses was collected. Seven cases were removed due to > 20% missing data. Little's Missing Completely at Random (MCAR) test revealed that the data could be treated as MCAR (X^2 [428] = 454.736, $p = .179$); expectation maximization was used to impute missing values. Skewness and kurtosis values were consistent with a normal distribution, standardized *z*-scores showed zero univariate outliers ($z \geq 3.29$), and Mahalanobis distances exhibited zero multivariate outliers, yielding a final sample of $N = 840$.

Participants ($N = 840$) ranged in age from 18 to 90 ($M = 48$; $SD = 18$). For gender identity, 52.0% ($n = 437$) self-identified as female, 46.7% ($n = 392$) male, 0.5% ($n = 4$) transgender, 0.4% ($n = 3$) non-binary, and 0.5% ($n = 4$) preferred not to answer. For ethnoracial identity, 1.0% ($n = 8$) self-identified as American Indian or Alaska Native; 10.0% ($n = 88$) Asian or Asian American; 11.5% ($n = 97$) Black or African American; 14.2% ($n = 119$) Hispanic, Latinx, or Spanish origin; 1.4% ($n = 12$) Multiethnic; 0.1% ($n = 1$) Native Hawaiian or Other Pacific Islander; 58.2% ($n = 489$) White or European American; 1.1% ($n = 9$) another race, ethnicity, or origin; 1.8% ($n = 15$) preferred not to answer; and 0.2% ($n = 2$) did not specify their ethnicity. For highest level of education, 37.5% ($n = 315$) reported high school degree, 16.8% ($n = 141$) associate degree, 27.3% ($n = 229$) bachelor's degree, 12.9% ($n = 108$) master's degree, 2.6% ($n = 22$) doctoral degree, 2.3% ($n = 19$) preferred not to answer, and 0.7% ($n = 6$) did not specify their level of education. For help-seeking history, 67.3% ($n = 565$) reported help-seeking history, 31.1% ($n = 267$) had no help-seeking history, and 1.7% ($n = 14$) did not specify their help-seeking history. For income, 27.7% ($n = 233$) self-identified as below the poverty line, 63.5% ($n = 533$) above the poverty line, and 8.8% ($n = 74$) did not specify their income.

Measures

Participants indicated their voluntary informed consent and confirmed that they met the inclusion criteria for participation, at least 18 years old and living in the United States. Next, respondents completed a demographic questionnaire, which included self-report items on age, gender identity, ethnoracial identity, help-seeking history, geographic location, income, and the number of people living in their household. Lastly, participants completed a battery of four screening tools.

Inner Wealth Inventory

The IWI is a screening tool for measuring IW,

> a growing, accruing, and deepening sense of internal enrichment, which can be enhanced by external recognitions, that empowers a person to navigate the world in relation to one's unfolding of who they really are as a person who is meaningful, valued, and who has great things to contribute by being simply true to oneself. (Bennett et al., 2023, p. 123)

Participants respond to declarative statements on the following Likert scale: 1 = *Strongly Disagree*, 2 = *Disagree*, 3 = *Not Sure*, 4 = *Agree*, or 5 = *Strongly Agree*. Bennett et al. (2023) validated scores on both a unidimensional and a two-dimensional IWI model via internal structure validity (EFA and CFA) and convergent validity testing with two large samples of child welfare professionals.

The unidimensional version of the IWI is comprised of 13 items, which collectively measure general IW (example item: "I believe I have the power to make positive changes in my day to day life."). The two-factor version of the IWI includes the 13 items from the unidimensional version plus seven additional items. The first subscale of the two-dimensional model, Internal IW, is comprised of 15 items that appraise intrapersonal elements of IW (example item: "I know how to calm myself down when I am upset."). The second subscale, External IW, consists of five items, which measure interpersonal components of IW (example item: "I feel comfortable in social situations.").

Bennett et al. (2023) found strong internal consistency reliability evidence for child welfare professionals' IWI scores on the unidimensional version (α = .90, ω = .90) and the Internal IWI scale (α = .91, ω = .91) of the two-dimensional model. Questionable-to-acceptable internal consistency reliability evidence of scores emerged for the External IWI scale (α = .67, ω = .65). Consistent with the results of Bennett et al. (2023), we found strong internal consistency reliability evidence of scores with the current sample of adults in the United States on the unidimensional IWI version (α = .942, 95% CI [.935, .948]; ω =. 942, 95% CI [.935, .949]) and the Inner IW subscale (α = .947, 95% CI [.940, .953]; ω =. 947, 95% CI [.941, .953]) and questionable-to-acceptable internal consistency reliability evidence of scores on the External IWI subscale (α = .684, 95% CI [.640, .722]; ω =. 645, 95% CI [.571, .701]).

Mental Health Inventory-5

The Mental Health Inventory-5 (MHI-5) is a screening tool for measuring general mental health in adults (Berwick et al., 1991). Participants respond to five different items concerning their mental health in the past month on the following scale: *none of the time, a little of the time, some of the time, a good bit of the time, most of the time*, and *all of the time* (Berwick et al., 1991). Past investigators found both internal structure (Rivera-Riquelme et al., 2019) and criterion validity evidence (Yamazaki et al., 2005) of MHI-5 scores. Multiple researchers also found satisfactory internal consistency reliability of MHI-5 scores including Rivera-Riquelme et al. (2019; α = .71, ω = .78) as well as Marques et al. (2011; α = .82). In the present study, we found acceptable internal consistency reliability evidence of MHI-5 scores (α = .841, 95% CI [.819, .860]; ω =. 833, 95% CI [.805, .856]).

Generalized Anxiety Disorder-7

The Generalized Anxiety Disorder-7 (GAD-7) is a self-report instrument used for measuring the severity of generalized anxiety disorder symptoms (Spitzer et al., 2006). Each of the seven items ask how often in the last two weeks were participants bothered by different symptoms of anxiety, for example, "feeling nervous, anxious, or on edge" and "being so restless that it is hard to sit still." Participants respond to each item on a response scale ranging from 0 (*not at all*), 1 (*several days*), 2 (*more than half the days*), or 3 (*nearly every day*). A number of past investigators (e.g., Dhira et al., 2021; Omani-Samani et al., 2018) found construct validity evidence for GAD-7 scores. Scores on the GAD-7 displayed moderate to strong internal consistency reliability estimates, including α = .91 (Seo & Park, 2015), α = .89 (Dhira et al., 2021), and α = .85 (Rutter & Brown, 2017). Among the sample of U.S. adults in the present study, strong internal consistency reliability estimates of GAD-7 scores emerged (α = .933, 95% CI [.925, .941]; ω = .933, 95% CI [.924, .940]).

Patient Health Questionnaire-9

The Patient Health Questionnaire-9 (PHQ-9) is a self-report instrument used to assess various depressive symptoms and their severity (Kroenke et al., 2001). Within the PHQ-9, individuals respond to the following prompt: "Over the last 2 weeks, how often have you been bothered by any of the following problems" with order responses ranging from 0 = *not at all*, 1= *several days*, 2 = *more than half the days,* or 3 = *nearly every day* (Kroenke et al., 2001). The PHQ-9 consists of nine items (example item:

"Feeling down, depressed, or hopeless"; Kalkbrenner, 2022). Maroufizadeh et al. (2019) demonstrated convergent validity evidence of PHQ-9 scores through moderate to strong correlations with measures assessing similar constructs. Internal structure validity of PHQ-9 scores were found through factorial invariance testing by J. S. Patel et al. (2019). Scores on the PHQ-9 have demonstrated moderate to strong internal consistency reliability scores when investigated by a variety of researchers including α = .90 (Dosovitsky et al., 2021), α = .85 (Maroufizadeh et al., 2019), and α = .78 (Dajpratham et al., 2020). Similarly, we found strong internal consistency reliability evidence of PHQ-9 scores with the present sample of U.S. adults (α = .926, 95% CI [.917, .934]; ω = .927, 95% CI [.917, .935]).

Data Analysis

Two single-order CFAs were computed to test the dimensionality of a national sample of U.S. adults' scores on the unidimensional and two-dimensional IWI models. We referred to Dimitrov (2012) and Schreiber et al. (2006) for cutoff scores to interpret model fit, including chi-square absolute fit index (CMIN, non-significant *p*-value or $\chi 2$ *to df* < 3), the comparative fit index (CFI, .90 to .95 = acceptable fit and > .95 = strong fit), standardized root mean square residual (SRMR < .08 = acceptable fit and < .06 = strong fit), and root mean square error of approximation (RMSEA < .08 = acceptable fit and < .06 = strong fit;). Pending acceptable fit, one or both models will be tested for factorial invariance of scores. Based on our review of the extant literature, the following sociodemographic variables were tested for factorial invariance: gender, help-seeking history, ethnoracial identity, income, and education (Kalkbrenner, 2022; Kobayashi et al., 2021; Patrick et al., 2020).

Meade and Kroustalis (2006) recommended that comparison groups for multiple-group confirmatory factor analysis (MCFA) should be comprised of at least 200 participants. Accordingly, the levels of the gender and ethnoracial identity variables were coded into the following levels in order to meet the sample size requirements for MCFA: gender identity (n = 437 female or n = 391 male) and ethnoracial identity (n = 489 White or n = 334 non-White). The levels of the help-seeking history (n = 565 with a help-seeking history or n = 261, without a help-seeking history), education (n = 315 high school diploma or n = 501 undergraduate degree or beyond), and income (n = 533 above the poverty line or n = 233 below the poverty line) variables met the minimum sample size requirement for MCFA.

Pending at least acceptable internal structure validity evidence of IWI scores (RQs 1 and 2), we will test convergent validity evidence by computing Pearson product moment correlations (r) between the IWI and the following well-established screening tools: the PHQ-9, GAD-7, and MHI-5. Strong negative correlations between the IWI and both the GAD-7 and PHQ-9 would prove convergent validity evidence of scores. A strong positive correlation between the IWI and MHI-5 would support convergent validity. A threshold of $r \geq +/- .50$ was used to evidence convergent validity of scores (Drummond et al., 2016).

Results

The unidimensional and two-dimensional IWI models were entered into two separate CFAs to test the dimensionality of scores on each model with adults in the United States (RQ 1). Pending acceptable model fit, the IWI items will be entered into an MCFA for invariance testing (RQ 2). The CFAs and MCFA were computed in IBM SPSS Amos version 26 with a maximum likelihood estimation method.

Single-Order Confirmatory Factor Analysis

The unidimensional IWI items were entered into the first CFA, and all the incremental fit indices displayed an acceptable model fit: CFI = .94, NFI = .93, IFI = .94. For the absolute fit indices, the SRMR indicated a strong model fit (SRMR = .04); however, the CMIN (χ^2 [65] = 498.61, p < .001, X^2/df = 7.67) and

RMSEA (.09, 90% CI [.08, .10]) displayed a questionable-to-poor fit. The CMIN tends to underestimate model fit with large samples (Dimitrov, 2012) and the RMSEA tends to underestimate model fit for shorter screening tools (Shi et al., 2019). Accordingly, the collective results of the CFI, NFI, IFI, and SRMR supported satisfactory fit for scores on the unidimensional model. Thus, we proceeded with the MCFA for the unidimensional model.

The two-dimensional IWI model items were entered into another CFA to test the fit of the baseline model. The CFA results revealed poor model fit: CMIN (χ^2 [169] = 876.11, $p < .001$, $X^2/df = 5.18$); CFI = .84; NFI = .81; IFI = .84; RMSEA = .11, 90% CI (.09, .11); and SRMR = .16. We decided not to proceed with factorial invariance testing for the two-dimensional IWI model due to both the poor internal structure validity evidence and questionable internal consistency reliability evidence of scores on the External IWI subscale (α = .684, 95% CI [.640, .722]; ω =. 645, 95% CI [.571, .701]).

Factorial Invariance Testing: Multiple-Group Confirmatory Factor Analysis

The unidimensional IWI items were entered into an MCFA (RQ2). To establish invariance of scores, we used the following recommendations from Chen (2007): < Δ 0.015 in the RMSEA, < Δ 0.030 in the SRMR for metric invariance or < Δ 0.015 in SRMR for scalar invariance, and < Δ 0.010 in the CFI. Results revealed strong measurement invariance (metric and scalar) for all sociodemographic variables (see Table 1). In other words, the MCFA provided strong evidence that IW had the same meaning among adults in the United States across gender identity, ethnoracial identity, help-seeking history, income, and education.

Table 1

Multiple-Group Confirmatory Factor Analysis: Inner Wealth Inventory

Invariance Forms	*CFI*	*ΔCFI*	*RMSEA*	*ΔRMSEA*	*RMSEA CIs*	*SRMR*	*ΔSRMR*	*Model Comparison*
Gender Identity: Male vs. Female								
Configural	.930		.067		.061, .072	.042		
Metric	.928	.002	.065	.002	.060, .070	.046	.004	Configural
Scalar	.925	.003	.063	.002	.058, .068	.046	< .0001	Metric
Ethnoracial Identity: White vs. Non-White								
Configural	.930		.067		.061, .072	.043		
Metric	.929	.001	.064	.003	.059, .070	.043	< .0001	Configural
Scalar	.928	.001	.062	.002	.057, .067	.043	< .0001	Metric
Help-Seeking History vs. No Help-Seeking History								
Configural	.934		.064		.059, .070	.038		
Metric	.935	.001	.061	.003	.056, .067	.039	.001	Configural
Scalar	.932	.003	.060	.001	.055, .065	.039	< .0001	Metric
Income: Below the Poverty Line vs. Above the Poverty Line								
Configural	.922		.071		.066, .077	.041		
Metric	.922	< .0001	.068	.003	.063, .074	.044	.003	Configural
Scalar	.921	.001	.066	.002	.061, .071	.044	< .0001	Metric
Education: High School vs. Undergraduate and Beyond								
Configural	.928		.068		.062, .073	.045		
Metric	.928	< .0001	.065	.003	.060, .070	.046	.001	Configural
Scalar	.928	< .0001	.062	.003	.057, .067	.046	< .0001	Metric

Convergent Validity Testing

Scores of a national sample of U.S. adults on the IWI were correlated with the following established measures to investigate convergent validity of scores: the MHI-5, PHQ-9, and GAD-7. A threshold of $r \geq +/- .50$ was used to evidence convergent validity of scores (Drummond et al., 2016). The IWI displayed a strong correlation with scores on the MHI-5 ($r = .66$, $r^2 = .44$, $p < .001$, 2-tailed). A strong correlation also emerged between scores on the IWI and PHQ-9 ($r = -.56$, $r^2 = .31$, $p < .001$, 2-tailed). Finally, we found a strong correlation between the IWI and GAD-7 ($r = -.52$, $r^2 = .27$, $p < .001$, 2-tailed).

Discussion

The primary aims of this study were to test the factorial invariance and convergent validity evidence of IWI scores with a national sample of adults in the United States. IW is a wellness-based construct that dovetails with the wellness orientation of the counseling profession (Bennett et al., 2023; Myers, 1992; Myers & Sweeney, 2014). Bennett et al. (2023) developed and validated IWI scores with samples of child welfare professionals; however, a score validation study was necessary to ensure that the measure was appropriately calibrated with a sample of U.S. adults. Collectively our results supported the psychometric properties of the unidimensional IWI model but not the two-dimensional model. The findings will be discussed accordingly.

Unidimensional IWI Model

The CFA and MCFA results were promising for the unidimensional IWI model. Unidimensional IWI scores demonstrated strong invariance (metric and scalar) for all sociodemographic variables, which is particularly noteworthy, as it is not uncommon for at least one fit index to evidence metric invariance only. These results supported the generalizability of a sample of U.S. adults' scores on the unidimensional IWI. Collectively, the MCFA results revealed that IW had the same meaning among U.S. adults between the following sociodemographic variables: income, gender, ethnoracial identity, help-seeking history, and education. These sociodemographic variables are associated with differences in terms of wellness (Kalkbrenner, 2022; Kobayashi et al., 2021; Patrick et al., 2020). This finding is encouraging, as professional counselors need wellness-based screening tools now more than ever considering the complex and comorbid nature of mental and physical health issues among U.S. adults (Clarke et al., 2020; NAMI, 2022). In particular, the IWI offers professional counselors a brief tool for measuring a wellness-based construct (IW) that is invariant among U.S. adults.

The results of convergent validity testing were also favorable, as the strength and direction of all correlations were in the expected directions. The effect size estimates (practical significance) for all correlations were in the strong range (Sink & Mvududu, 2010). The strength of the effect size estimate for the co-variance between IWI scores and MHI-5 scores was particularly noteworthy and evidenced 44% shared variance. Also as expected, IWI scores of a sample of U.S. adults demonstrated strong negative correlations with the GAD-7 (anxiety severity) and the PHQ-9 (depression severity). This finding is promising for a couple of reasons. First, it supports the convergent validity evidence of IWI scores, as wellness-based constructs tend to display negative correlations with both anxiety and depression severity (Kalkbrenner, 2022). In other words, the results of convergent validity testing supported that the IWI measured the intended construct of measurement. Second, these findings are promising when considering the prevalence of anxiety and depressive disorders among U.S. adults (Clarke et al., 2020; NAMI, 2022). Future outcome research is needed to establish causality between latent traits. However, the findings of the present study provide tentative evidence surrounding a notable proportion of co-variation between a sample of U.S. adults' IWI scores and lower anxiety and depression scores.

Two-Dimensional IWI Model

In the initial instrument development and score validation study, Bennett et al. (2023) found support for the internal structure validity of scores on both unidimensional and two-dimensional IWI models. However, in the present study, we found questionable internal consistency reliability and poor internal structure validity evidence of scores on the two-dimensional IWI model. Differences in the normative samples might account for the discrepant findings between Bennett et al. (2023) and the current study. The present study was comprised of a non-clinical sample of U.S. adults, and Bennett et al. (2023) sampled child welfare professionals, who were defined as mental health professionals who were working "directly and indirectly in public child welfare agencies to ensure the safety, protection, and well-being of children" (p. 122). Mental health professionals have training in providing mental (and sometimes physical) health care to clients in need of support services. Perhaps mental health professionals' clinical training and work experience is what led to them understanding IW as a two-dimensional construct. In other words, mental health professionals' training in interpersonal communication might have contributed to their recognizing both internal and external dimensions of IW (the two-dimensional model), whereas IW might have a unidimensional meaning among a non-clinical sample of adults living in the United States. Future research is needed to test this possible explanation for this finding.

Implications for Practice

The results of this study show strong psychometric support for the unidimensional IWI model with a sample of U.S. adults, which has a number of implications for counseling practitioners. The National Board for Certified Counselors (2023) encourages professional counselors to use screening tools with validated scores as one way to enhance clinical practice. In fact, professional counselors have an ethical duty to make sure that screening tools have valid and reliable scores with representative client samples to ensure their proper use (AERA et al., 2014; Lenz et al., 2022; National Board for Certified Counselors, 2023). CFA and MCFA are rigorous tests of construct validity and evidenced that the IWI accurately appraised the intended construct of measurement (IW). The results of the present study extend the generalizability of IWI scores from child welfare professionals (Bennett et al., 2023) to adults in the United States. Accordingly, as one implication for practice, professional counselors can use the IWI to measure their clients' IW. This is a particularly salient implication for practice, as demonstrating measurable treatment outcomes is becoming increasingly important in professional counseling and related health care settings (de Ossorno Garcia et al., 2021). In particular, professional counselors are expected to provide evidence of measurable client goals and outcomes. The IWI has potential to help professional counselors demonstrate such goals and outcomes. Suppose, for example, that a professional counselor is working with a client who is struggling with IW, which can manifest in a number of ways, such as struggles with self-efficacy and/or one's sense of self-worth being dependent on external validation from others (Bennett et al., 2023; Glasser & Lowenstein, 2016). The counselor can use the IWI to track their client's IW throughout treatment. The client's test scores might serve as one way to quantify their progress throughout therapy.

The NHA has been implemented for decades to help individuals grow their IW and reduce workplace stressors (e.g., burnout) as well as increase resilience (Bennett et al., 2023; Glasser & Lowenstein, 2016). However, to date, there is a dearth of empirical NHA studies in the extant literature, as a screening tool for measuring IW (the primary outcome variable in NHA) did not exist until recently. The results of the present study build on the initial score validation study by Bennett et al. (2023). Specifically, the MCFA in the present study took construct validity testing to another level by demonstrating that IWI scores have the same meaning across important demographic factors among a national sample of U.S. adults. Collectively, the results of CFA, MCFA, and convergent validity testing

suggest that the IWI is particularly well calibrated for measuring IWI among adults in the United States. Accordingly, professional counselors and professionals in related fields can use the IWI as one way to measure the utility of NHA interventions.

Practicality of the IWI and Consistency With the Counseling Profession

Practicality is a cornerstone of test-worthiness and involves the degree to which a screening tool is logistically feasible for use in clinical practice (Neukrug & Fawcett, 2019). Brief screening tools with validated scores enhance the practicality of screening tools, as they provide practitioners with a quick and feasible method for measuring their clients' scores on latent variables (Shields et al., 2021). The IWI has potential to be a highly practical screening tool in professional counseling settings, as it is comprised of reasonably few items (13 items in the unidimensional model), which has implications for reducing respondent fatigue. The IWI is also available in the public domain, free to use, and can be scored in minutes. Accordingly, the IWI has potential to be a practical screening tool that professional counselors can use in the intake process to establish baseline IW scores. The brevity and feasibility of the IWI makes it practical for professional counselors to administer the IWI to their clients as one way to monitor their progress in treatment.

Consistent with the underlying strengths-based principles of the counseling profession (Long et al., 2022; Myers, 1992), the IWI's construct of measurement, IW, is a strengths-based latent characteristic (Glasser & Lowenstein, 2016). Accordingly, professional counselors are encouraged to use strengths-based assessment tools to measure well-being and keep track of treatment effectiveness (Fullen, 2016; Young et al., 2015) rather than focusing solely on measures of symptomatic distress or psychopathology. NHA and IW emphasize empowerment, strength, and resilience. The IWI is a strengths-based screening tool for measuring a growing, accruing, and deepening sense of inner enrichment (Bennett et al., 2023). Considering the promising psychometric support for the unidimensional IWI model in the present study, practitioners can use the IWI to measure IW when working with adults in the United States. In addition, the current results revealed strong correlations between IWI and MHI-5, which further supports that IW is a form of mental wellness.

Inner Wealth, Anxiety, and Depression

Anxiety and depression are the two most common mental health conditions among adults living in the United States (NAMI, 2022). The PHQ-9 and GAD-7 are screening tools with rigorously validated scores for measuring depression and anxiety severity with normative samples of adults in the United States (e.g., J. S. Patel et al., 2019). Accordingly, the results of convergent validity testing between the IWI and the GAD-7 and PHQ-9 in the present study support the IWI's psychometric properties and have implications for counselors who are working with U.S. adults living with anxiety or depression. Specifically, the IWI's strong correlations with the PHQ-9 and GAD-7 suggest that the IWI might have utility for tracking treatment outcomes related to potential protective factors against depression and anxiety. Future research is needed; however, the results of the present study tentatively suggest that higher levels of IW might have utility for predicting lower levels of anxiety and depression among U.S. adults. To this end, it might be helpful for professional counselors to include the IWI in assessment batteries for clients who are living with anxiety and depression. Treatment plan goals can reflect both aiming to reduce negative symptoms (anxiety or depression) and increase wellness-based symptoms (e.g., IW). In addition, counselors and their clients can refer to the content of IWI items as semi-structured discussion prompts. Suppose, for example, that a client scores high on the following IWI item: "When I receive a compliment, I think it is likely untrue." The client and counselor can use this information to discuss how and in what ways the client can work on giving themselves credit when they receive a compliment.

Two-Dimensional IWI Model

At this stage of development, we recommend that clinicians and researchers use the two-dimensional IWI tentatively, if at all, to measure IW among U.S. adults due to the questionable-to-poor validity evidence of scores that we found for this model. Future researchers or practitioners who are seeking to use the two-dimensional model with adults in the United States should test for reliability and validity evidence of IWI scores with their sample before interpreting the meaning of scores.

Limitations and Future Research

The findings of this study present limitations and implications for future research. We hired a data collection contracting company to employ a rigorous data collection procedure to recruit a national sample of U.S. adults stratified by the census data (U.S. Census Bureau, 2022). However, the statistical aggregation procedure that we used to dummy code variables into subsamples that were substantial enough for invariance testing may have limited the external validity of the findings. In particular, the results might not have detected differences in the meaning of IW among U.S. adults with (a) gender identities besides female or male, (b) ethnoracial identities beyond White or non-White, and/or (c) levels of education that were more specific than having a college degree or not. To these ends, we recommend that future investigators examine the factorial invariance of IWI scores with more ethnoracially, educationally, and gender-diverse samples. In addition, future researchers can extend the existing line of research on the IWI by testing for temporal internal structure validity via a time series factor analysis. Results might reveal insights into the time series psychometric properties of the IWI.

The results of convergent validity testing revealed strong co-variation (i.e., both statistical and practical significance) between IWI scores of a sample of U.S. adults and their depression and anxiety severity scores. However, causal directionality between variables cannot be inferred from the results of any cross-sectional study. Accordingly, future outcome research on the potential utility of IW in a possible treatment for anxiety and depressive disorders is recommended. For example, future researchers can test for changes in anxiety and depression severity before and after the NHA training (Glasser & Lowenstein, 2016), which is geared toward increasing IW. In addition, the results of the present study are based on a non-clinical sample of adults in the United States. There might be utility in future researchers testing the psychometric properties of the IWI with samples of participants who are living with mental and/or physical health conditions.

Summary and Conclusion

Consistent with the wellness orientation of the counseling profession, IW is a strengths-based construct that emphasizes internal enrichment and empowerment (Glasser & Lowenstein, 2016). The IWI is a screening tool for appraising IW, which was normed with two large samples of child welfare professionals (Bennett et al., 2023). The purpose of the present study was to extend the generalizability of IWI scores to a normative national sample of U.S. adults (stratified by the U.S. Census Bureau [2022] data for gender identity, age, ethnoracial identity, and geographic location). We found support for the psychometric properties of the unidimensional IWI model but not the two-dimensional IWI model with U.S. adults. Specifically, the results of factorial invariance (MCFA) and convergent validity testing evidenced strong support for the psychometric equivalence in the meaning of IW across gender, ethnoracial identity, help-seeking history, education, and income for U.S. adults' scores on the unidimensional IWI model. When working with adults in the United States, professional counselors can use the unidimensional IWI as one way to measure and track their clients' IW throughout treatment. The IWI offers a number of practical advantages to professional counselors, including brevity, simple scoring instructions, and free availability in the public domain.

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Enhancing Counselor Trainee Preparedness for Treating Eating Disorders: Recommendations for Counselor Educators

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Eating disorders (EDs) are increasingly prevalent and pose significant public health challenges. Yet, deficits exist in counselor education programs regarding ED assessment, conceptualization, and treatment. Consequently, counselors report feeling incompetent and distressed when working with ED clients. We propose a conceptual framework, the 3 Cs of ED Education and Training, to enhance trainee development. The 3 Cs are: (a) cultivating trainee self-awareness through reflexivity and deliberate skill practice, (b) capturing contextual and sociocultural factors with culturally responsive approaches, and (c) collaborating with interdisciplinary ED professionals while strengthening counselor professional identity. Implications for counselor educators include incorporating activities aligned with this framework into curriculum and experiential training in order to facilitate trainee competence in ED assessment and treatment.

Keywords: **eating disorders, 3 Cs of ED Education and Training, framework, counselor education, trainee development**

Eating disorders (EDs) remain one of the most lethal mental health illnesses, contributing to roughly 3 million deaths globally each year (van Hoeken & Hoek, 2020) and impacting 29 million or 9% of Americans over their lifetime (Deloitte Consumer Report, 2020). In the United States alone, EDs directly result in 10,200 deaths annually, averaging one death every hour (Deloitte Access Economics, 2020). The steady rise of EDs across genders and countries is of increasing concern, with scholars noting in their systematic literature review that rates have doubled from 3.5% in 2000–2006 to 7.8% in 2013–2018 (Galmiche et al., 2019). EDs also exact a significant economic toll in the United States. In the 2018–2019 fiscal year, Streatfeild et al. (2021) found that EDs generated financial costs of nearly $65 billion, averaging about $11,000 per affected individual. Moreover, their study estimated an additional $326.5 billion in non-financial costs due to reduced well-being among those with EDs. Given their associated comorbidities with other mental health illnesses (Ulfvebrand et al., 2015), enduring somatic issues (Galmiche et al., 2019), and facilitation of psychological distress (Kärkkäinen et al., 2018), EDs pose significant public health and economic threats that necessitate further consideration. However, the literature lacks meaningful attention to ED prevention and treatment (van Hoeken & Hoek, 2020), an oversight that needs to be redressed within counselor education (CE) graduate training programs. A failure to examine this clinical issue threatens the maintenance of quality assurance and ethical standards within the profession, enabling short- and long-term client harm.

Challenges and Gaps in ED Education and Training

Given the steady rise in the prevalence of EDs and their associated consequences, counseling trainees must be equipped with comprehensive training in order to effectively conceptualize and treat these complex conditions. However, across the decades, research has illuminated ED education and training deficits, particularly in graduate programs (Biang et al., 2024; Labarta et al., 2023; Levitt, 2006; Thompson-Brenner et al., 2012). For instance, Labarta et al.'s (2023) recent study examined clinician

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attitudes toward treating EDs, revealing challenges related to the lack of specialized graduate training. Among surveyed respondents, only 25.7% reported that their programs offered a specialized course on EDs, while approximately half of the sample (41.3%) divulged that their program dedicated only 1–5 hours of ED-related instruction throughout the curricula. Furthermore, one participant indicated that ED education is "rarely more than one lecture at the master's level" (Labarta et al., 2023, p. 21). This is particularly concerning as research shows that trainees are not only very likely to encounter a client battling an ED at some point in their professional career (Levitt, 2006) but are also going to be less prepared and effective in treating such clients without specialized ED training in graduate programs (Biang et al., 2024; Labarta et al., 2023).

As a result of this lack of ED education, scholars have noted negative implications for helping professions, contributing to clinician incompetence, increased burnout, and diminished self-efficacy when working with ED clients (Labarta et al., 2023; Levitt, 2006; Thompson-Brenner et al., 2012). Clinician competence is a necessary vehicle to not only promote individual accountability but to also ensure the integrity of the broader counseling profession. However, holistic competency development is threatened without adequate, targeted ED training, increasing the likelihood that counselors-in-training (CITs) will encounter recurring treatment failures when working with clients struggling with an ED (Williams & Haverkamp, 2010). Williams and Haverkamp (2010) echoed this sentiment, stating that the field risks the occurrence of "iatrogenesis . . . particularly when the practitioner has a poor understanding of EDs, the negative reactions that eating disordered clients can evoke in the clinician are not managed, and/or there are specific types of process and relationship errors made in therapy" (p. 92). For example, although a school counselor may not serve as the primary treatment provider for an adolescent with bulimia nervosa, their understanding of warning signs and symptoms, supportive collaboration with students and families, and knowledge of specialized community referrals are invaluable to the counseling process (Carney & Scott, 2012). As such, counselor educators must assist CITs with developing essential competencies for treating EDs during graduate training programs, ultimately working toward bridging this gap and improving the quality of care.

Addressing the deficit of multicultural research in the field of EDs is of paramount importance, as it directly impacts the practice and education of counselors. Accrediting and professional bodies expect counselor educators to impart multicultural knowledge and skills to CITs, including a focus on diverse cultural and social identities (American Counseling Association [ACA], 2014; Council for the Accreditation of Counseling and Related Educational Programs [CACREP], 2023). Furthermore, Levitt (2006) emphasized that the significant consequences and growing prevalence of EDs across diverse cultural groups necessitate that clinicians "gain exposure to the etiology, manifestation, and treatment of eating disorders within multiple contexts" (p. 95). This assertion underscores the critical need for a more inclusive and culturally competent approach to assessing, treating, and educating about EDs, emphasizing the urgency of addressing the existing gaps in research. Ultimately, the absence of targeted ED research and training, notably conceptualization and assessment strategies, poses ethical concerns for safeguarding clients' welfare, rendering trainees ill-equipped to address milder presentations of these disorders, let alone complex cases with more severe symptoms, such as heightened suicidality, enduring medical complications, and acute psychological distress (Kärkkäinen et al., 2018).

Research concerning client experiences is also imperative when assessing education and training needs for effective ED treatment. Babb et al. (2022) conducted a meta-synthesis of qualitative research on ED clients' experiences in ED treatment, illuminating important themes on clinicians' roles in supporting clients. Several clients reported that some staff perpetuated stereotypes about EDs (e.g., viewing the client as an illness versus a person) and tried to fit clients into specific theoretical frameworks. Clients attributed this lack of awareness and sensitivity to the providers' lack of specialized training in

EDs. Conversely, clients in this study felt empowered when providers were empathic and provided individualized approaches to treatment. These participants noted that "being seen as an individual" facilitated motivation for treatment, with the therapeutic alliance as an essential factor in this process (Babb et al., 2022, p. 1289). These client perspectives provide valuable insights that should inform the development of CE training programs to better prepare CITs for working with individuals with EDs.

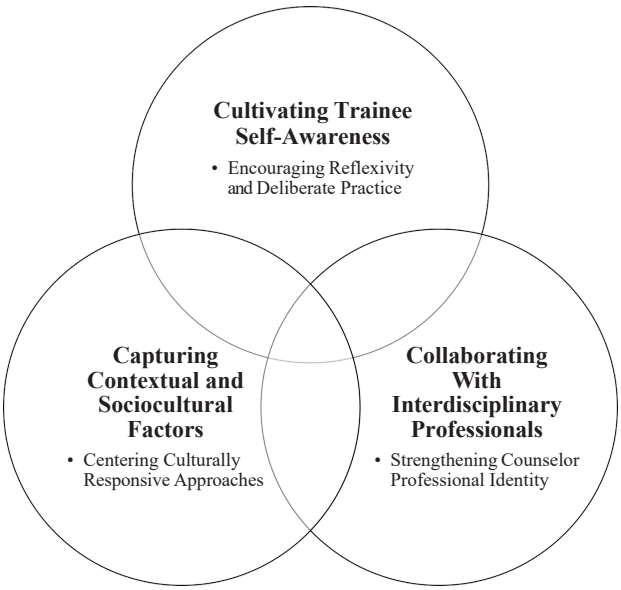
Training Recommendations for Counselor Education Programs

Collectively, the findings cited above underscore the importance of comprehensive ED training for counselors to be able to effectively and compassionately serve diverse clients with EDs. However, accessibility to such education and training remains a challenge to both the graduate students and practitioners (Biang et al., 2024; Labarta et al., 2023). Furthermore, despite the efficiency of manualized approaches, Babb et al.'s (2022) study emphasized the need for both flexibility and avoiding a one-size-fits-all approach to ED treatment, particularly given the diversity of clients with EDs, including those from traditionally underrepresented backgrounds (Schaumberg et al., 2017). Clients' lived experiences corroborate these gaps, reporting instances of stereotyping, rigid adherence to theoretical frameworks, and a lack of empathy stemming from inadequate specialized training (Babb et al., 2022). These findings highlight the pressing need for training strategies that ensure competence and uphold ethical standards within the treatment of EDs, including ongoing education for new practitioners entering the field.

The following section offers competency-based recommendations for CE programs to incorporate into their curricula and experiential training. We propose a conceptual model that we call the 3 Cs of ED Education and Training. The 3 Cs are: (a) cultivating trainee self-awareness, (b) capturing contextual and sociocultural factors, and (c) collaborating with interdisciplinary professionals (see Figure 1). We also provide an overview of recommended activities and associated reflective prompts that can be used in a special topics course on EDs (see Appendix A), as well as suggested adaptations for integration across counseling curricula. By integrating these teaching strategies, CE programs can enhance competency-based education for EDs (Williams & Haverkamp, 2010), which may empower CITs to provide compassionate, empirically supported services to this vulnerable population.

Figure 1

The 3 Cs of ED Education and Training



Cultivating Trainee Self-Awareness

Cultivating trainee self-awareness is essential to ethical and multiculturally competent ED treatment. As espoused in our ethical codes (ACA, 2014), counselors are expected to examine their own beliefs, attitudes, and emotional responses when working with clients. Without such conscious examination, clinicians risk projecting their personal biases onto their clients or responding in ways that might inadvertently cause harm. For instance, the pervasive weight stigma embedded in our society can unconsciously influence counselors and may result in microaggressions, victim blaming, or the dismissal of symptoms, particularly when working with clients in larger bodies (Veillette et al., 2018). Counselors may also experience countertransference reactions triggered by ED behaviors or other challenging treatment components, such as high relapse rates, resistance to treatment, or insurance coverage issues (Labarta et al., 2023; Warren et al., 2013), negatively influencing the therapeutic relationship (Graham et al., 2020). Reflexive exercises, paired with targeted deliberate skill practice, are valuable mechanisms for facilitating conscious self-examination and building relevant knowledge and skills for effective ED treatment.

Encouraging Reflexivity and Deliberate Practice

Reflexivity, defined as "a practice of observing and locating one's self as a knower within certain cultural and socio-historical contexts," allows CITs to engage with courses on cognitive, affective, and experiential levels (Sinacore et al., 1999, p. 267). The integration of reflexive exercises and critical discussions into ED curricula is essential for cultivating self-awareness and, in effect, mitigating potential client harm. Such practices create opportunities for trainees to identify and address any unconscious biases or beliefs, which, if unaddressed, can undermine the quality of care provided. By establishing a habit of mindful self-inquiry, educators can take the first critical step in preparing ethically conscientious counselors attuned to ED clients' diverse needs (Labarta et al., 2023).

This intentional practice of reflexivity should be paired with deliberate practice strategies focused specifically on promoting skill development for treating EDs. Deliberate practice is a systematic and intentional training method that targets skill development in order to attain expert performance in a given area or domain (Ericsson, 2006; Irvine et al., 2021). Research shows that integrating deliberate practice strategies early in CE training promotes competency development (Chow et al., 2015). Ericsson (2006) developed five crucial tasks of deliberate practice: self-assessment, skill repetition, formative feedback, stretch goals, and progress monitoring. The first task is a necessary step in increasing trainee self-awareness, which is particularly crucial when working with vulnerable populations, such as those struggling with EDs. Deliberate practice empowers trainees to refine their skills and continuously evolve as competent, empathic, and effective counselors. Thus, deliberate self-reflection on personal assumptions is key, as examining one's relationship with food and body is imperative to prevent issues like value imposition and orient the focus of treatment to the client's healing process.

Integrating reflexivity and deliberate skill practice early in CE training is vital to promoting lasting competency. CITs often overestimate their competence at the end of their training, necessitating that CE programs systematically monitor the congruence between CITs' self-assessments and counselor educators' assessments of CITs' competency and skill development (Gonsalvez et al., 2023). Routine reflexive exercises can illuminate areas for growth, while deliberate practice strategies provide structured mechanisms for targeted skill refinement. As trainees embark on their professional journeys, ongoing and intentional efforts to self-reflect and evolve through skill refinement will empower them to provide safe, ethical, and effective ED treatment.

Capturing Contextual and Sociocultural Factors

It has been well-documented that EDs impact individuals across social and cultural identities despite the misconception that only thin, White, affluent, cisgender women are affected (Schaumberg et al., 2017). Indeed, scholars have pointed to the need for intersectional, social justice–informed research that addresses the unique ways that context and culture influence EDs and body image concerns (Burke et al., 2020; Halbeisen et al., 2022). The prevalence of EDs and pervasive body image issues is alarming in today's sociocultural landscape. For instance, the recent increase in gender-affirming care bans and anti-LGBTQ+ legislation poses profound and detrimental effects on individuals battling an ED (Arcelus et al., 2017), as these restrictive policies exacerbate the mental and emotional distress already experienced by LGBTQ+ individuals, further isolating them and undermining their access to critical health care services (Canady, 2023). As a result, members of this community are more apt to experience intensified body dysphoria, heightening the risk of developing or worsening an ED in an attempt to conform to societal norms (Arcelus et al., 2017).

In the wake of the COVID-19 pandemic, the world has experienced a collective trauma that triggered a series of physical and mental health consequences that will linger for years to come, including rising rates of disordered eating and body-related concerns. Termorshuizen et al. (2020) surveyed 1,021 individuals across the United States and the Netherlands, revealing that ED diagnoses increased at a rate of roughly 60%, with respondents noting increased binge episodes (30%) and restriction behaviors (62%) during this time. Scholars have also shown the deleterious effects of the pandemic on body image perception. For instance, in one study of 7,878 respondents, 61% of surveyed adults and 66% of surveyed children (17 and under) disclosed frequent negative feelings regarding their body image, with 53% of adults and 58% of children reporting that the pandemic has significantly exacerbated these feelings (House of Commons, 2021). Unfortunately, weight stigma was also pervasive in the media, with concerns regarding quarantine weight gain (e.g., "Quarantine-15") contributing to eating and body image challenges (Schneider et al., 2023). Amidst the multifaceted challenges presented by recent sociopolitical events and the intersecting struggles faced by diverse individuals with EDs, it is essential that counselors implement culturally responsive approaches to treatment and advocacy efforts.

Centering Culturally Responsive Approaches

Given the diversity of clients who struggle with eating and body image concerns (Schaumberg et al., 2017), CE programs must integrate culturally sensitive theories into the curriculum to ensure that CITs possess the necessary competencies to explore relevant cultural factors and effectively treat diverse clients with EDs (Williams & Haverkamp, 2010). Two theories that fostered the development of the Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2016) are intersectionality theory and relational–cultural theory (Singh et al., 2020). Intersectionality is a framework for comprehensively understanding the interaction of systemic inequalities and oppression that significantly affect marginalized community members (Burke et al., 2020; Crenshaw, 1991). This theoretical paradigm deepens our understanding of factors such as age, race, ethnicity, sexual orientation, ability status, body size, and gender identity and how these factors influence an individual's lived experience. Intersectionality is vital for promoting social justice and culturally responsive treatment while also serving as a tool to dismantle oppression and colonizing practices within the profession (Chan et al., 2018; Singh et al., 2020). Intersectionality-informed practice may assist researchers and counselors with considering risk and protective factors for EDs; however, the lack of attention to the intersecting roles and identities of ED clients (e.g., a Catholic, bisexual, Latina) remains a concern, which is crucial for informing culturally competent counseling and training practices (Burke et al., 2020).

Relational–cultural therapy (RCT; Jordan, 2009) is another promising theory that may decolonize dominant counseling approaches (Singh et al., 2020). Due to its emphasis on relational connection, social justice, and empowerment, RCT has been applied to the treatment of EDs (Labarta & Bendit, 2024; Trepal et al., 2015). Infusing RCT into practice may help counselors understand sociocultural influences that maintain ED (e.g., diet culture, weight stigma, acculturation) and perpetuate feelings of disconnection for individuals who do not conform to prevailing body or appearance standards. RCT also aligns well with counseling's wellness orientation due to its relational and strengths-based focus, emphasizing resilience over pathology in the treatment of ED (Labarta & Bendit, 2024). Counselor educators can expand beyond traditional ED treatment approaches by integrating culturally responsive theories like intersectionality and RCT into course curricula, thus highlighting the intrapersonal, interpersonal, and systemic components that impact clients with EDs.

Collaborating With Interdisciplinary Professionals

The counseling profession has recognized the importance of interdisciplinary practice, encouraging counselors to participate in "decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines" (ACA, 2014, Code D.1.c, p. 10). The CACREP *Standards* (2023) also emphasize the need for counseling students to learn about collaboration, consultation, and community outreach as part of interprofessional teams (Section 3.A.3). Indeed, interdisciplinary collaboration provides an opportunity for individual and systems-level advocacy (Myers et al., 2002). The challenge remains in how counselors can balance establishing a distinct professional identity while simultaneously fostering a sense of community among various helping professions (Klein & Beeson, 2022). Researchers have underscored common experiences of counselors within interdisciplinary teams, including challenges with building legitimacy and credibility, especially among more well-established helping professions such as psychiatry or psychology (Klein & Beeson, 2022; Ng et al., 2023). Given that multidisciplinary collaboration is also crucial to ED treatment (Crone et al., 2023; Williams & Haverkamp, 2010), counselor educators must prepare CITs to effectively work within interdisciplinary treatment teams while utilizing their counseling values and training to best serve their clients and advocate for the inclusion of counselors across ED treatment settings (Labarta et al., 2023).

Strengthening Counselor Professional Identity

Given that EDs are biopsychosocial in nature, effective treatment commonly involves collaboration among various health professions (e.g., medicine, psychiatry, counseling, psychology, dietetics) to ensure holistic, comprehensive client care (Crone et al., 2023). Counselors' developmental, preventive, and wellness-based perspectives can help provide a strengths-based approach to interdisciplinary collaborations (Labarta et al., 2023). For example, a psychiatrist at a residential facility may focus on assessing a client's pathology, comorbidity, and changes in symptoms throughout treatment. Although counselors can also focus on assessing client symptoms, their training allows them to provide insight into protective factors that foster client resilience in their recovery process (e.g., social support and cognitive flexibility). Both professionals bring unique expertise, knowledge, and skill sets that provide a distinct conceptualization of the client's concerns with food or with their body. However, the ultimate goal of the treatment team is to ensure ethical and competent care for the client.

Outside of intensive ED treatment, counselors in school settings and community agencies can offer prevention-based approaches to mitigate risk factors leading to the development of EDs. Prevention-based efforts, such as community programs and workshops, are essential to the field of ED, given the alarmingly low rates of help-seeking in adults with lifetime EDs (34.5% for anorexia nervosa, 62.6% for bulimia nervosa, and 49.0% for binge eating disorder), which are even more pronounced among

marginalized communities (Coffino et al., 2019). As such, counselors and other helping professionals can collaborate on ways to increase accessibility to mental health services for underserved groups with increased risk of eating or body image concerns (e.g., LGBTQ+; Nagata et al., 2020). Regardless of the settings within which CITs will work, students can benefit from developing teamwork, leadership, and advocacy skills, as well as a systemic conceptualization of client care (Ng et al., 2023). Ultimately, counselor educators can encourage the exploration of shared goals across helping professions and the utilization of counseling values and training to enhance interdisciplinary work for diverse clients and communities recovering from EDs (Klein & Beeson, 2022; Labarta et al., 2023; Ng et al., 2023).

Implications for Counselor Educators

The 3 Cs for ED Education and Training pose several implications for counselor educators and counseling programs. Although intended for ED treatment, this framework captures essential competencies across counseling specialties, such as counselor self-awareness, cultural and diversity issues, and interdisciplinary practice (CACREP, 2023). As such, integrating these foci into the counseling curriculum can help reinforce competencies regardless of the settings within which students will work. Counselor educators teaching about EDs should also consider ways to incorporate other ED counseling competencies, such as relevant ethical issues, assessment and screening, and evidence-based treatments into coursework (Williams & Haverkamp, 2010). These topics can be integrated into the 3 Cs for ED Education and Training in several ways. For instance, ethical issues and scenarios, such as determining when a client may need a higher level of care, can be presented to students as a standard component of collaborating with interdisciplinary professionals. Counselor educators can also review common ED assessments and encourage students to critically evaluate gaps in the diagnostic process that impact underrepresented populations (e.g., men with EDs), capturing contextual and sociocultural factors and enhancing culturally responsive care (see Appendix B for more examples.)

We also recognize the potential challenges of implementing the 3 Cs of ED Education and Training, as a stand-alone, special topics course on EDs may not be possible for all counseling programs. However, counselor educators can adapt and incorporate the suggested activities in Appendix A into various CACREP core courses to enhance ED education across the curriculum. CE programs can also utilize their Chi Sigma Iota chapters to host events on EDs, such as an interdisciplinary panel discussion followed by a group discussion on professional counseling identity and advocacy (Labarta et al., 2023). Opening these events to the local community could encourage continuing education, collaboration, and advocacy.

Directions for Future Research

Given that the 3 Cs of ED Education and Training is a conceptual framework, there are several directions for future research. Counselor educators and researchers may consider developing a stand-alone course to test the effects of this framework on CITs' competence in treating EDs. To our knowledge, limited ED competency measures exist, especially for counselors. As such, researchers could explore developing an instrument that measures ED competency areas that include the 3 Cs of ED Education and Training. Such a tool would be helpful for research, clinical, and teaching purposes. An ED competency tool may also enhance CITs' and counselors' deliberate practice efforts, promoting quality care for clients across ED treatment settings. Additionally, one theoretical framework educators can modify to help enhance trainees' clinical competencies in treating EDs is Irvine and colleagues' (2021) Deliberate Practice Coaching Framework (DPCF), given its structured guidance for skill refinement through individualized coaching and feedback. The development and future testing of an adapted DPCF for EDs may further enhance reflexive and deliberate practice efforts for CITs and counselors working with this population.

Conclusion

In this article, we have proposed our 3 Cs of ED Education and Training to address current gaps in ED education and enhance trainee preparedness across CE programs. Informed by existing literature, this framework incorporates essential elements of comprehensive ED treatment, including counselor self-awareness, cultural and contextual factors, and interdisciplinary practice. The flexibility of this framework allows educators to adapt current curricula to strengthen ED training in CE programs and to meet the needs of their students. Further research that tests a stand-alone course incorporating this framework is needed. The 3 Cs of ED Education and Training offer a path forward in remedying the salient gaps in ED education, ultimately advocating for more compassionate, ethical, and inclusive care across counseling settings.

Conflict of Interest and Funding Disclosure
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Appendix A

The 3 Cs of ED Education and Training: Suggested Activities and Reflective Prompts

3 Cs of ED Education & Training	Suggested Activities	Activity Sample Reflective Prompts	Adaptations for Integration Across Counseling Curricula
Cultivating Trainee Self-Awareness	***Reflexive Journaling:*** • Have CITs maintain a journal, reflecting on their experiences (e.g., biases, assumptions, insights, challenges) throughout the course. • Instructors can provide suggested weekly prompts based on the content or topic area discussed. ***Deliberate Practice:*** • During the first week, CITs will read Williams and Haverkamp's (2010) article on ED counseling competencies. • CITs then write a reflection paper identifying 2–3 targeted, actionable areas for development and growth. • Revisit these competencies at the end of the course to assess CIT growth and ongoing development areas.	***Reflexive Journaling Prompts:*** • Reflect on your beliefs, values, and attitudes about counseling ED clients. What would you like to learn? What challenges do you anticipate? • How might cultural factors impact how counselors work with ED clients? Consider how your cultural and social identities shape your relationship with food and body image. • Complete the Anti-fat Attitudes Questionnaire (Crandall, 1994) and interpret your score. What insights did you gain? Why might self-assessment in this domain be an important tool for counselors? (Kerl-McClain et al., 2022) ***Deliberate Practice Prompts:*** • Using a Likert scale of 1 (*not confident*) to 5 (*very confident*), how confident do you feel to treat clients with EDs? • Using a Likert scale of 1 (*not prepared*) to 5 (*very prepared*), how prepared do you feel to treat clients with EDs? • Identify 2–3 areas of personal or professional development and growth. • Identify 2–3 actionable steps for this semester and beyond.	***Psychopathology and Diagnosis Courses:*** • Before teaching ED diagnoses, facilitate a brief activity to promote reflexive practice (see suggested prompts). • Follow up with a class discussion on CITs' reflections, reactions, insights, and the possible impact of biases or assumptions on the diagnosis and treatment process for ED clients. ***Practicum and Internship Courses:*** • CITs working in ED treatment settings can use the deliberate practice prompts to continually assess strengths and growth areas. • Encourage CITs to complete the self-assessment on ED knowledge and skills. Based on the identified gaps, campus instructors can invite guest lecturers to discuss topics of interest.

3 Cs of ED Education & Training	Suggested Activities	Activity Sample Reflective Prompts	Adaptations for Integration Across Counseling Curricula
Capturing Contextual and Sociocultural Factors	***Media Critique:*** • Have CITs select and analyze a form of media (e.g., movies, TV series, social media). • CITs can then consider the messages conveyed about EDs and body image. ***Class Discussion:*** • Engage in a class discussion on CITs' observations, noted themes, and implications for counseling practice. • Educators may also initiate a discussion on media literacy and how to broach similar discussions with clients and colleagues.	***Individual Reflection Prompts:*** • How were EDs and/or body image concerns portrayed explicitly and implicitly? • How do sociocultural factors (e.g., race, ethnicity, gender, etc.) influence media portrayals and messages about EDs/ body image? • How might these portrayals or messages influence one's beliefs about EDs? ***Class Discussion Prompts:*** • What were the overarching themes or messages across the various media? • How can culturally responsive theories (e.g., RCT, intersectionality) inform how we conceptualize the impact of media on EDs and body image concerns? • How can counselors work with clients impacted by harmful media ideals? • How can counselors advocate for more culturally inclusive and responsible ED portrayals in media?	***Social and Cultural Diversity Course:*** • Facilitate a discussion on CITs' observations of ED media portrayals, considering the impact of limited representation on mental health access. • Provide a case study of a client with intersecting minoritized identities and encourage CITs to identify culturally responsive treatment approaches and theories that can benefit the client's recovery.

3 Cs of ED Education & Training	Suggested Activities	Activity Sample Reflective Prompts	Adaptations for Integration Across Counseling Curricula
Collaborating with Interdisciplinary Professionals	***ED Expert Panel:*** • Invite professionals across disciplines specializing in treating EDs (e.g., M.D., psychiatrist, psychologist, dietician). • Engage the panelists in a discussion on their respective training, roles, responsibilities, and experiences working in interdisciplinary treatment teams. • Reserve Q&A time for CITs to share any thoughts, questions, and insights (Labarta et al., 2023). ***Professional Identity Reflection Paper:*** • After the ED expert panel discussion, have CITs write a reflection paper on what they learned from the panelists. • CITs can reflect on how counselors contribute to interdisciplinary teams using their developmental, prevention-focused, and wellness-based training. • Facilitate a broader discussion with CITs during the subsequent class meeting.	***Expert Panel Discussion Prompts:*** • Briefly discuss your ED treatment experiences and describe your main roles and responsibilities. • Discuss the benefits and challenges of working in interdisciplinary treatment teams. • What would you say are the most prevalent issues faced by ED professionals today? • What words of wisdom can you share with CITs considering working with ED clients? ***Professional Identity Paper Prompts:*** • What challenges and opportunities do you foresee as a counselor working in an interdisciplinary treatment team? • How can counseling values inform an interdisciplinary perspective on ED treatment? • What personal strengths could you contribute as an interdisciplinary treatment team member? • Reflect on the MJSCC (Ratts et al., 2016), discussing how they can inform a counselor's work with diverse clients struggling with eating and/or body image concerns.	***Introduction to Mental Health Counseling Course:*** • If coordinating an ED expert panel is not feasible, consider inviting other professionals across specialty areas (e.g., EDs, addictions, integrated behavioral health) to share their experiences • CITs can complete a reflection paper on their insights and reactions to the guest panelists using the professional identity paper prompts as a guide.

Appendix B

Educator Checklist for Integrating the 3 Cs of Eating Disorder (ED) Education and Training Into Counselor Education Curricula	
Cultivating Trainee Self-Awareness	
☐	Increase trainee awareness by incorporating ED warning signs, risk factors, and conceptualization strategies into assessment and treatment approaches.
☐	Routinely assess student competency on ED-related knowledge and skills, evaluating for any incongruence between the students' and educators' scores. Additionally, assess multicultural counseling competencies related to EDs during student evaluations. Provide feedback for growth.
☐	Encourage student attendance at ED-focused workshops, webinars, and conferences to enhance deliberate practice efforts, promoting professional growth and development.
☐	Promote student exploration of their own cultural identities, values, and biases related to appearance, health, and eating behaviors.
Capturing Contextual and Sociocultural Factors	
☐	Incorporate diverse ED case examples and vignettes that reflect a range of intersecting cultural identities and experiences.
☐	Provide training on culturally responsive ED treatment approaches like RCT and intersectionality. Be sure to cover strategies for adapting evidence-based ED treatment approaches to be culturally relevant for diverse clients.
☐	Emphasize the importance of cultivating cultural humility and client empowerment, particularly when working with ED clients from diverse or marginalized backgrounds.
Collaborating With Interdisciplinary Professionals	
☐	Critically examine course syllabi to identify where ED content and scholarship could be incorporated or expanded (e.g., textbooks, media, articles). Include resources from interdisciplinary helping professionals.
☐	Compile a list of interdisciplinary community referrals and resources to support students working with ED clients.
☐	Provide opportunities (e.g., guest lecture, course assignment) for students to learn from ED experts in various helping disciplines. Encourage students to reflect on ways to utilize their counseling values and training within interdisciplinary treatment collaborations.

Note: This checklist is a framework for integrating ED education into CE graduate training. Consider modifying components to align with your specific curriculum, resources, and student population. The goal is to integrate ED education in a way that provides students with foundational knowledge, skills, and practical experience to effectively support clients struggling with EDs and body image issues in their future counseling practice.

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