The Professional Counselor™

Spring 2026

Publication Excellence Since 2011

Digest

Volume 16, Issue 1

The Professional Counselor™

National Board for Certified Counselors®

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The Professional Counselor™

The Professional Counselor *Digest*

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Counseling and the Neurodiversity Paradigm

A Call to Action

Emily Goodman-Scott, Rawn Boulden, Aaron Albright, Jenna Alvarez, Betsy M. Perez

The counseling profession has long championed social justice, prevention, and wellness, yet an important area of human diversity—neurodiversity—remains underrepresented in counseling scholarship and training. In this article, we urge the counseling profession to embrace neuro-affirming principles rooted in critical disability theory (CDT) and the broader neurodiversity movement. We emphasize that neurological differences such as autism, ADHD, and dyslexia are natural variations of the human mind rather than deficits requiring correction.

Drawing on critical theories such as feminism, critical race theory, and intersectionality, the article situates disability within the context of systemic power and privilege. These frameworks call on counselors to examine how structural inequities, ableism, and Eurocentric standards have historically shaped counseling practice. We explain that disability is not a singular concept, but an umbrella encompassing physical, cognitive, and psychiatric differences, all of which intersect with other social identities such as race, gender, and socioeconomic status.

The article outlines the historical evolution of disability models from the moral and medical models that pathologized disability to the social model that reframed barriers as societal rather than individual. Building on this foundation, CDT advances a social justice–oriented view that advocates for autonomy, equity, and recognition of disability as a culture. The neurodiversity paradigm extends CDT by affirming that neurodivergence is a valuable part of human diversity that is deserving of dignity and inclusion. Originating in the 1990s through the work of sociologist Judy Singer, the neurodiversity movement calls for shifting from fixing individuals to transforming systems.

Despite the prevalence of neurodivergence, estimated at 15%–20% of the global population, the counseling literature seldom directly references neurodiversity. In contrast, allied fields such as psychology, occupational therapy, and speech-language pathology have already integrated neuro-affirming frameworks. To close this gap, we offer a call to action across seven domains: awareness and introspection, guiding documents, professional organizations, research, clinical practice, counselor preparation, and supervision.

We recommend that counselors and educators engage in critical self-reflection to identify ableist assumptions and advocate for systemic change. Key professional documents, such as the ACA Code of Ethics, the Multicultural and Social Justice Counseling Competencies, and the ACA Advocacy Competencies, should explicitly include disability and neurodiversity as cultural variables. Professional divisions within ACA, such as the Association for Multicultural Counseling and Development and the Association for Counselor Education and Supervision, could integrate disability justice and neurodiversity initiatives more visibly.

In clinical settings, we propose adopting neuro-affirming counseling practices that center client strengths, tailor communication and sensory environments, and validate neurological identity rather than pathologize it. In counselor education, programs should embed neurodiversity content throughout coursework and supervision and recognize neurodivergent students and professionals as vital members of the counseling community.

Ultimately, we affirm that embracing neurodiversity aligns with the counseling profession's deepest values: equity, advocacy, and holistic wellness. Infusing neuro-affirming principles across research, training, and practice not only enhances counselor competence but also contributes to dismantling systemic ableism. By recognizing neurological differences as an expression of human diversity, the profession moves closer to its mission of empowering all individuals and communities to thrive.

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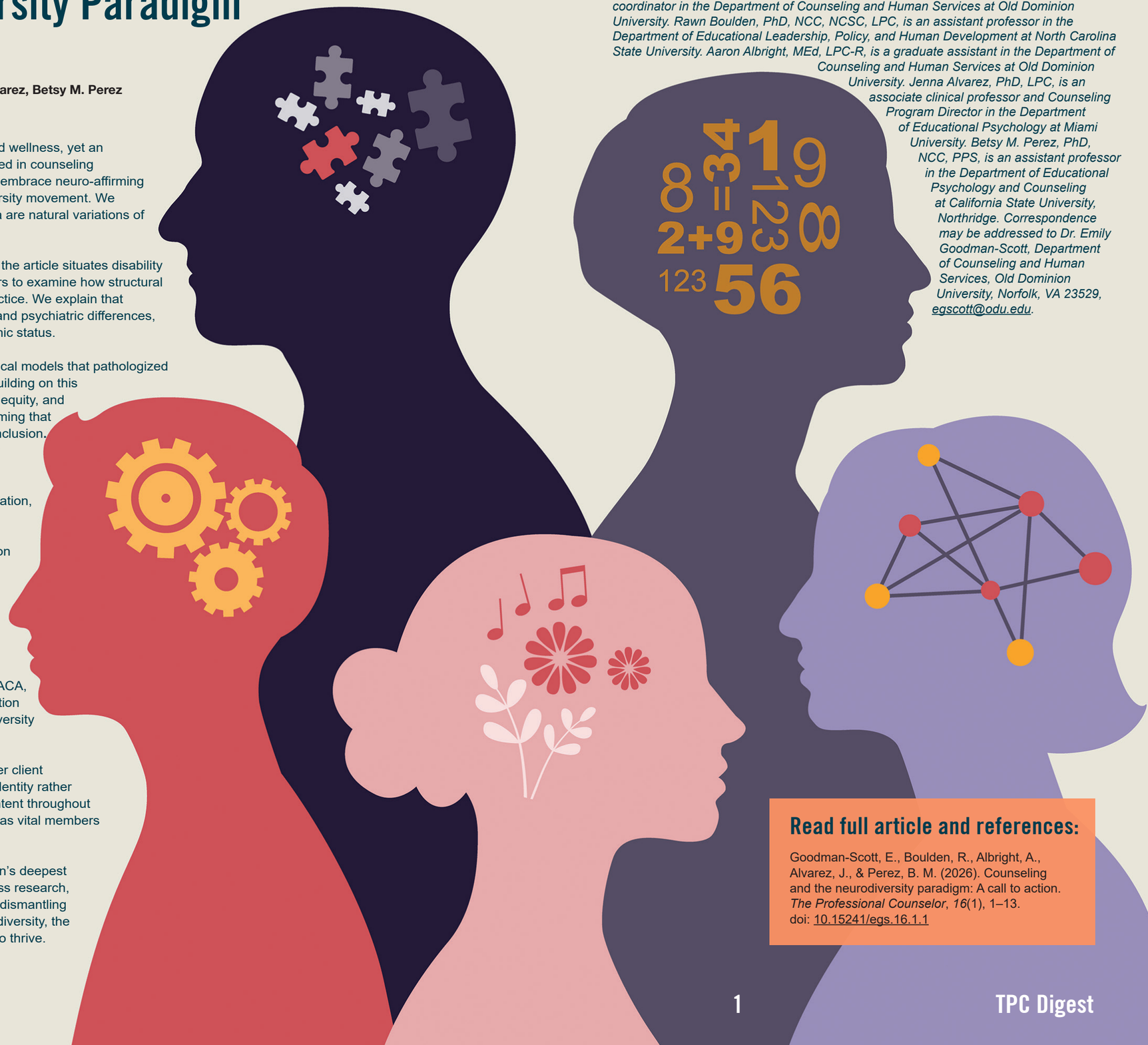

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Goodman-Scott, E., Boulden, R., Albright, A., Alvarez, J., & Perez, B. M. (2026). Counseling and the neurodiversity paradigm: A call to action. *The Professional Counselor*, *16*(1), 1–13. doi: 10.15241/egs.16.1.1

Read full article and references:

Prasath, P. R., Romero, D. E., Interiano-Shiverdecker, C. G., Harrichand, J. J. S., & Mendoza, L. C. G. (2026). Post-trauma growth experiences among sex trafficking survivors in the United States: A transcendental phenomenological exploration. *The Professional Counselor*, *16*(1), 14–31. doi: 10.15241/prp.16.1.14

Post-Trauma Growth Experiences Among Sex Trafficking Survivors in the United States

A Transcendental Phenomenological Exploration

Priscilla Rose Prasath, Devon E. Romero, Claudia G. Interiano-Shiverdecker, John J. S. Harrichand, Leslie Citlalli Garza Mendoza

This article explores how survivors of sex trafficking in the United States describe positive psychological changes that occur after trauma, a process known as post-traumatic growth. Using a transcendental phenomenological approach, the study centers survivors' voices rather than researcher assumptions. Ten adults participated in in-depth interviews in which they reflected on their personal journeys of change after exiting trafficking. Their stories reveal how survivors rebuild identity, reclaim power, and create meaning in the aftermath of severe exploitation.

Participants described post-traumatic growth as an ongoing process that unfolds gradually rather than suddenly. Growth was not a return to the life they once lived but a transformation into someone new. Many participants spoke about developing personal strength through confidence, self-awareness, forgiveness, and embracing a survivor or warrior mindset. These internal strengths often emerged as they learned to trust their intuition, reestablish emotional presence, and view themselves with greater compassion. Participants also described finding meaning in daily life, including gratitude, acceptance, and reconnecting with joy or a sense of purpose.

Creating pathways forward was another key experience. Many survivors pursued new educational or career goals, especially in helping professions. They sought opportunities to support other survivors, advocate for systemic change, and educate communities about trafficking. This sense of purpose gave their experiences meaning and empowered them to break societal stigma while helping others.

Spirituality played an important role for several participants. Some maintained or renewed their faith. Others redefined their spiritual identity altogether. Faith and spirituality helped participants make sense of their trauma and recognize their worth.

Participants also described how survival mechanisms used during trafficking later evolved into adaptive coping strategies. Dissociation, hypervigilance, emotional distancing, or substance use once helped them survive dangerous situations. As they healed, survivors reframed these behaviors, transforming them into intentional coping tools or insights about themselves. This reframing contributed to empowerment and self-understanding.

External factors also supported growth. Survivors identified close relationships, supportive family members, survivor-led peer groups, and meaningful community connections as essential for healing. These relationships helped counter feelings of isolation and mistrust that often follow trafficking.

Access to supportive resources further influenced growth. Survivors named counseling, mental health services, educational pathways, faith-based groups, advocacy agencies, and vocational programs as vital to rebuilding their lives. Counseling that was patient, honest, compassionate, and trauma-informed created a foundation of safety. Survivors emphasized the importance of counselors who understood trafficking dynamics, respected survivors' autonomy, and incorporated alternative healing modalities such as movement, somatic work, and animal-assisted therapy. Support groups and survivor-led programs were described as especially helpful.

Overall, this study highlights that post-traumatic growth among sex trafficking survivors is shaped by an interplay of inner strengths and external support systems. Survivors' reflections extend existing theory by showing how survival strategies can evolve into tools for meaning-making and growth. The findings show the importance of strengths-based, trauma-informed, and survivor-centered approaches in counseling. Counselors are encouraged to view growth as possible, honor survivors' own definitions of healing, collaborate with survivor-led programs, and incorporate a range of therapeutic approaches that recognize the complex, unique journeys of survivors rebuilding their lives after trafficking.

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Read full article and references:

Pester Boyd, D., Jones, L. K., Maier, C., & Hays, D. G. (2026). Broaching the social determinants of mental health in counseling practice. *The Professional Counselor*, *16*(1), 32–47. doi: 10.15241/dpb.16.1.32

Broaching the Social Determinants of Mental Health in Counseling Practice

Danielle Pester Boyd, Laura K. Jones, Courtney Maier, Danica G. Hays

Counselors are called upon to integrate multicultural competence and social justice advocacy into their practice, particularly in addressing systemic and environmental factors that shape client well-being. The Multicultural and Social Justice Counseling Competencies (MSJCC) and relevant constructs such as the social determinants-based counseling model (SDCM) and the multidimensional model of broaching behavior (MMBB) provide guiding frameworks for ensuring culturally responsive care. Taken together, these models inform concrete methods for integrating discussions of systemic, environmental, and structural influences into counselor–client interactions, creating a foundation for a set of broaching behaviors focused specifically on the social determinants of mental health (SDoMH).

This article describes six SDoMH broaching behaviors for counselors grounded in the MMBB and SDCM: (a) counselor development, (b) client psychoeducation, (c) contextualization, (d) attending to differences of lived experience, (e) addressing emergent needs, and (f) SDoMH-informed termination practices. These SDoMH broaching behaviors represent an interactive approach in which counselors shift among these behaviors throughout their own development as well as during assessment, intervention, and termination within the counseling relationship.

The first SDoMH broaching behavior is initiated during a counselor's preparation to work with clients. To facilitate self-awareness, counselors are encouraged to engage in reflective practices that identify areas of strength in addressing SDoMH with clients and areas that require skill and dispositional development. Client psychoeducation is the next SDoMH broaching behavior, beginning during the intake and assessment process, to increase client knowledge and awareness about the potential impact of SDoMH on well-being. As a client develops awareness, the counselor should also use broaching to contextualize that knowledge on an individual level. In this way, counselors go beyond educating clients about SDoMH in general and instead seek to collaborate with the client to understand how they are uniquely impacted by those factors.

As SDoMH factors are integrated into the therapeutic process, counselors must also attend to the interpersonal process of the therapeutic alliance by intentionally broaching any differences that may exist between the counselor and client. Clients from historically marginalized backgrounds may experience heightened economic instability, community violence, and health care barriers, which are all factors that may differ significantly from their counselor's lived experiences. We suggest that differences in lived experience related to SDoMH be treated comparably to racial, ethnic, and cultural differences to ensure culturally responsive and effective care.

Counselors should also be mindful to broach emergent client needs throughout the therapeutic process. While counselors may assess clients for SDoMH at the beginning of the counseling process, that information must be viewed within a dynamic client context that requires an ongoing response. Therefore, counselors must remain attuned to emerging SDoMH needs throughout the therapeutic process and utilize immediacy skills to broach and address concerns as they arise. Finally, the SDoMH need to be broached in the context of termination due to their impact on client dropout rates and early termination of treatment. Incorporating SDoMH broaching behaviors throughout the counseling relationship lays the foundation for effective clinical termination, even if termination occurs prematurely. These broaching behaviors provide specific guidance for how to integrate the SDoMH into counseling practice, operationalizing the mandate of the MSJCC to address systemic and environmental factors impacting client mental health.

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Self-Compassion as a Buffer

Mitigating Impostor Phenomenon and Promoting Resilience During Counselor Development

Brian J. Clarke, Michael T. Hartley, Austin M. Guida

Impostor phenomenon (IP), the belief that one's competence is fraudulent or undeserved, is very common among developing counselors. Even with evidence of their abilities, many experience persistent self-doubt, difficulty internalizing positive feedback, and fear of being "found out." These experiences can carry real consequences, including elevated anxiety and depression, reduced resilience, and a reluctance to bring concerns to supervision.

This study examined whether self-compassion—treating oneself with kindness during moments of struggle, recognizing common humanity, and staying mindful rather than self-critical—can protect developing counselors from the negative impacts of IP. A national sample of 281 counselors-in-training enrolled in CACREP-accredited programs completed validated measures of IP, self-compassion, resilience, anxiety, and depression.

Consistent with national trends, IP was extremely common in this sample: more than 96% of participants reported at least moderate impostor feelings, and 65% fell in the "frequent" or "intense" range. There is indication that over the last 15 years, IP has been growing more prevalent and severe. Participants with stronger impostor feelings also tended to report greater anxiety and depression and lower resilience. However, the central contribution of this study is the finding that self-compassion meaningfully buffered these harmful associations.

Across multiple statistical models, self-compassion explained why some developing counselors maintained well-being and resilience despite experiencing impostor feelings. Specifically, self-compassion fully mediated the relationship between IP and resilience. This suggests that counselors with higher self-compassion remain more adaptable and persistent despite impostor fears. Self-compassion also mediated the relationship between IP and depression, indicating that compassionate self-responding disrupts patterns of shame and self-criticism that can contribute to depressive symptoms. For anxiety, self-compassion served as a partial buffer, greatly reducing but not eliminating the association. This aligns with anxiety's strong connection to the developmental process and performance evaluation.

Our second set of analyses showed clear and practical differences across levels of self-compassion. Even small increases in self-compassion were associated with lower IP, lower anxiety and depression, and higher resilience. These were notable differences and could indicate a "dose–response" pattern in which incremental increases in self-compassion correspond with a more manageable and sustainable internal experience of counselor training.

Taken together, our findings suggest that self-compassion is a developmental competency, rather than just a self-care practice. Self-compassion supports balanced self-evaluation, healthier coping, and openness to learn from mistakes, all of which are central to counselor development. Given its accessibility and fit with counseling values, self-compassion can be integrated into coursework, supervision, and peer support. Supervisors may play a particularly important role by modeling self-compassion and openly normalizing impostor experiences.

Overall, this study provides an important takeaway for counselor educators, supervisors, and practitioners: IP may be nearly universal during early counselor development, but its impact can be mitigated. Cultivating self-compassion can interrupt the impostor cycle, protect mental health, and enhance the resilience necessary for ethical and sustainable practice.

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Read full article and references:

Clarke, B. J., Hartley, M. T., & Guida, A. M. (2026). Self-compassion as a buffer: Mitigating impostor phenomenon and promoting resilience during counselor development. *The Professional Counselor*, *16*(1), 48–63. doi: 10.15241/bjc.16.1.48

Read full article and references:

Green, D. A., Stanzilis, K., Roach-Coye, S., & Sullivan, C. (2026). Social connectedness as a mediator of racial trauma resulting from exposure to online racism. *The Professional Counselor*, *16*(1), 64–78. doi: 10.15241/dag.16.1.64

Social Connectedness as a Mediator of Racial Trauma Resulting From Exposure to Online Racism

Darius A. Green, Kade Stanzilis, Sierra Roach-Coye, Connor Sullivan

Online racism—the communication of racially denigrating and discriminatory content through digital means—has long persisted as a prevalent concern related to mental health, especially with the vast and growing uses of social media. Emerging research has highlighted the impact of exposure to this form of online aggression, such as indicating links to increased symptoms of anxiety, depression, trauma, substance use disorders, and suicidal ideation among adults. This highlights the relevance of online racism to professional counselors who work with clients who endure exposure to online racism.

Despite the risk of online racism to the mental health of vulnerable client populations, emerging research has not yet framed or examined online racism as a racially traumatic stressor. Our study aimed to address a noticeable gap in existing and emerging research by exploring the connections between exposure to online racism and symptoms of racial trauma. Additionally, we examined how online social connectedness might impact this link between online racism and racial trauma.

From our sample of 227 adult social media users, average scores from participants were above the established clinical cutoff score for the Racial Trauma Scale. Moreover, our study found that exposure to online racism significantly predicted increases in racial trauma symptoms. We also found evidence that this link between online racism exposure and increased racial trauma symptoms was mediated by online social connectedness. These results suggest that while increased exposure to online racism may be linked to increased symptoms of racial trauma, having a greater social connectedness to others online may reduce the impact of this exposure.

This study highlights the importance for professional counselors to be aware of the nature of online racism as a chronic racially traumatic stressor for clients. We recommend that professional counselors integrate online racism into assessment of traumatic stressors while also allowing space to validate and process the trauma of online racism among impacted clients. We also recommend supporting clients establishing and participating in digital counterspaces, which are environments and relationships that may serve as respite and spaces for developing critical consciousness toward resisting and healing from racial trauma. We also recommend professional counselors to consider group counseling as a potential modality to enhance social connectedness for clients who are exposed to online racism. Lastly, we recommend that professional counselors move beyond the provision of traditional counseling services by engaging in advocacy in resistance to the prevalence and impact of online racism. Advocacy strategies might include engagement in public education, creating safe spaces, and facilitating educational and therapeutic workshops that raise awareness of online racism and its racially traumatizing impact.

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