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In This Issue *Contents*



-
- 79** **Racial Trauma in Academia: Experiences of Black Women Counselor Educators**
April D. Brown, LaShauna M. Dean, Matthew Lyons
-
- 96** **Counseling With a Child Holding Afghan Parolee Status in the United States**
Shadin Atiyeh, Tahani Dari
-
- 106** **Providing Wellness Counseling in Older Adult Living Communities:
Challenges and Opportunities**
Matthew C. Fullen, Jonathan D. Wiley, Paul M. Delaughter, Connie C. Tomlin,
Jordan B. Westcott, Nick Gowen
-
- 120** **Invisible Community: The Counseling Considerations of Working With MENA Individuals**
Shane M. Faulk, Dania Fakhro
-
- 133** **A Journey, Not a Destination: The Intersection of Trauma and Substance Use Recovery**
Dana Ripley, Justin R. Jordan, Jyotsana Sharma, Taylor Allesch
-



Racial Trauma in Academia: Experiences of Black Women Counselor Educators



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This transcendental phenomenological study explored the lived experiences of Black women counselor educators mitigating experiences of racial trauma in the workplace. Bell's critical race theory and Crenshaw's intersectionality served as the frameworks for this study. Six participants were selected based on specific criteria: They held a PhD or EdD in counselor education and supervision, worked full-time in a CACREP-accredited program, were employed for at least 2 years, and self-reported that they experienced racial trauma in the workplace. Data collection involved semi-structured interviews, which were transcribed and analyzed for themes. Findings revealed the following textural themes: disrespect from colleagues and students, diminished well-being, lack of trust in competency, expressing concerns for safety/hypervigilance, a heightened awareness of intersectionality, awareness of social conditioning/exposure to sexualization, and the cognitive process. The final theme, surviving the environment, contributed to the structural description. Finally, the results provide implications for counselor educators, mental health professionals, and counselor education program administrators.

Keywords: racial trauma, Black women, counselor educators, workplace, transcendental phenomenological

The intersection of race and gender has long been a critical focal point in understanding the lived experiences of Black women, particularly in professional settings (Crenshaw, 1989). Black women occupy a unique space within the workforce, often navigating the compounded challenges of racism and sexism. These dual oppressions are pervasive and deeply ingrained in the structures of many workplaces, including counselor education. This study focuses on a central research question: What are the lived experiences of Black women counselor educators mitigating instances of racial trauma in the workplace? This article contributes to the body of literature that explores how Black women counselor educators experience oppression and racial trauma in the workplace.

Black women are disproportionately affected by workplace discrimination, and their experiences are often dismissed or minimized by colleagues and supervisors (Comas-Díaz et al., 2019; Williams, Printz, & DeLapp, 2018). Almost 92% of Black women reported racial discrimination in the workplace (Carter & Forsyth, 2010), which is compounded by a lack of representation of Black faculty within postsecondary institutions (National Center for Education Statistics [NCES], 2022). NCES (2022) found that among the 1.6 million faculty in degree-granting postsecondary institutions, Black women comprised 4% of full-time faculty. The 2024 Vital Statistics Survey of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) revealed that 18.27% of full-time faculty in CACREP-accredited programs identified as Black, whereas 61.16% identified as White (CACREP, 2025). However, there is a lack of research explaining how Black women faculty in counselor education perceive racial trauma in the workplace.

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Mental Health and Racial Trauma

Racism has detrimental effects on mental health and can cause psychological distress (Clark et al., 1999; Pieterse & Carter, 2007; Pieterse & Powell, 2016). Carter and Forsyth (2010) found that encounters with racism resulted in several harmful emotions, such as guilt, shame, anxiety, and hypervigilance. Other effects of racism include identity issues, internalization, isolation, aggression, substance abuse, domestic violence, race-related stressors, sexual promiscuity, and suicidal ideation, all of which can look different individually, institutionally/structurally, and culturally (Hemmings & Evans, 2018; Pieterse & Powell, 2016).

There is a pressing need to address the effects of racism in all settings, as Black women experience more mental health problems than other racial groups (Allen et al., 2019; Catabay et al., 2019). Black women experience not only individual racism, but also institutional or structural racism, which can lead to health disparities (Holder et al., 2015; Jones, 1997; Knighton et al., 2022; Pieterse & Powell, 2016; Sotero, 2006). Workplace hostility can cause severe traumatic stress, including increased anxiety, depression, hypervigilance, avoidant reactions, and other poor mental health outcomes (Carter & Forsyth, 2010; Dickens & Chavez, 2018; Loo, 2003; Shih et al., 2013; Triana et al., 2015; Williams, Printz, & DeLapp, 2018).

Racial trauma is “a form of race-based stress referring to people of color and Indigenous individuals’ reactions to real or perceived experiences of racial discrimination” (Comas-Díaz et al., 2019, p. 1). Racial trauma results from overt acts of racial hostility and subtle, insidious forms of racism, such as microaggressions or the pressure of having to conform to predominantly White workplaces. For Black women counselor educators, instances of racism include racialized marginalization, pressure to prove their competence, and invalidation of their experiences (Haskins et al., 2016; Pérez & Carney, 2018). The cumulative effect of these experiences can lead to chronic stress, anxiety, depression, and other mental health challenges, which are exacerbated by the intersectional nature of Black women’s identities (Arday, 2022; Bernard et al., 2017; Crenshaw, 1989; Pieterse & Powell, 2016; Pizarro & Kohli, 2020).

Due to racialized and gendered microaggressions, Black women faculty might feel *racial battle fatigue* (Behar-Horenstein et al., 2012; Chancellor, 2019), which is often made worse by the *Strong Black Woman* schema, a cultural expectation for Black women to exhibit resilience in the face of adversity (Castelin & White, 2022; Liao et al., 2019). Similar to the effects of racial trauma, the Strong Black Woman schema can cause adverse psychological effects (Castelin & White, 2022; Liao et al., 2019). While this stereotype may serve as a coping mechanism, it can also discourage Black women from seeking mental health support, leading to a reluctance to acknowledge or address the psychological harm they endure.

Racial Trauma in the Workplace

Because Black women are more susceptible to mental health concerns, exploring their lived racial trauma experiences in counselor education programs could provide insight into the associated mental health outcomes (Carter & Forsyth, 2010). Research supports that many Black women experience ongoing workplace discrimination (Dickens & Chavez, 2018; Holder et al., 2015; Shih et al., 2013; Velez et al., 2018). For Black faculty, racial trauma negatively impacts job satisfaction (DeCuir-Gunby & Gunby, 2016). Black women frequently feel the need to identity-shift or alter their cultural behavior, often through code-switching, causing psychological distress (Dickens & Chavez, 2018; Fields & Cunningham-Williams, 2021; Shih et al., 2013). Unfortunately, these changes do not always prevent adverse outcomes (O’Brien et al., 2016).

There is an unfulfilled need to discuss and address racial trauma in the workplace. While there are promising clinical approaches, such as race-based therapy (Bryant-Davis & Ocampo, 2006), racial trauma recovery (Comas-Díaz, 2016), feminist therapy (Brown, 2008), and trauma-focused cognitive behavioral therapy (TF-CBT; Phipps & Thorne, 2019), there are no empirically supported treatments for racial trauma (Comas-Díaz, 2016; Williams et al., 2018a). This research seeks to investigate how Black women faculty conceptualize and interpret the impact of racial trauma in academia, aiming to elucidate the nuanced meanings and implications.

Methods

The central research question guiding this study was: What are the lived experiences of Black women counselor educators mitigating instances of racial trauma in the workplace? This question was explored using Moustakas's (1994) transcendental phenomenological design. Transcendental phenomenology allows the researcher to understand the natural essence of the phenomenon through intentionality and intuition (Descartes, 1977; Husserl, 1999). The researchers captured the essence of each participant's experience by constructing textural descriptions of what the participants experienced and how they experienced it (Moustakas, 1994), which were constructed into composite textural and structural descriptions.

Research Positionality

Three authors are involved in this study, and before discussing our results, we want to acknowledge our positionality in relation to this research. The first author, April D. Brown, originally developed this study for her doctoral dissertation. She is an African American cisgender woman and a practicing counselor who acknowledges experiencing racial trauma. As a licensed professional counselor, Brown has worked closely with clients who experienced racism and discrimination in the workplace. She also encountered her own internalized racism and experienced vicarious trauma as she listened to participant stories. She attended therapy, engaged in reflective meditation repeatedly, and consulted a peer reviewer to ensure objectivity in this study.

The second author, LaShauna M. Dean, is an African American cisgender woman who has been a faculty member in counselor education for 12 years. She recognizes that her social position may influence her interpretation of participant narratives, given her experiences as a Black faculty member. Dean has a strong commitment to accurately conveying participants' stories, as she recognizes the potential benefits of addressing racial trauma in counselor education and has reflected on her own biases through the research process by engaging in critical self-reflection.

The third author, Matthew Lyons, is a White cisgender male counselor educator and academic administrator. Diversity is a significant part of his personal and professional priorities. Lyons acknowledges the ever-present reality of racism and the importance of sharing stories of racial trauma. He was the chair of the dissertation committee for Brown and, therefore, involved in this research from the early stages.

Recruitment and Participants

All participants in this study were Black women counselor educators employed as full-time faculty in CACREP-accredited programs. Researchers recruited participants by first utilizing the CACREP directory to send emails to faculty, secondly by posting the recruitment flyer in the Facebook group for the Association for Multicultural Counseling and Development, and lastly by

posting study details on the CESNET-L listserv. Each recruitment attempt included a description of the study, the interest and inclusion survey to verify eligibility and the contact information of the primary researcher. Eligible participants self-identified as a Black woman, held a terminal degree in counselor education and supervision, had at least 2 years of faculty experience, and self-reported experiencing racial trauma. Participants were provided with the Comas-Díaz et al. (2019) definition of racial trauma and responded “yes” or “no” to whether their experiences met the definition. Six participants met all recruitment criteria, including availability for the interview. One participant did not disclose gender pronouns and is referred to using gender-neutral pronouns (they/them) in this manuscript. Participants’ demographics and pseudonyms are presented in Table 1.

Table 1

Participants’ Demographic Characteristics

Participants	Amber	August	Hazel	June	May	Summer
Age	25–40	41–56	25–40	25–40	41–56	25–40
Gender pronouns	She/her/hers	She/her/hers	Prefer not to say	She/her/hers	She/her/hers	She/her/hers
ACES region	NCACES	SACES	SACES	NCACES	SACES	SACES
State of residence	MN	AL	MD	WI	LA	TN
Years of experience	6–10	11–14	2–5	2–5	2–5	6–10

Note. ACES = Association for Counselor Education and Supervision; NCACES = North Central Association for Counselor Education and Supervision; SACES = Southern Association for Counselor Education and Supervision. Regional classifications are based on the five ACES regions (ACES, 2021).

Data Collection

Semi-structured interviews, lasting approximately 60 minutes, served as the primary source of data. The interview protocol included questions about experiences of racial trauma as well as supports that mitigated those experiences (see Appendix). The interview protocol was developed to address identified gaps in the literature around workplace trauma explicitly experienced by Black women in counselor education and was aligned with the principles of transcendental phenomenology.

Data Analysis

Data analysis followed the eight-step process outlined by Moustakas (1994), which involves a systematic and reflective approach to understanding lived experiences. Our research team began by transcribing interviews and engaging in horizontalization, identifying all relevant statements with equal value. Through reduction and elimination, nonessential or overlapping data were removed, and significant expressions were distilled into invariant constituents, which were then clustered into core themes. We then verified the relevance of these themes in the final identification phase to ensure they authentically reflect participants’ experiences. Using these themes, we constructed individual textural descriptions (what was experienced) and structural descriptions (how it was experienced). These were then synthesized into textural–structural descriptions to capture the full essence of each

participant's experience. Finally, these insights were integrated into a composite description that represents the collective meaning and essence of the phenomenon across all participants, ensuring both depth and rigor in capturing the lived experience.

Interviews were conducted via Microsoft Teams video calls and transcribed using Rev, a transcription service. Following transcription via Rev (n.d.), the interview data were analyzed using Delve (n.d.), a cloud-based qualitative data analysis platform designed to support rigorous thematic analysis. Delve assisted the researchers in systematically coding, clustering, color-coding, and visually mapping qualitative data to identify patterns and themes across transcripts. This process facilitated an iterative and structured approach to data analysis consistent with phenomenological methodology. Delve and Rev comply with General Data Protection Regulation standards, ensuring participant confidentiality and the secure handling of sensitive data throughout transcription and analysis (Delve, 2022; Rev, n.d.). Upon completing the data analysis process, each participant received copies of the constructed descriptions from their interviews to provide feedback in alignment with member checking procedures.

Trustworthiness

Several methods were employed to ensure trustworthiness during the study's interview and data analysis portions. First, Brown used a detailed field log and reflexive journal to record decisions and processes throughout the research, which facilitated self-reflection and enhanced self-awareness throughout the research process. The journal documented thought processes and supported data interpretation (Silver & Lewins, 2014; Tobin & Begley, 2004).

Member checking was also used to ensure trustworthiness by sending participants their textural-structural descriptions after the interview. Participants could confirm or modify their descriptions in writing to ensure that they accurately reflected their experiences (Humphrey, 1991; Moustakas, 1994), and this feedback was used to make adjustments. For unresponsive participants, Humphrey (1991) suggested that their descriptions should reflect the researchers' interpretation of the data.

Finally, an independent peer reviewer participated in the data analysis to confirm the findings and served as a sounding board to ensure objectivity throughout the research. The peer reviewer had experience conducting phenomenological research. Brown met with the peer reviewer three times to discuss the data analysis process, during which they reviewed the initial list of themes, reviewed the reduction and elimination process, identified core themes, and incorporated the relevant information into the study. All participants were aware of the peer reviewer's role from the informed consent form.

Results

This transcendental phenomenological study explored the lived experiences of Black women counselor educators and their experiences of racial trauma in the workplace to highlight ways in which they navigated those experiences. Our results indicated that the experiences of Black women counselor educators were unique to their individual contexts and settings. The following themes emerged from our data: 1) disrespect from colleagues and students, 2) diminished well-being, 3) lack of trust in competency, 4) expressing concerns for safety/hypervigilance, 5) heightened awareness of intersectionality, 6) awareness of social conditioning/exposure to sexualization, 7) the cognitive process (i.e., how racial trauma experiences impacted their thought process), and 8) surviving the environment.

Theme 1: Disrespect From Colleagues and Students

While discussing their experiences of racial trauma in the workplace, the participants described navigating disrespect from colleagues and students, such as name-calling, retaliation, microaggressions, and professional demotions (e.g., not being addressed by their professional titles or credentials). For Hazel, experiencing disrespect in predominantly White institutions was a “reality check.” They stated, “[In the] field of counseling and psychology . . . as a counselor educator, you will be called by your first name. You’ll be demoted by students, by faculty, by colleagues, by everyone.” They recalled, “I’ve gotten emails from students, ‘Hey, can you change [something]?’” August stated, “One student . . . didn’t get the A she thought she [would], and she stopped speaking to me.” She recalled another incident, stating, “I had another student [who] was like, ‘All you talk about is race.’” She also recalls being told, “I am the worst teacher.”

Theme 2: Diminished Well-being

Participants expressed diminished well-being while navigating racial trauma at work. May described experiencing significant physical and psychological distress as well as social–emotional concerns, noting an unintentional 77-pound weight loss, disrupted sleep, diminished appetite, and medical issues such as elevated blood pressure, along with cognitive distortions and heightened perfectionistic tendencies. She explained:

My presentation changed, and [there were] rumors. I’ve gained the weight back, but I had lost a lot of weight rapidly, and I had started to become more isolated and closed-off and cryptic. So, some folks were like, “Your personality went from bubbly to more withdrawn.”

August also expressed how racial trauma affected her well-being. She noted that she was diagnosed with pneumonia, an autoimmune disorder, and shingles while navigating racial trauma at work. She stated, “Long story, it’s not really short, but health. Health was the main thing that [racial trauma] really impacted. And mental health as well.”

Theme 3: Lack of Trust in Competency

Lack of trust in competency was a key theme that emerged from the participants’ experiences. While most participants described experiencing a lack of trust in competency in previous workplaces, one participant, June, was actively facing it in her current workplace. Her experience provides a critical perspective on how racial trauma manifests in real time. She recalled:

[The students would] ask me a question, and I’d respond. Then they’d look it up and be like, “Well, actually, dah, dah, dah.” Or I’d give them a response; they’d run to someone else and be just doing all this stuff. Or one group, they do an exit survey and stuff. They just ripped into every class that was specific to what I taught. No grace of, “Oh, it’s your first time teaching.”

June perceived a lack of trust in her competency as an ongoing issue in the workplace. She explained, “It was a reminder of, no matter what, it doesn’t matter if I’m super competent or know what I’m talking about, there’s always going to be people questioning every last thing I tell them.”

Theme 4: Expressing Concerns for Safety/Hypervigilance

June expressed concerns for safety while actively navigating experiences of racial trauma. Unlike other participants, who had processed their experiences after leaving harmful workplaces, June

was currently navigating a series of traumatic incidents. She was “fearful of things,” displayed hypervigilance, and frequently assessed potential threats at work. The first incident occurred when a magazine published content criticizing her work. She stated, “That moment was just like, whoa. There’s a lot of fear with that.”

After the incident, June expressed concerns for her safety by not wanting to put her location on her institution’s website. She stated, “I don’t want to make it easier for people to find me. I know they can find me if they really want to.” Her fears extended to food delivery. She explained, “Oh, my gosh. You never know who’s going to deliver [the food]. What if they recognize my name and want to harm me in some way, or what if I come on campus and something happens?” June worried about her safety returning to work in person during the COVID-19 pandemic. She described attending the “first all-college meeting” at her predominantly White institution and how she felt being the only Black person in the room. She stated, “Actually, it was kind of overwhelming because I was like, ‘We’re all in this room. I don’t like it.’” June recalled walking to class when she saw a van approaching her slowly. She stated, “The windows rolled down, and they yelled, ‘“Trump 2020’ or something.’” She explained:

It was jarring because I wasn’t expecting that to happen. Then they drove off. I remember feeling so disoriented that I’ve been walking to class this whole time, that I started to, in a way, get lost, not remember where my classroom was, just because I was still in disbelief. I’m like, “It’s broad daylight.”

After these incidents, June took measures to protect herself. She stated, “I ended up buying a key chain. I forgot what it’s called, but it’s a little metal thing that I guess, worst-case scenario, you just jab someone with it, right, but it’s not sharp or anything.”

Theme 5: Heightened Awareness of Intersectionality

Participants experienced a heightened awareness of intersectionality, recognizing that their intersections of race and gender impacted their workplace experiences. For participants, navigating these intersections in the workplace was the norm, something to be expected. August explained that in counselor education, “You’re the unicorn—you’re just unusual.” For Summer, navigating race and gender required a constant attunement to self-awareness. She stated, “It’s a constant knowing. It’s a constant double consciousness. I have to think about how other people are experiencing me [and] how I’m experiencing the situation. Also, [I’m] thinking about how I’m showing up in these particular environments.” Similarly, Amber shared, “I am very cognizant that I have a worldview and a perspective unique to being a Black woman.” She also said that navigating race and gender “takes a little bit of work,” including “learning how to do some compartmentalizing with my identity.”

Theme 6: Awareness of Social Conditioning/Exposure to Sexualization

Awareness of social conditioning/exposure to sexualization described participants’ awareness of society’s assumptions of Black women and of being sexualized at work. Our participants believed that preconceived notions such as societal assumptions, stereotypes, and expectations for Black women exacerbated their racial trauma experiences. Summer reflected on how societal stereotypes prevent Black women from being seen as whole individuals. She noted that Black women are often perceived as strong, emotionless, or lacking intellectual credibility, leaving little room for their full humanity to be acknowledged. Consequently, she believed that her identity contributed to colleagues dismissing her experiences of racial trauma in the workplace.

June said, “I think it’s interesting because, on one hand, I feel like Black women are always kind of seen as strong, right, and scary, and angry, and whatever.” August’s awareness of social conditioning meant managing work and caregiving responsibilities. She mentioned, “Sometimes, it gets very stressful being a woman and being that nurturing person because that’s what is expected of me.” August believed that Black women are socialized to do it all. She explained:

I have to, in a sense, be a liaison for adjunct professors and everything. I’m doing all of this, I’m teaching, and I was trying to publish so I wouldn’t perish, going to conferences, and taking care of my mom. I was juggling [everything].

Participants were sexualized at work by colleagues and students. Summer perceived being sexualized by her colleagues as a form of name-calling. She stated, “I’d gotten an award for something, and someone said [I received the award] because my boss had jungle fever, [not] because of my expertise or my knowledge. They thought it was a joke.” Summer found the joke inappropriate, stating it “sexualized” her. She also felt “ostracized” and “traumatized.” In contrast, May experienced sexual harassment from a student. She recalled feeling stunned and in disbelief, noting that she never expected a student to address her in such a sexualized manner or to encounter this kind of harassment in a professional setting.

May attributed her experience to her identity. She noted that Black women are oversexualized in the media. As a result of her experience, she adjusted her appearance and behavior to reclaim her sense of agency and reduce unwanted attention. She stated:

At one point, I thought I was becoming the asexual mammy archetype because I was becoming more coddling, more docile, and more, whatever you say, let’s go with the flow. I remember how my dress had changed. I started wearing [what] I call the deaconess buns, like the braided buns, after the situation. I wouldn’t put on nothing but chapstick, and I would dress down. But the outfits I was picking were like those floral-pattern, shapeless [dresses] so you couldn’t see a single curve.

Theme 7: The Cognitive Process

The participants described how their racial trauma experiences impacted their thought processes. May initially felt unsupported at her institution. She explained, “Being a Black woman in academia, in the beginning, it was very lonely, isolating, and tokenized for me for [the] years 2018, 2019, [and] 2020.” May’s perspective shifted when her department hired another Black woman. She stated, “I immediately felt the love; it was the missing component.”

June believed that her racial identity made her more susceptible to racial discrimination. She stated, “I know that it’s always going to be a thing because there’s always going to be students coming in who have never encountered a Black woman in a role like this.” She also viewed racial trauma as inevitable at a predominantly White institution. She explained:

I think, in some ways, I kind of expected to run into some stuff. In some ways, I maybe thought it might have been a little bit [worse], actually. I think that’s just having an awareness of, “Yeah, I’m entering a predominantly White environment.”

June perceived the incidents she experienced on campus as intense, which left her feeling threatened and intimidated.

Hazel expressed a mistrust of the institution. They refused to teach a course again after the administration withheld pertinent information about a student in their class. They stated, “I don’t trust the admin to be protective or to keep me safe. Yeah, the mistrust is definitely there.” Hazel became suspicious and questioned joining professional organizations and the integrity of the profession as a whole. They explained, “[Racial trauma] made me question my field, question my counterparts, and wonder, ‘How are we really helping?’”

Theme 8: Surviving the Environment

Participants employed various strategies to reduce the impact of racial trauma in the workplace and maintain well-being. Many relied on spiritual and therapeutic practices. Summer shared that her “church family” provided support, and her spirituality increased as she navigated racial trauma. May echoed, “My church, my God, [and] my higher power [helped me cope].” Participants also used therapeutic resources. Summer stated, “For my mental health and well-being, I went to counseling.” May found individual therapy and coaching helpful, August benefited from group therapy, and June engaged in the sandplay process. August and Summer also found journaling beneficial. Similarly, Amber relied on self-awareness and shared, “The more I understand about myself . . . the better I’m able to navigate.” August found that “using [her] senses to ground [her]” was highly beneficial.

Community support was another key strategy. Amber noted, “I think it’s really important to have support, to not try to address it alone.” Summer emphasized “a positive support group, an affinity group . . . committed to actionable steps to help you navigate a racist academy.” May similarly highlighted the importance of forming “a united front” with colleagues. June’s relationships with marginalized colleagues created spaces to process, “support each other,” and have “all kinds of conversations.” She also found connecting with students “exciting” and meaningful.

Some participants coped by giving back to the community. June felt responsible for Black students, drawing on the concept of “other mothering” and expressing a desire to nurture and look out for students facing racism. Hazel continued working at an institution where they experienced racial trauma because they were committed to supporting a Black student. They stated, “I’m on a student’s dissertation. . . . She’s an African American student, and I really want to support her. I’m trying to hang in there.”

Participants also found relief through intentional diversity, equity, and inclusion (DEI) efforts. June routinely incorporated multiculturalism, equity, and social justice into her courses. She shared, “I tell students about [racial battle fatigue]. I find any reason to bring it up at least once.” She noted, “It gives you hope so that it’s healing in that way.” Summer similarly infused Ratts et al.’s Multicultural and Social Justice Counseling Competencies (MSJCC; 2015) across her program, explaining that diversity was present “not [in] just one day of the schedule but [in] every conversation we’re having.” Amber, as program chair, remained committed to promoting DEI and relied on a “social justice lens” to review policies and ensure equity.

Several participants turned to counseling literature as a coping strategy. Hazel described using exercises from *The Racial Healing Handbook* by Anneliese Singh and referencing Jennifer Fraser’s work on workplace bullying. May accessed the MSJCC and the work of scholars such as Derald Wing Sue, David Sue, Cirecie West-Olatunji, Kent Butler, and writers like Gwendolyn Brooks, bell hooks, and Patricia Collins.

Overall, participants' coping strategies reflected key relational dimensions: self, others, space, and time. August's and Amber's focus on self-advocacy, self-awareness, and self-care fostered resilience. June and Summer emphasized relationality through peer and student connections. Spatial awareness informed decisions to leave unsafe environments, as seen in Hazel's and Summer's stories. May's experience highlighted time as a resource that required boundaries and intentional management. Together, these strategies demonstrate the multidimensional ways Black women in counselor education coped with and made meaning of their racial trauma experiences.

Discussion

This transcendental phenomenological study explored Black women counselor educators' lived experiences of racial trauma in the workplace, and our results indicate that those experiences of racial trauma were unique to the participants' contexts and settings. The participants perceived their experiences of racial trauma in the workplace as a larger systemic issue that was beyond their control, supporting the idea that racial inequality results from institutional and structural factors rather than individual prejudice (Reece, 2018). Previous research has explored racial microaggressions in the workplace, racism on college campuses, racial battle fatigue among educators, and microaggressions among female faculty (Avent Harris et al., 2019; Blackshear & Hollis, 2021; Pérez & Carney, 2018; Rollock, 2021). Past research also indicated that Black women faculty in predominantly White institutions frequently experience microaggressions from students, colleagues, and staff (Blackshear & Hollis, 2021).

Our study provided new insight into Black women counselor educators' perspectives on their racial trauma experiences in the workplace. Participants described disrespect from colleagues and students, including microaggressions, name-calling, retaliation, and professional demotions that indicated being devalued in their professional roles. Participants also described feeling several negative emotions, such as hurt, frustration, and outrage, while navigating racial trauma in the workplace (Carter & Forsyth, 2010). As outlined in previous research (Anderson, 2012; Bernard et al., 2017; Carter & Forsyth, 2010; Pieterse & Powell, 2016), our participants confirmed that race-related stress resulted in physical and mental health challenges, which aligns with previous studies that link the prevalence of racism to ailments among people of color (Allen et al., 2019; Alvarez et al., 2016; Catabay et al., 2019; Loo, 2003; Williams et al., 2018) and the detrimental impact of workplace discrimination on overall well-being (Dickens & Chavez, 2018; Knighton et al., 2022; Shih et al., 2013; Triana et al., 2015). Black women often feel compelled to prove their competence and credibility to colleagues and students, particularly White colleagues (Haskins et al., 2016; Kelly et al., 2017; Pérez & Carney, 2018). Our study revealed that a lack of trust in competency was an ongoing issue for a participant working in a predominantly White setting. Results suggest that students primarily questioned and challenged this participant's competence.

Participants expressed concerns about their physical and psychological safety, with a participant describing the need to protect herself after experiencing a series of traumatic incidents on campus. Two participants left the institutions where they experienced racial trauma to find safer work environments. This finding suggests that emphasizing the "E" stage (enhancing safety) within the TF-CBT PRACTICE framework may help reduce the impact of racial trauma (Metzger et al., 2020). Therefore, counselor education program administrators might focus on prioritizing psychological safety in the workplace to reduce racial trauma experiences among Black women counselor educators.

Participants knew their social locations, societal stereotypes, and assumptions negatively impacted their roles in the workplace and believed preconceived notions influenced their experiences of racial trauma. They were aware of the intersectionality of racism and sexism (Crenshaw, 1989), which they believed increased their susceptibility to workplace racism (Avent Harris et al., 2019; Behar-Horenstein et al., 2012; Chancellor, 2019; Rollock, 2021).

Past research showed that Black women encounter racism and sexism in higher education (Behar-Horenstein et al., 2012). Our participants described experiences of sexual harassment by colleagues and students, indicating that their intersecting identities exacerbated their racial trauma experiences. Participants' heightened awareness of intersectionality developed as they navigated the complexities of race and gender in their workplace (Bell, 1995; Delgado & Stefancic, 2017). Their deep understanding of intersectionality, shaped by lived experiences of oppression at the intersection of race and gender, underscores the need for deeper exploration of the unique perspectives and worldviews that emerge from navigating these systemic barriers.

In alignment with previous research finding that Black faculty experience daily microaggressions in the workplace and feelings of victimization (Arday, 2022), our participants described feeling excluded and isolated within their institutions as they navigated the workplace alone. These experiences are consistent with previous research highlighting the challenges that marginalized faculty face in counselor education (Haskins et al., 2016; Pérez & Carney, 2018). Another participant perceived her experiences of racial discrimination as inevitable, supporting past research that Black tenured faculty reported and expected racism in institutions (Blackshear & Hollis, 2021), while mistrusting the institution involved, feeling suspicious, and lacking confidence in the work environment. This finding supports previous literature that documents suspiciousness as a psychological effect of racial trauma (Bryant-Davis & Ocampo, 2006; Comas-Díaz et al., 2019). Our study's results indicate that cognitively processing racial trauma experiences was an emotional release for participants.

Amidst their challenges, our participants navigated and processed racial trauma in distinct and deeply personal ways, reflecting varied coping strategies and resilience. Participants discussed how they employed several internal and external coping strategies to reduce the impact of racial trauma. The coping strategies described by participants parallel previous recommendations for addressing racial trauma, including Black women's reliance on internal resources for coping (Stevens-Watkins et al., 2014), community support (Chioneso et al., 2020; Liu & Modir, 2020), and integrating relaxation techniques (Metzger et al., 2020).

Past research found that Black women and people of color are less likely to seek mental health services (Stevens-Watkins et al., 2014) and support for stress and racism (Carter & Forsyth, 2010); however, our study participants sought counseling to cope with their experiences. Two participants left their institutions when they felt unsafe, confirming that racism negatively impacts job retention and well-being (Pizarro & Kohli, 2020). Participants focused on DEI work as a strategy for coping, explicitly advocating for faculty diversity to reduce racial trauma experiences. Our study revealed that participants used counseling literature to cope and unknowingly applied Ratts et al.'s (2015) MSJCC advocacy domains. Despite this, study participants did not consciously consider using the MSJCC to address workplace issues such as racial trauma. This finding supports the recommendations of previous scholars to fully operationalize the MSJCC (Hays, 2020; Singh et al., 2020).

Implications for the Profession

This study has implications for Black women counselor educators experiencing racial trauma in the workplace, mental health professionals supporting clients facing racial trauma, and counselor education program administrators who supervise Black women faculty and implement policies affecting their work. Black women counselor educators must consider how systemic issues contribute to their workplace experiences and overall well-being. Mental health professionals working with clients who may be experiencing racial trauma should identify and screen for racial trauma, use culturally relevant interventions and racial models of recovery to treat racial trauma, utilize cognitive and behavioral strategies that promote relaxation, and help clients identify internal and external resources for coping.

Mental health professionals also have a responsibility to address issues related to oppression, privilege, and social inequities (Lee, 2007). When working with Black women counselor educators, mental health professionals should be aware of anti-DEI policies and legislation while empowering clients to engage in social justice and advocacy to reduce racial trauma at work. As DEI programs are no longer permitted within federal government agencies (The White House, 2025), implications for counselor education program administrators include recognizing the impact of anti-DEI mandates, policies, programs, and activities on counselor education programs. Administrators should inform counselor educators, staff, and students about how these changes impact employment, hiring practices, workplace policies and procedures, and curriculum. Although recent executive orders emphasize advancing a policy of equal dignity and respect (The White House, 2025), counselor education administrators should consider strategies to foster a workplace culture that upholds federal civil rights protections for all employees. They should also familiarize themselves with anti-discrimination laws and focus on enhancing psychological safety and support to reduce the impact of racial trauma in counselor education programs.

Limitations

Our recruitment strategy limited our sample size due to the criteria we set and the sensitive nature of the research topic, which consequently restricts the transferability of our findings. Our sample size also lacks racial and gender diversity, with all participants identifying as Black women. Black people experience racial trauma more than any other racial group (Comas-Díaz et al., 2019; Williams, Printz, & DeLapp, 2018). However, the exclusion of male participants is a limitation, and understanding Black men's experiences as counselor educators is also worth exploring in depth.

Finally, bracketing personal experiences in phenomenological research is difficult because researchers always bring their own assumptions to the study (Moustakas, 1994; van Manen, 1990, 2014). Hence, our interpretation of the data could reflect our biases, beliefs, and values. Because all of us have counselor educator experience, our professional experiences may have shaped our interpretation of participants' experiences. Therefore, we took intentional steps to minimize our biases and bracket our experiences, including journaling, member checking, and peer review throughout the research process.

Conclusion

This study aimed to explore Black women counselor educators' lived experiences of racial trauma in the workplace. The findings showed that the participants had experiences unique to their contexts and settings. Participants experienced significant challenges, including disrespect from colleagues and

students, diminished well-being, a lack of trust in their competency, expressing concerns for safety/hypervigilance, a heightened awareness of intersectionality, an awareness of social conditioning/exposure to sexualization, and the cognitive process. Despite these hardships, they employed various coping strategies to survive the environment, thus mitigating racial trauma in the workplace. This study contributes essential knowledge to counselor education by highlighting the systemic conditions that shape the experiences of Black women counselor educators and revealing a critical need for structural and institutional change to ensure safe, equitable, and culturally responsive environments that support the well-being and professional longevity of Black women faculty.

Conflict of Interest and Funding Disclosure

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Appendix

Interview Protocol

1. What does it mean to be a Black woman counselor educator?
2. Tell me about your experiences working as a Black woman counselor educator.
3. Tell me about the racial trauma you have experienced in the workplace.
 - a. What was it like for you? How did these experiences impact you?
4. Tell me what areas in your life were most impacted due to these experiences.
5. How would you describe the role that race and gender played in these experiences?
6. Let's talk about what you have done to mitigate experiences of racial trauma in the workplace.
 - a. How would you describe the intentional choices you made to deal with these experiences?
 - b. What specific actions did you take?
 - c. What specific interventions helped you overcome these experiences?
7. Tell me, was there anything from the counseling literature that helped you?
 - a. What about the Multicultural Social Justice Counseling Competencies?
8. Tell me who was a part of your work experience and helped you overcome racial trauma in the workplace.
9. What external factors helped you overcome these experiences?
10. As you reflect on your experiences, is there anything else you want me to know about your experiences mitigating racial trauma in the workplace?

Counseling With a Child Holding Afghan Parolee Status in the United States



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Currently, 200,000 Afghans live in the United States, including the 76,000 Afghan nationals who arrived in 2021 under Operation Allies Welcome. Afghan refugees have often lived their entire lives under strife and occupation, presenting specific concerns unique to this population. To demonstrate how mental health and social and economic factors can manifest traumatic responses in children from migrant backgrounds, the article presents a case study involving a school-aged child and recommendations for how a counselor would work with this client in the school setting. The article also presents practical applications and interventions that could be beneficial in these cases while also considering the limitations that exist in the current case study regarding relevant issues for immigrants in counseling.

Keywords: counseling, Afghan refugees, case study, children, migrant

Afghan migration to the United States started to increase significantly in the late 20th century, growing from 4,000 in 1980 to 45,000 by 2000 (Saydee & Saydee, 2025). Currently, about 200,000 Afghans are living in the United States (Saydee & Saydee, 2025). The Afghan immigrant population in the United States has a lower median age than other immigrant and native-born groups in the United States, and 30% of Afghan immigrants are under 18 years old (Montalvo & Batalova, 2024). We present historical and contextual information related to the experiences of Afghan parolees in the United States and how counselors may work with a school-aged Afghan parolee and their family through a case study. *Parole* in this context refers to a temporary, discretionary immigration status allowing admission to the United States for humanitarian concerns or significant public benefit (Immigration and Nationality Act, 2025, 8 U.S.C 212(d)(5)). We demonstrate counseling using an integrative ecological approach with an Afghan child who arrived in the United States with humanitarian parole status through the case study. For this case study, we define children as school-aged (6–18). The case study is hypothetical, incorporating elements based on our experiences working with Afghan parolees in community and school settings in the United States post-evacuation in 2021. We illustrate through the case study of a school-aged child an integrative approach relevant for both school and mental health counselors.

Operation Allies Welcome

In August 2021, 76,000 Afghan nationals arrived in the United States under Operation Allies Welcome, an emergency evacuation effort after the American withdrawal from Afghanistan and subsequent takeover by the Taliban (U.S. Department of Homeland Security, 2022). Before arrival, these Afghans completed a rigorous health and security screening process and were granted humanitarian parole to enter the United States (U.S. Department of Homeland Security, 2022). This parole status allows individuals to enter the country without a visa in cases of humanitarian concern or benefit to the United States (National Immigration Forum [NIF], 2021), such as requiring protection from harm, seeking critical medical treatment within the United States, caring for a sick relative living in the United States, attending a funeral, or participating in a legal proceeding. Under this status, Afghan

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evacuees were allowed to remain in the country and to work legally for a period of 2 years. Similar past evacuation efforts occurred after the Hungarian Revolution in 1957, the withdrawal from Vietnam in 1975, the withdrawal from Iraq in 1996, and the evacuation of interpreters from Iraq in 2007 (NIF, 2021).

The recent exodus of displaced persons from Afghanistan after the U.S. withdrawal joined refugees fleeing the country in response to decades of conflict and hardship, including the Soviet invasion in the 1980s, civil war in the 1990s, the Taliban takeover in 1996, and the American invasion in 2001 (Montalvo & Batalova, 2024). Once in the United States, Afghan parolees were initially housed at Army base camps across the country (which closed by February 19, 2022), until referred to a refugee resettlement agency for permanent resettlement. Parolees had 2 years to apply for an immigration status that allows for a pathway to citizenship, such as asylum or a special immigrant visa (SIV; Bruno, 2023). This process differs from the typical refugee resettlement process, in which refugees must have fled their country because of persecution, been granted refugee status, and been referred to the U.S. resettlement screening process, which can take 5 to 8 years. Refugees who arrive under this process are eligible to work from the day of arrival in the United States and have a pathway toward citizenship.

Although Afghan parolees were deemed eligible for public benefits, resettlement, and other integration services benefits upon arrival to the United States, and were spared the long waiting process for refugee resettlement (Bruno, 2023), they were required to apply for work authorization as well as an immigration status that would allow them to stay in the country permanently (Bruno, 2023). The influx of Afghan migrants also overwhelmed resettlement agencies, many of whom were already operating under limited capacity because of COVID-19 and years of low arrivals (Office of the Inspector General, 2023). Because of the urgency of the evacuation, many of these migrants had little time to prepare or consider the implications of the decision to leave Afghanistan. Some had to leave behind family members, even spouses and children, with no pathway toward family reunification (until the family reunification initiative launched almost 2 years later; Rush, 2023).

Contextual Considerations for Counseling

It is important for counselors not to regard any country as a monolith and to assess the individual ethnic and cultural background of their clients. Afghanistan is diverse, made up of more than 19 different ethnic groups with distinct languages and cultures (Saydee & Saydee, 2025). The two primary languages are Dari and Pashto, and the primary ethnic groups include Pashtuns, Tajiks, Hazaras, and Uzbeks (Saydee & Saydee, 2025). Three-fourths of children in Afghanistan report experiencing violence at home, and children are at risk for child labor, early marriages, sexual violence, military recruitment, and honor killings (Saydee & Saydee, 2025). Although exposure to violence may be prevalent, counselors should never assume that a client is abusive or being abused solely because of ethnicity nor label the culture as inherently violent. Symptoms of trauma, such as hypervigilance and avoidance symptoms, can be exacerbated by honor values in Afghan culture (Missmahl, 2018). For example, an Afghan woman may lean heavily on cultural expectations that she serves as homemaker and caretaker to avoid uncomfortable experiences in a new country. A counselor may not question her behavior out of respect for her cultural beliefs, further enabling her isolation. Alternatively, a counselor may perceive culturally appropriate behavior, such as refusing to be in a room alone with a man, as indicative of paranoia, social phobia, or another pathological symptom.

Socioeconomic circumstances can contribute to psychological distress in children (Golberstein et al., 2019). Counselors may expect that a person who has experienced trauma such as war and sudden flight from their country must be traumatized. They might attribute symptoms of distress to traumatic experiences from overseas, and therefore miss that possible present unemployment, social

isolation, homelessness, and/or food insecurity might be responsible for these symptoms (Im et al., 2021). In these cases, counselors should be prepared to investigate and address the socioeconomic circumstances that contribute to psychological distress (Missmahl, 2018).

Uncertain legal status complicates the daily life and integration of Afghan parolees resettled in 2021 and can contribute to symptoms of traumatic distress (Droždek et al., 2013). The traditional refugee resettlement process includes coordination between several federal agencies, nonprofit organizations, and local communities that includes security and health screenings and clearance overseas, placement and travel, and reception and connection to services (Office of Refugee Resettlement, 2015). Although the initial parole status granted them legal presence for 2 years, they had to apply for employment authorization cards and wait for approval before starting work. Their only pathway toward permanent residency in the United States was to apply for asylum, which can also be an expensive and lengthy legal process, or to apply for an SIV, if they were eligible, by being able to prove that they worked with Americans in Afghanistan for at least 1 year. Asylum involves demonstrating evidence of persecution in the country of origin based on race, religion, nationality, membership in a particular social group, or political opinion (Bruno, 2023). Receiving an SIV involves demonstrating evidence that the Afghan individual assisted the U.S. government in the fight against the Taliban or eligible employment by or on behalf of the U.S. government in Afghanistan (Bruno, 2023). Those who left behind immediate family members in Afghanistan had no pathway toward applying for them to join them in the United States.

Grief over separation from family and fear for their safety can be a major source of distress (Bryant et al., 2021), as can fear of discrimination in the United States (Yang et al., 2025). A young person coming to the United States from Afghanistan in 2021 is likely to have lived their whole life under American foreign occupation. Additionally, this person may feel a sense of betrayal for abandoning their country, and that sense of betrayal may color each decision, either to acculturate to American life or to cling to traditional Afghan ways. Afghan evacuees left behind their hometowns and the social structures inherent in them. Hence, practicing their cultural or religious beliefs may be difficult in a new country when these practices involve community, because this new community needs to be rebuilt.

In addressing the psychosocial needs of Afghan children resettled from the evacuation effort, counselors need to provide a comprehensive approach that considers the legal, physical, emotional, and social needs to begin the reconstruction of a new community structure for these children. Miller et al. (2006) conducted a study exploring Afghan conceptualizations of mental health and distress and found that well-being was made up of three areas: community (honor), family (respect, harmony), and the individual (hope, faith, calm). Young refugees, in general, benefit from a multidisciplinary approach (Stammel et al., 2017). Family can be a source of protection, belonging, and strength for immigrant children (Burgos et al., 2017). In Afghanistan, families are often tight-knit, and each contributes to the extended family unit. Although it can be a source of stress, children of immigrants often become involved in caring for parents as adults struggle to navigate new systems (Burgos et al., 2017). At the same time, contributing to the family can increase self-esteem for youth (Burgos et al., 2017). For Afghans, this can be a way of honoring culture, building social support, and promoting self-esteem.

Maintaining ethnic identity, religious practices, and family cohesion can lead to well-being among immigrant children (Burgos et al., 2017). Reimagining ethnic identity in the process of immigration can be a crucial step in integration and identity development. For example, an Afghan child can identify with other refugees from different countries who have experienced a similar process of flight from war and resettlement in a new country. This can be balanced against maintaining other

important aspects, such as religious identity. Using religious practices and tenets to resolve family and internal distress can be useful, such as increasing tolerance and patience, practicing listening and respect, and using various relaxation techniques like prayer or aromatherapy (Faqiri, 2018). Children arriving from Afghanistan with humanitarian status are unique from other refugee groups because of the nature of their evacuation directly to the United States and the differences in their immigration status and its implications for long-term integration (Saydee & Saydee, 2025). We highlight these dynamics in the following case study.

Case Study: Aaisha

Ten-year-old Aaisha recalls the dangers of her home country, Afghanistan, and the limitations she experienced growing up in a war-torn country. These dangers forced her family to seek asylum in the United States. During her escape, her immediate family—her mother, father, and younger sister—were unable to stay with other close family members with whom she had grown up, such as her grandparents, aunts, uncles, and cousins. The separation from extended family and subsequent immigration to a new country disrupted her life and continues to affect the life her family is trying to build in the United States, where she now lives and attends elementary school.

While Aashia was still living in Afghanistan, the parents tell the school counselor, she was unable to play outside or attend school because of the danger of sniper and missile attacks. She reports that she even learned to identify what type of weapon was being used based only on the sound it made. Her mother tells the school counselor that they were able to get on a plane out of Afghanistan, during which her younger sister almost died because of the heat and crowded conditions. The family lived on an Army base in Texas for 2 months until they were assigned to a resettlement agency in another state. They have been staying at a local hotel for 2 months since then and are waiting for employment authorization and permanent housing.

Aaisha is struggling to adjust. She fears she is too far behind the other students in her grade at school, and the language barrier prevents her from connecting to classmates or fully expressing herself. She remembers the violence of her home country and, despite the new environment, thinks often about her past, in which she needed to hide. She still misses her extended family and her home in Afghanistan deeply. Leaving her family each day to go to school makes her feel nervous, and when at home, she suffers from restless sleep, further adding to her stress at school. She struggles to pay attention, and her teacher complains that she is distracted and often excuses herself to the restroom, which prevents her from engaging fully in the lessons. She does not want to complain and worry her parents, but the teacher assigned her to sit with two Afghan male students in class who have been in the country longer. They do not speak her language and ignore her when she tries to ask them for help. The girls in the class also seem to laugh at her and make fun of her clothes. At home after school, she procrastinates doing homework, often complaining that she has a headache. She also changes the subject when asked about her school day, frequently reporting that she does not feel well. The school counselor is concerned about Aaisha's psychological well-being and has approached her and her parents about possible therapy options. The school counselor has suggested that her parents explore art therapy as a constructive way for their daughter to creatively express and process her emotions and trauma. Her parents like this idea but cannot afford therapy or even art classes. The school counselor refers the student to an on-site school-based clinic staffed by clinical mental health interns. The school counselor meets with the intern to discuss her concerns before the clinical mental health intern meets with the client. School-based mental health clinics can be effective and bridge gaps in accessibility for counseling services (Solomon et al., 2020).

An ecological approach can help school counselors promote equity for students like Aaisha (Savitz-Romer & Nicola, 2022). Children develop within and are influenced by multiple levels of society, including the immediate family, school environment, community, and wider sociological forces (Bronfenbrenner, 1979). The ecological approach can be useful in understanding the dynamic factors involved in refugee children's development and potential areas of intervention (Yoon et al., 2023). Below, we show how an ecological approach can help us understand the case and provide a productive starting point for intervening to help Aaisha.

Ecological Approach

Case conceptualization and treatment planning with refugees should take an ecological approach that considers all relevant factors, highlighting areas of challenge and strength (Yoon et al., 2023). The ecological model attends to different spheres of the child's life pre- and post-migration. The model includes any education, trauma, information, coping skills, and medical support the child would have received before immigration to a new country (Minhas et al., 2017). Assessing a child's needs using an ecological approach can provide useful information to important individuals in the child's life (Minhas et al., 2017), including caregivers, medical teams, pediatricians, physicians, and school staff who can help support successful acculturation. Minhas et al. (2017) developed an ecological approach to assessing risk factors among refugee children. This approach is represented by the acronym EMPOWER: Education, Migration, Parents and family, Outlook, Words, Experiences of trauma, and Resources (Minhas et al., 2017). Using this model, the school counselor and clinical mental health intern meet and discuss the possible ecological factors relevant to Aaisha's case, applying the EMPOWER model, to coordinate her care. For her educational background, they know that she's currently in an English as a Second Language (ESL) class and is perceived by her instructor as struggling with attention and focus. She is proficient in both spoken and written Dari and has some proficiency with English. She also experienced an interruption in her formal education because of her migration experience. Her migration experience included a forced migration from her home country to the United States, one that she did not have time to plan or prepare for. Her family was evacuated from Afghanistan and held in a temporary shelter in Texas at a military base for 2 months until they were referred to the local nonprofit agency for 3 months of resettlement services. Her family is now living on a temporary parole status and has to pay a lawyer to help with processing an application for asylum, leading to a more permanent pathway to staying in the United States. For her family, she lives with her mother, father, and sister who serve as a resource and source of strength for her. She is experiencing grief over the loss of her family and social network in Afghanistan. For her outlook, she is motivated to do well in school and to feel a sense of belonging and safety in a community. She worries about her extended family overseas and is troubled by loneliness. Related to words, she speaks Dari and some English. For resources, she can seek support from the local nonprofit that resettled the family and that offers additional social services such as a food pantry, after-school tutoring, and assistance navigating public benefits. She has limited support from the local Afghan community because they were also resettled recently and many of them came from a different ethnic group.

Evidence-Based Treatments

Counselors can help in a variety of ways by addressing grief related to the loss of friends and family, the effects of being a minority, perceived discrimination and acculturation, exposure to trauma and harassment, and the effects of social issues (Beehler et al., 2011; Beiser et al., 2015; Goh et al., 2007; Kopala et al., 1994). To meet the unique needs of children and families, practitioners must use evidence-based interventions, such as cognitive behavioral therapy (Sullivan & Simonson, 2016), while making appropriate adaptations to render them logistically and culturally accessible. Counselors using an integrative approach can utilize evidence-based interventions to address

various aspects of the mental health challenges a child is facing. Counselors can focus on grieving the loss of family and friends (Goh et al., 2007), the effect of being a minority (Kopala et al., 1994), perceived discrimination (Beiser et al., 2015) and acculturation (Beehler et al., 2011; Beiser et al., 2015), exposure to trauma (Beehler et al., 2011), harassment, and social issues (Goh et al., 2007). With Aashia, these elements are all involved. She is experiencing migratory grief, which is often unnamed and unrecognized (Yoon et al., 2023), as well as the loss of family, friends, and the comfort of living in a familiar climate, environment, and surrounded by a familiar language. The experience of being perceived as a religious and racial minority in a different social system in the United States is also distressing. Aaisha was exposed to trauma overseas before migration, and the experience of migration and resettlement was further traumatizing. Evidence-based interventions are needed to assist with the processing of trauma associated with these experiences.

School-based mental health professionals can play an important role in offering mental health services for migrant children. Two-thirds of students surveyed said they preferred to seek counseling at school (Fazel et al., 2016; Sullivan & Simonson, 2016). Because of their ability to identify distress, address psychosocial functioning, and implement creative expression (Goh et al., 2007; McNeely et al., 2020), schools are well-situated to support student wellness, offering an opportunity to provide mental health services for migrant children in an acceptable and accessible manner (Sullivan & Simonson, 2016). For Aaisha, the school could be an accessible place to receive these services. The school counselors would not be able to provide the individual treatment themselves, but they can support the on-site clinics and coordinate with the individual practitioners. The school counselors would also be able to organize and offer group sessions to build peer psychosocial support. By providing referrals to individualized services, offering group sessions, and facilitating advocacy to build a welcoming and supportive school environment, the school counselor is meeting ethical responsibilities through a holistic approach (Harrichand et al., 2022).

Art Therapy

Creative expression through evidence-based art therapy provides an outlet for children, such as refugees struggling with traumatic past experiences, and can be an effective way for them to begin to process their complex emotions and trauma (Rowe et al., 2017; Sullivan & Simonson, 2016). In the absence of a shared common language, art provides a mechanism for communication and expression among peers (St. Thomas & Johnson, 2001). Rowe and colleagues (2017) reported that the use of assessment tools like the Diagnostic Drawing Series can be helpful as a baseline because art therapy can initially cause depressive symptoms as the trauma surfaces but ultimately leads to decreased anxiety and depression. If working with Aaisha, the school-based clinical mental health counselor could use art therapy to help reduce her anxiety and depression through either structured drawing or the Diagnostic Drawing Series. Art therapy could also offer Aashia a way to communicate her emotions in a safe environment.

Peer Support and Groups

It is up to counselors to develop an encouraging environment for students to address and process their present and past feelings (St. Thomas & Johnson, 2001). St. Thomas and Johnson (2001) investigated a 12-week program to help children process their feelings through puppetry in a supportive peer group setting. Panter-Brick et al. (2018) found that high levels of traumatic distress can be managed using psychosocial groups. They found that small peer groups help adolescents develop trusting relationships with individuals from different cultures. Groups also have the benefit of supporting acculturation for refugees and immigrants through rebuilding communities and offering opportunities to practice interpersonal skills (Atiyeh et al., 2020). As Aaisha is navigating life

in a new country and rebuilding community, the school counselor can provide a group intervention that could assist her in learning new skills and reducing isolation. The school counselor would lead a peer support group for Aaisha and other new students to offer support in acclimating to the school environment, address social skills, and develop peer support. A group intervention can offer an opportunity for the school counselor to address Aaisha's social needs, facilitating her connection with peers in a supportive environment. The school counselor would also be able to identify shared barriers or concerns new students face in the school and advocate more effectively for a welcoming environment among school faculty, staff, students, and families.

Cognitive Behavioral Therapy (CBT) and Trauma-Focused CBT

Interventions that focus on helping refugees and immigrants through trauma can be very therapeutic (Im et al., 2021). Cognitive behavioral therapy (CBT) interventions like narrative exposure therapy, creative exercises, cognitive restructuring, trauma-focused therapy, and psychoeducation are effective for children with post-traumatic stress disorder (PTSD), anxiety, and depression (Kangaslampi et al., 2015). The clinical mental health counselor working with Aaisha could implement these techniques to treat symptoms of trauma and facilitate adaptive coping techniques for acculturative stress. Trauma-focused cognitive behavioral therapy (TF-CBT) can be used to process and understand trauma (de Arellano et al., 2014). TF-CBT focuses on helping children with processing trauma and working through PTSD, depression, anxiety, and behavioral issues. TF-CBT has also helped counselors work with children who have struggled with depression, PTSD (de Arellano et al., 2014; Scheeringa et al., 2011), and behavioral issues (de Arellano et al., 2014). Scheeringa et al. (2011) completed a 12-session model for reducing PTSD and depression in children. TF-CBT could be productive with a client like Aaisha, who witnessed the danger of sniper and missile attacks. Addressing and focusing on her trauma could help reduce PTSD symptoms over time. The counseling intern working in the school-based clinic would offer TF-CBT to support with art therapy techniques to help Aaisha process grief and past trauma, and to strengthen coping skills to manage worries and anxiety. The counseling intern starts with a thorough informed consent process with both Aaisha and her parents, with an interpreter present to discuss the counseling process, the time limitation of her internship, and the plan for ongoing services after the end of the TF-CBT protocol. The intern develops a treatment plan that identifies manageable goals important to Aaisha for the timeframe they have to work together.

Integrative Approach

Using an integrative, school-based approach that addresses the logistical and cultural needs of the client in treating trauma and adjustment-based concerns, the school counselor working with Aaisha would need to hire a trained contractual interpreter to assist with co-facilitating an integrative group intervention. The school counselor could work with her teachers to identify other girls within her age bracket who might share similar concerns. The group sessions could follow the general protocol of TF-CBT, including psychoeducation, relaxation, affect regulation skills, integration of the trauma narrative, communication skills, and parenting skills. Art therapy techniques at each stage will make activities more accessible and meaningful. These techniques might include creating group murals or collages with coping techniques. While the clinical mental health counselor is working with the students, the school counselor could lead parenting skills and psychoeducation sessions with the parents so that they can be brought into the group sessions to support their children effectively.

Limitations/Considerations

While we offer an integrative approach in this case study, school counselors must account for their school contexts and resource limitations. Within those limitations, we advocate for an approach that honors the client's cultural background, family and community involvement, and holistic needs

for well-being. School and clinical mental health counselors must work in partnership with each other, students, interpreters, families, and wider school communities to meet these needs ethically. The ASCA National Model (2025a) and the ASCA School Counselor Professional Standards & Competencies (2025b) outline school counselors' responsibility to build partnerships among schools, families, and communities. Seeking supervision and consultation can support creative advocacy efforts to address migration-related trauma and acculturation concerns within resource constraints.

Conclusion

Equipped with background knowledge of migration issues, cultural norms, and relevant social systems as well as skills in evidence-based interventions, advocacy, and cultural brokering, counselors can successfully support refugee and immigrant children in their pursuit of wellness. An ecological approach that includes consideration for poverty, trauma, and culture is best suited to facilitate understanding of both the pressing challenges and areas of strength and resilience among refugee and immigrant children. Counselors are well-positioned in the community and school settings to help facilitate psychosocial adjustment in collaboration with schools, service providers, health care providers, and families.

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Providing Wellness Counseling in Older Adult Living Communities: Challenges and Opportunities



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Older adult living communities (OALCs; i.e., continuing care retirement communities, assisted living facilities, and long-term care settings) are growing in number and complexity, and industry leaders are recognizing that promoting wellness among their residents is a top priority. Although OALCs offer services to keep their residents engaged and active, residents' emotional needs often go unmet. Adults who reside in OALCs are likely to benefit from counseling services, especially when delivered within a wellness framework; however, there is inconsistent availability of wellness counseling within OALCs. Our article describes how wellness approaches can be utilized, addresses the unique counseling needs of OALC residents, and considers the importance of multicultural competence when serving older adults. The included case study highlights the promise of wellness counseling in OALCs.

Keywords: older adults, counseling, wellness, living communities, assisted living

Older adult living communities (OALCs) play an essential role in promoting multidimensional wellness among older adults (Hettler, 1976). OALCs are growing in number and complexity, and industry leaders suggest that promoting wellness among residents is a top priority (Johnson, 2025). Although OALCs offer services that engage residents' multidimensional wellness, their mental health needs often go unmet (Fullen, Wiley, et al., 2020). Adults who reside in these communities are likely to benefit from counseling services; however, counseling is not consistently available within OALCs (Fullen, Wiley, et al., 2020).

Concurrent with the population increases of older adults, the number of OALCs, such as continuing care retirement communities, assisted living facilities, and long-term care settings, is increasing across the United States (Christman, 2025). According to the U.S. Census Bureau, by 2060 almost a quarter of all U.S. residents will be over age 65 and life expectancy will reach 85 years (Medina et al., 2020). It is estimated that OALCs will need to hire 1.2 million new employees across professional domains in order to meet residents' needs and account for this growth in the older adult population (Argentum, 2016).

Demographic and industry trends point to counselors being well-positioned to meet the mental health and emotional wellness needs within OALCs. This is a timely development in the counseling profession, as licensed counselors recently became eligible to enroll as Medicare-eligible providers (Consolidated Appropriations Act, 2023). However, counselors face the challenges of understanding the counseling needs of older adults, practicing culturally competent care, and overcoming the obstacles related to providing professional counseling services within OALCs (Fullen, Wiley, et al., 2020). Therefore, we describe the unique counseling needs of residents of OALCs, as well as specific challenges to providing counseling services within OALCs related to mental health services integration,

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payment and reimbursement, and counselor education, training, and supervision. Because OALCs are increasingly using a wellness framework in their approaches to older adult health care, we will also describe how wellness can be used to introduce counseling within these settings.

Older Adult Wellness Counseling

To better conceptualize older adult wellness, it is helpful to summarize the eight dimensions of older adult wellness that have been described in our previous work (Fullen, 2019). These dimensions include physical, relational, emotional, developmental, spiritual, cognitive, contextual, and vocational domains. These dimensions are briefly defined in Table 1, with a corresponding assessment question included for reference.

Table 1

Eight Dimensions of Wellness in Older Adulthood

Wellness Dimension	Brief Definition (derived from Fullen, 2019)	Sample Assessment Question
Physical	Taking care of one's body, as well as attending to needs associated with disability, chronic illness, or pain	In what ways do you continue to care for your body?
Relational	Maintaining meaningful relationships with friends, family, and others in your community	Do you feel supported by those around you, and how do you support others?
Emotional	Maintaining hope and resilience in spite of challenges one faces	Are you content, and do you think you will be in the future?
Developmental	The need to develop healthy, realistic attitudes about growing older	What does growing older mean to you?
Spiritual	Exploring your meaning and purpose	Where do you find meaning in your daily life?
Cognitive	Fostering control, self-efficacy, and commitment to brain health and lifelong learning	How do you exercise your brain?
Contextual	Inhabiting a community where you belong and thrive	Do you feel secure and supported where you live?
Vocational	Pursuing your life's calling, regardless of whether the calling is associated with paid work	What is your calling?

Wellness Counseling

Multidimensional wellness is based on the assumption that older adults have holistic needs that may reflect intersections between physical, emotional, social, or spiritual domains (Fullen, 2019). Wellness counseling occurs when counselors incorporate multidimensional assessment and treatment planning, a focus on client strengths, and a paradigm shift from addressing illness to promoting

growth and self-discovery (Fullen, 2016). Frameworks for wellness counseling across client ages have been described (Ohrt et al., 2019), and specific modifications for using wellness counseling with older adults exist (Fullen, 2019). Wellness counseling has been identified as a strategy to counteract ageism (Fullen, 2019), particularly because of the medicalization of aging and the shift away from illness and client deficits that is emphasized within the wellness paradigm. Because older adult wellness is multidimensional, counselors using a wellness framework may identify several wellness dimensions that correspond with particular presenting problems. Therefore, the practice of wellness counseling begins with a multidimensional assessment of a client's wellness, followed by a review of the client's strengths, and ongoing discussion about how to apply these strengths to meet specific, multidimensional wellness goals and challenges that older adult clients may bring to counseling. Consistent with its focus on holism, counselors using a wellness counseling approach emphasize how client strengths can be leveraged to address areas of vulnerability (Fullen, 2016). Areas of strength may be targeted for additional growth, whereas areas of present vulnerability may be highlighted for intervention. As interventions are applied, ongoing assessment of wellness dimensions occurs to advance the pursuit of holistic wellness.

Wellness Challenges Facing Older Adults in OALCs

Older adults residing in OALCs face many of the same challenges as their peers living outside of these settings. Living in a residential setting can provide older adults with security and comfort, enabling them to age in place. Many OALCs offer a range of care options, including independent living, assisted living, skilled nursing, long-term care, and memory care (Shippee, 2012). Although these communities are designed to promote aging well in multiple dimensions (e.g., physical wellness, social wellness, intellectual wellness; Johnson, 2025), some residents will experience wellness challenges that necessitate counseling intervention (Fullen, 2016). Counselors working in these settings need to be prepared to meet residents' counseling needs and to be aware of the unique challenges that older adults living in OALCs routinely face. When considering how to apply a wellness framework to counseling older adults in OALCs, counselors can respond by engaging clients in dialogue about how common challenges impact their wellness, identifying clients' wellness strengths, and developing strategies to leverage strengths to address specific challenges.

Grief and Loss

Grief and loss issues are common among older adults. In addition to grief associated with the loss of family members and friends, there are other substantial losses that older adults face, including the loss of independence, home, health and mobility, vision and hearing, career and purpose, finances, preferred living arrangements, and cognitive abilities (Gitterman & Knight, 2019). Sometimes the decision to move into an OALC is made after losing a spouse, which could include a long-term grieving process (Sopcheck, 2020). In some cases, people decide to move into OALCs shortly after retirement, anticipating a comfortable life with fewer responsibilities, appealing amenities, and the comfort provided by being surrounded by others in their same age cohort (Brecht et al., 2009). Considerations of both contextual and developmental wellness can be valuable when responding to grief and loss. For example, asking an OALC client to define what it would look like to feel secure and supported (i.e., contextual wellness) during a period of bereavement may promote their sense of belonging within the OALC, which could contribute to the belief that the next phase of life is still worthwhile (i.e., developmental wellness). Moreover, helping clients identify wellness strengths during a period of grief and loss can be beneficial. For example, an OALC client may experience encouragement at the thought that a deceased loved one would be proud of them for meeting new friends in their OALC community, which reflects a form of relational wellness.

For those moving into these communities shortly after retiring, the loss of career and vocation may result in tremendous challenges (LaBauve & Robinson, 2011). This life stage transition can result in feelings associated with a lack of purpose and belonging, and the loss of a social network that may have been in place for many years (Myers & Degges-White, 2007). Another challenging adjustment for older adults occurs when they are no longer able to drive. This decision is often prompted by other family members who encourage them to stop driving, making many older adults feel as if they have lost a key element of their independence (Bell & Menec, 2015). Supporting clients in reappraising their vocational wellness, which may involve broaching how they continue to pursue a sense of meaning and purpose in their lives, can be beneficial.

Adjustment

In contrast, other older adults are forced to move into these settings because of failing health, mobility issues, or cognitive decline (Krout et al., 2002). Adjustment issues related to failing health can be difficult for older adults, and many live with chronic pain, limited mobility, and full reliance on others for care. Older adults who relocate to an OALC may have left behind a home of many years, familiar surroundings and routines, as well as friends and neighbors. Many older adults are surprised by the intense feelings that arise shortly after moving into a facility (Ayalon & Green, 2012), including an extended period of grief. For older adults who have lived most of their lives in single family dwellings, sharing common areas such as dining halls and activity spaces may be difficult (Chaudhury et al., 2013). These adjustments are particularly pronounced for older adults who transition to higher levels of care in OALCs. Nighttime sleep disturbances are common and may result in a variety of physical and mental health issues (Martin & Ancoli-Israel, 2008). For individuals facing physical health challenges, the dimension of physical wellness may be most relevant. Specifically, encouraging clients to consider ways in which they continue to care for their bodies, despite bodily changes they may be experiencing, can shift the emphasis from a focus on client deficits to one of resilience and strength.

Moving into an OALC is a significant life adjustment that can lead to emotional distress. In the early stages of adjustment, residents may find it difficult to refer to their OALC as their home; instead, they may hold on to emotional connections to their prior residence. They may feel ambivalent and uncertain as they struggle to place themselves within the existing categories of residents, which may reflect the disenfranchisement of their grief and grieving process (Ayalon & Green, 2012). For some, this may be the first time they have been in a setting where most people around them use assistive devices such as canes, walkers, and wheelchairs (Ayalon, 2015). Mental health concerns may rise to a level of depression and/or anxiety. Depression may result from various factors, including the adjustment to living in an OALC, profound grief and loss, failing health, and lack of purpose and belonging (Ayalon & Green, 2012). Anxiety can also be a concern for adults in these settings as they face their mortality, financial worries, fear of decline and death, and loss of independence, which would require them to rely on others for care (Creighton et al., 2016). Understanding the impact of these adjustments on emotional wellness may be an important first step in these cases.

Relationships

One of the most challenging life transitions older adults face is the shift in family dynamics that occurs when children begin to take care of their parents (Branson et al., 2019). As older adults move into advanced levels of care in OALCs, their adult children may experience guilt for having placed their parents in a "home." This guilt may lead to overinvolvement and overprotection by their children, which can be a source of frustration for the older adults (Davis et al., 2019). For spouses moving into OALCs together, the strain of living in a smaller environment may create tension

(Ayalon & Greed, 2016). Oftentimes, one spouse may be the primary caregiver for the other, which can also create relational challenges (Polenick & DePasquale, 2019). Approaching these cases from a relational wellness perspective allows both the counselor and the client to assess changes in their relationship and how clients continue to receive and provide emotional support. The therapeutic relationship can also function as a source of relational wellness, which may provide clients with the foundation they need to pursue other relationships with OALC community members, friends outside the OALC, or family members.

Alzheimer's Disease and Other Related Dementias

As the size and proportion of the U.S. population aged 65 and older continue to increase, the number of Americans with Alzheimer's and other related dementias will continue to rise. There are currently an estimated 7.4 million Americans living with Alzheimer's dementia (Alzheimer's Association, 2026). Those in the earlier stages of the disease are often undiagnosed and still capable of living independently (Savva & Arthur, 2015). Older adults residing in OALCs during this phase of the disease may withdraw from social activities because of feelings of inadequacy associated with their cognitive impairment (Nelis et al., 2011). Others may not recognize the changes they are experiencing, which can lead to confusion, frustration, and embarrassment in social situations (Robinson et al., 2012). Maximizing the length of independence for those with early-stage dementia is critical because it is likely their last phase of life for living independently. Quality of life is likely to be significantly reduced as the disease progresses. Counselors can play a vital role for these individuals by maximizing the length of time they can live independently. Although counseling can be instrumental for people in all stages of dementia, OALC residents with early-stage dementia may find counseling services particularly beneficial.

Given the complexity of Alzheimer's Disease and other related dementias, a multifaceted approach to older adult wellness could be useful (Fullen, 2019). By using the eight dimensions of wellness, a counselor may find specific strengths or shortcomings in areas such as relational wellness, cognitive wellness, emotional wellness, or contextual wellness. Clients who are caregivers may have needs in the same dimensions, as well as in areas such as vocational wellness, developmental wellness, and spiritual wellness. Identifying wellness dimensions in which clients and caregivers maintain strengths may be a helpful strategy in maintaining quality of life and bolstering a sense of resolve during what can be an overwhelming and discouraging experience.

Substance Misuse

As the Boomer generation (i.e., adults born between 1946 and 1964) continues to enter older adulthood, a growing number of older adults are at risk for alcohol and substance abuse (Barry & Blow, 2016). Misuse of alcohol and prescription drugs among older adults is currently higher than in previous generations, partially attributed to the 25% of older adults who are prescribed potentially addictive psychoactive medications, which are the most prevalent medications prescribed to this age group (Ogbonna & Lembke, 2019). Older adults residing in OALCs typically have convenient and frequent access to alcohol at planned social gatherings. Researchers assert that alcohol may be used as a coping mechanism for those living in these settings (Sacco et al., 2015). There may be less concern about limiting social drinking, as driving is less common. However, there are numerous negative consequences for older adults, including increased fall risks and harmful drug interactions (Barry & Blow, 2016). Many older adults are unaware of substance abuse ramifications, particularly related to the physiological changes related to aging that make them more vulnerable to these adverse effects (Williams et al., 2005).

Counselors can play a supportive role for these older adults through both psychoeducation and professional treatment. Problematic substance use has a multifaceted connection to wellness, requiring counselors to consider an array of relevant wellness dimensions, such as physical wellness, emotional wellness, and relational wellness. Once one or more areas of wellness are identified for greater emphasis during treatment, it is also important to discuss which areas of wellness continue to be sources of strength. For example, an OALC resident whose alcohol use has negatively impacted their relationships may describe how taking care of their body through walking or lifting weights (physical wellness) continues to provide a healthy sense of control and self-efficacy (cognitive wellness).

Ageism

Counseling professionals in OALCs should be knowledgeable about experiences associated with aging, including societal stigma against older adults. Ageism, or prejudice, stereotyping, and discrimination against older adults based on age (Butler, 1969), negatively influences older adults' mental health (Gendron et al., 2016). Like other forms of prejudice, ageism is systemic (Fullen, 2018). For example, stereotypes about older adults permeate American culture and can lead to poor mental health outcomes for older adults (Fullen, 2018). Systemic ageism is reinforced by individual, interpersonal expressions of ageism, which older adults may experience from medical professionals, family members, and even OALC staff.

Furthermore, older adults may assimilate negative stereotypes about aging and late life into their self-concept, leading to internalized ageism, through which they may believe negative stereotypes about themselves or discriminate against other older adults (Gendron et al., 2016). Counselors working in these settings should be aware of the impact that ageism can have on older adults and remain vigilant in identifying ways in which ageism is organizationally embedded in OALCs. Attitudes toward aging contribute to a person's developmental wellness, which can be more broadly assessed through therapeutic dialogue (Fullen, 2019). When clients describe internalized aging attitudes, it is important to identify the origin of these messages. Gently challenging these ageist assumptions can enhance the therapeutic relationship (relational wellness) and result in a greater sense of resilience (emotional wellness) and self-efficacy (cognitive wellness).

Culturally Responsive Care With Older Adults in OALCs

In addition to being prepared to work with a wide variety of clinical concerns using a wellness framework, counselors working in OALCs should be prepared to work with clients from many different backgrounds with diverse lived experiences. It is important to ask clients how their sociocultural experiences, as well as gender, socioeconomic status, and religious affiliations, influence how they define the eight dimensions of wellness for themselves. Counselors can best meet their clients' needs when they understand clients contextually, considering the unique experiences that have informed clients' lives based on their sociocultural identities (Ratts et al., 2016). Although all clients have specific cultural considerations counselors should attend to, counselors who desire to work in OALCs must be aware of specific issues in later life and how sociocultural factors can influence development across the lifespan (Fullen, 2020b).

Use an Intersectional Lens

Counselors who practice in OALCs will undoubtedly work with clients who have been impacted by ageism. However, many clients will hold additional marginalized identities that influence their experiences of aging and ageism. The intersection of age with other marginalized identities significantly

alters the experiences of aging for older adults (Wang et al., 2025). Crenshaw (1989) introduced the construct of intersectionality to explain how occupying two or more marginalized positionalities creates a gestalt experience of discrimination. Intersectionality is a framework that enables people to understand how interlocking systems of oppression can exacerbate one another, creating a unique experience for individuals who hold multiple minoritized identities (Crenshaw, 1989). In essence, understanding clients in OALCs through an intersectional lens is crucial for developing a nuanced understanding of their experiences and clinical concerns. Therefore, in addition to the necessity of understanding systemic ageism (Fullen, 2018), counselors who provide services in the context of OALCs should be aware of the unique intersections other sociocultural factors can have with age in such settings.

Social determinants of health, such as race/ethnicity, gender/gender identity, sexual orientation, and socioeconomic status, influence clients' mental health across the lifespan, with some effects emerging in later life (Allen et al., 2014). Additionally, there is evidence that inequity across the lifespan leads to poorer mental health outcomes in older adulthood for marginalized groups, such as racial/ethnic minority older adults (Ferraro et al., 2017); lesbian, gay, bisexual, and transgender (LGBTQ+) older adults (Fredriksen-Goldsen et al., 2017); and older adults with disabilities (Kattari et al., 2017). These findings suggest that the older adults who are most likely to need counseling are also more likely to have experienced unique intersectional challenges. Therefore, understanding clients' contexts and backgrounds, selecting appropriate interventions and assessments that account for clients' unique cultural considerations, and providing opportunities for clients to process experiences of discrimination and stigma are all critical components of culturally competent care for all clients.

Broach Culture

Counselors should endeavor to learn about their clients' cultures, broach cultural differences, select culturally appropriate interventions and assessments, and engage in advocacy within OALCs to ensure equitable access to resources and programming (Day-Vines et al., 2007; Ratts et al., 2016). To understand the salience of client identities and how these identities have influenced the client's life, it is crucial to directly discuss both the client's culture and the cultural differences between the counselor and the client early in the counseling process (Day-Vines et al., 2007). Broaching the client's culture provides them with the opportunity to share their most salient identities, how those identities have shaped their lives, and how those identities influence their experience in their OALC. This strategy also provides an opportunity for the counselor to demonstrate cultural humility and indicate that they will not perpetuate the same harm that clients may experience from staff or other residents in the community.

Similarly, counselors must commit to learning about their clients' cultures, including the influence of age and generational cohort (Ratts et al., 2016). For example, counselors who work in OALCs should familiarize themselves with adult development and aging rather than educating themselves on the basics related to that process. By developing a knowledge base around the aging process, counselors create space for their clients to share their unique experiences of aging. In order to conceptualize their clients through an intersectional framework, counselors should also research how aging is perceived in the various cultures their clients belong to (Ratts et al., 2016). This approach may require the counselor to develop self-awareness concerning implicit biases they may possess regarding their clients' cultural identities to ensure that they do not contribute to their clients' experience of marginalization. Particularly salient is ageism, which counselors may invoke in counseling if they do not develop awareness around their biases related to the aging process (Fullen, 2018). In learning about their clients' cultures, counselors have the opportunity to select interventions and assessments that are culturally appropriate based on age and other sociocultural factors that impact the client.

Address Systemic Barriers

Finally, inequitable access to resources impacts older adults who reside in OALCs. Counselors should advocate within their workplace to address systemic barriers to access within the community (Ratts et al., 2016), help specific clients access necessary resources (Ratts et al., 2016), and develop programming that meets the unique needs of residents who are disproportionately impacted. Ultimately, counselors must attend to their clients' holistic cultural experiences and maintain an awareness of the risks posed to older adults by a lifetime of marginalization. An essential consideration for culturally responsive work with older adults is selecting appropriate theory and empirically sound interventions.

Case Study

Michelle, a licensed counselor, begins a new staff position at a local continuing care retirement community, where she will provide talk therapy services to residents. This is the retirement community's first counselor, and Michelle understands that this may be some of the residents' first experience with a mental health professional. To broach the topic of mental health at a services fair hosted by the community, Michelle creates a booth and designs a flyer outlining the eight dimensions of wellness and describing how they relate to older adult mental health. Residents stop by Michelle's booth at the services fair, and she uses the tool as a conversation starter about mental health and also a preview of what working with her in individual therapy sessions may entail.

One community resident, Roy, tells Michelle that he is struck by her description of vocational wellness, particularly the question, "What is your calling?" Roy admits that he has only thought about "vocation" in terms of his career, from which he retired over a decade ago. He tells Michelle that he has been struggling with the concepts of purpose and meaning since moving to the community, and Michelle invites Roy to schedule an individual session with her to discuss these ideas in depth.

During their intake session, Michelle reminds Roy of the eight dimensions of wellness and asks him to point out any dimensions that are going particularly well in his life. She also broaches culture with Roy and invites him to share how aging is viewed among people who share his cultural background. Roy remarks that he had previously seen aging as "only going downhill" and admits that he has not thought about his *wellness* so much as his *illness*. Michelle uses this as an opportunity to take a strengths-based approach with Roy, explaining that enhancing certain aspects of wellness can help offset any inevitable or sudden deterioration in other aspects of wellness. Hearing this, Roy describes his robust social life in the retirement community—a sign of high relational wellness—and how his relationships increased his well-being, in spite of a worsening eye condition that has left him unable to see far distances (an example of decreasing physical wellness). Michelle notes how Roy's increased relational wellness may be positively offsetting his declining physical wellness; she uses this as an example of the importance of a holistic approach to wellness in Roy's life. Michelle and Roy decide to include vocational, physical, and relational wellness in Roy's treatment plan. Together, they decide on three counseling treatment goals: 1) Determine what gives Roy meaning and purpose, and identify concrete actions to incorporate meaning and purpose into each day (vocational wellness); 2) Care for his eyesight as best he can while also maintaining a healthy diet and routine exercise in consultation with his primary care provider (physical wellness); and 3) Invest in existing and new friendships within his OALC with a goal of thriving in the area of relational wellness.

After the initial session, Michelle reflects on her session with Roy. She is pleased that the eight dimensions of wellness provide her with a helpful, strengths-based lens through which to view aging

and older adulthood. She reflects that previously in her career, she overly focused on older adults' physical wellness, often medicalizing the aging process and "othering" aging bodies. By exposing herself to a holistic approach to older adult mental health, Michelle challenges her own ageist beliefs and behaviors and notes that wellness can exist at any age.

Challenges Facing Counselors Working in OALCs

Despite the numerous benefits of integrating wellness-based counseling services within OALCs (Fullen, 2020b), there are several challenges to consider. Historically, OALCs have been slower to integrate mental health services compared to medical services. Payment barriers for counseling have historically interfered with creating opportunities to work within this context. Finally, there are barriers associated with how counselor education programs prepare students, which have limited the growth of counseling within OALCs. The following section will describe each of these barriers.

Mental Health Services Integration Challenges

Although older adults' mental health needs are well documented (Moye et al., 2019), the number of OALCs that employ or contract with a mental health professional is unclear. In a large survey of counseling professionals, only 1.6% described 65 years of age and older as a primary area of clinical emphasis (Fullen, Lawson, & Sharma, 2020). Additionally, in a study of psychologists, scholars found that only 1.2% described geropsychology as a specialty area (Moye et al., 2019). Moye and colleagues found that psychologists who specialize in working with older adults were more likely to work in independent practice, including over half of private practice practitioners. However, it is not clear how often their services were integrated into OALCs.

The presence of counseling services within long-term care settings is slightly more apparent. A survey of Florida nursing homes indicated that approximately 50% had a psychiatrist and a psychologist present at their site on a weekly basis. However, 90% of these providers were independent practitioners who were not formally affiliated with the long-term care facility (Molinari et al., 2009). Meanwhile, wellness programming, which aims to address the holistic needs of OALC members, is increasingly being implemented within OALCs, particularly in communities that provide ongoing care to older adults as their needs evolve. Those wellness initiatives are often focused on enhancing physical and social wellness (Edelman et al., 2010), frequently excluding other dimensions, including psychological or emotional well-being (Fullen, Wiley, et al., 2020).

Counselors who aim to work within OALCs should consider that some residents prioritize finding resources available on the community's campus over seeking counseling services outside the community (Plys & Kluge, 2016). This suggests that until counseling services are offered in the OALC setting's immediate vicinity, residents may continue to experience a barrier to access. Therefore, efforts are needed to integrate counseling services into the range of other on-site services offered directly to OALC residents (Fullen, Wiley, et al., 2020). Two other barriers are payment challenges and a dearth of training opportunities for working with older adults in counselor preparation programs.

Counselor Education, Training, and Supervision Challenges

Developing counselor training opportunities to provide services for older adults, including those who reside in OALCs, is an additional barrier that must be addressed. Historically, the counseling profession has not adequately prioritized the counseling needs of older adults. For example, the 2016 Standards of the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) failed to include any reference to terms like *old*, *older*, *older adults*, or *ageism*, and only

one reference each to the words *age* and *aging* (CACREP, 2015; Fullen, 2018). A content analysis of 26 years of research in the counseling profession indicated that only 1.6% of all publications focused on issues associated with aging (Fullen et al., 2019). However, following revisions to the Medicare mental health law, there have been recent indications that efforts to equip counseling students and counseling professionals to work with older adults are underway. The 2024 CACREP Standards include subtle improvements, such as including age and generational status in glossary definitions of diversity, cultural identity, and marginalized populations (CACREP, 2023). This reflects the viewpoint that older adults should not be overlooked in discussions of how social and cultural identities impact the needs of clients. There is evidence that exposure to working with older adults and greater self-efficacy around this work are associated with increased interest in working with older adults (Schmidt et al., 2024; Wagner et al., 2019). Likewise, Moye et al. (2019) found that psychologists expressed a strong interest in further gerontology education on depression, dementia, anxiety, bereavement, caregiver stress, and adjustment to medical illness or disability. These findings suggest that there is recognition of the need for greater emphasis on aging-related topics during training programs and beyond.

To address this shortage of training opportunities, developing partnerships between university-based mental health training programs and local OALCs is essential (Silva-Smith et al., 2011). Fortunately, OALCs near universities are common and university-based OALCs are popular among older adults (Gresham, 2024). Expanding counseling services in OALCs by embedding a mental health trainee represents an innovative approach to service delivery that is mutually advantageous for students, training programs, community residents, and the OALC (Fullen, Wiley, et al., 2020). Anecdotally, we have curated a counselor training program within a local OALC. Recognizing the need for emotional well-being supports, the counselor training program at Fullen's university (Virginia Tech) partnered with a local OALC in 2018 to launch an innovative program in which graduate students in counseling provide pro bono counseling services to older adults. Individual, couples, and group counseling services are provided to residents in independent living, assisted living, skilled nursing, and long-term care, resulting in a diverse array of opportunities to address unmet mental health needs and promote emotional well-being.

This partnership alleviates cost barriers by enlisting graduate students who are completing their clinical internships. Accessibility concerns are mitigated by integrating the counseling services directly on the OALC campus. By making counseling available and visible within the community, stigma about working with older adult clients appears to be shrinking. Students are exposed to older adults' mental health needs within their counselor training program using a strengths-based wellness model. This approach introduces students to the effectiveness of counseling services for older people while addressing myths about aging. Counseling services are advertised at the site's health and wellness fair, at meet and greets, and in the OALC newsletter. Referrals from site staff or other residents are customary. Overall, the services have been well-received by residents of the community. The OALC, counselor training program, and counseling interns all report a high degree of program satisfaction.

Future Research

There is considerable opportunity for future research to illuminate the impact of wellness counseling within OALCs. For example, outcome research on the use of a multidimensional wellness framework within OALCs, such as the eight-dimensional model previously described, is needed to demonstrate the utility and effectiveness of this approach to counseling. Similarly, research

demonstrating whether certain wellness dimensions are prioritized more or less by OALC clients would be useful. If more counselor training programs are developed within OALCs, future research on the supervision of counselor trainees using wellness counseling within OALCs would be beneficial.

In addition to a focus on wellness counseling outcomes, more research on multicultural competence when working with OALC clients is necessary. For example, research is needed to improve the practice of broaching in the areas of age and ability, given the fact that most counselors and counselor trainees will hold chronological ages, and in some cases ability levels, that differ from their OALC clients. Studies are needed to better understand how counselors proactively engage their older adult clients in dialogue around age identity, age differences, ageism and ableism, and the potential for misunderstanding within the therapeutic relationship based on these differences.

Conclusion

In conclusion, OALCs are an emergent setting for the delivery of wellness counseling services. The interest in wellness among industry leaders, combined with a growing awareness of the mental health needs of older adults, suggests that OALCs have a great deal of potential for counselors. By incorporating multidimensional wellness approaches that are responsive to the unique needs of older adults, counselors have an opportunity to expand their footprint and promote mental health and well-being across the lifespan.

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Invisible Community: The Counseling Considerations of Working With MENA Individuals



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Middle Eastern and North African (MENA) individuals are a largely ignored community. Historically, they have been portrayed negatively in the broader media and American society. This lack of understanding has extended to the counseling profession as well. This article seeks to address this lack of understanding and stigma. Who MENA individuals are, along with a brief history of these individuals, common values, experiences of discrimination, and the impact of counseling, are discussed. The aim of this work is not only to raise awareness of this community but also to discuss counseling considerations to support their mental health.

Keywords: Middle Eastern, North African, counseling, stigma, mental health

The American Counseling Association's (ACA; 2014) *Code of Ethics* compels counselors to advocate for underserved communities and to provide culturally responsive treatment grounded in social justice. Middle Eastern and North African (MENA) Americans meet the definition of an underserved population (Resnicow et al., 2022), yet counselors often receive little formal training specific to their sociocultural and historical contexts. As a result, many counselors are asked to work with MENA clients without having access to practice-oriented guidance that reflects their lived experiences.

MENA Americans come from diverse cultural, religious, and national backgrounds shaped by migration, political conflict, discrimination, and longstanding invisibility within U.S. systems (Mechammil et al., 2019). These experiences carry important implications for mental health, help-seeking, and counseling engagement, and they require competencies that extend beyond general multicultural frameworks. However, counseling-specific literature addressing the unique needs of MENA clients remains limited (Atari-Khan et al., 2025; Awad, 2010; Erickson & Al-Timimi, 2001; Samari, 2016).

This gap is especially concerning as global conflict, political violence, and public discourse increasingly shape the daily realities of MENA communities in the United States. Counselors are more likely than ever to encounter MENA clients presenting with identity-related stress, discrimination, and trauma, yet many remain underprepared to address these concerns within clients' sociopolitical and cultural histories (Basma et al., 2019; Cho, 2018). Although approximately 3.5 million individuals in the United States identify as MENA, this population has historically not been counted as a distinct group in U.S. census data, which contributes to ongoing invisibility and limited research attention (Awad et al., 2021; Cho, 2018). This absence in both research and counselor preparation creates significant clinical consequences.

The purpose of this paper is to address these gaps by offering a clinically grounded, culturally responsive framework for counseling practice with MENA Americans. The sociopolitical and

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historical contexts relevant to MENA communities, such as identity, racialization, and discrimination, are addressed. In addition, we seek to explore how cultural values and psychosocial factors influence help-seeking. Lastly, counseling considerations, ethical and counselor education implications, and directions for future research are also presented.

Sociopolitical and Historical Context of MENA Communities

The literature consistently documents challenges in defining MENA identities, which often result in confusion across clinical and research contexts (Amer & Hovey, 2007; Awad et al., 2021, 2025; Haboush, 2007). Clarifying the diversity within MENA communities is essential, as it supports a more accurate understanding of individuals' identities and lived experiences. Individuals who identify as MENA originate from or have ancestry in the Middle East and North Africa (Awad et al., 2021) and represent a highly diverse population (Cho, 2018; Erickson & Al-Timimi, 2001; Nassar-McMillan, 2003). Historically, many of these individuals have been labeled as Arab and have ancestry from one of the 22 Arab League member states, which extend from northern Africa to southwestern Asia (Awad et al., 2021, 2025). These countries include Algeria, Bahrain, Comoros, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates, and Yemen (Awad et al., 2025). This categorization also includes three non-Arab countries—Iran, Turkey, and Armenia (Awad et al., 2025).

Historically, this diversity has not always been clearly recognized within the counseling profession (Amer & Hovey, 2007; Awad et al., 2021, 2025; Haboush, 2007). For counselors, recognizing the diversity within the MENA population is vital to building rapport and conducting accurate assessments. When counselors mislabel clients as Arab, White, or Muslim, this can undermine rapport and trust and contribute to the sense of invisibility that many MENA individuals already experience. Such misunderstandings highlight the importance of attending to the sociopolitical and historical contexts that shape how MENA individuals understand and express their identities.

The history of MENA individuals is an aspect of cultural competence in working with this population and a significant counseling consideration (Erickson & Al-Timimi, 2001; Nassar-McMillan, 2003; Zarrugh, 2016). MENA individuals came to the United States in three waves: the first was from the late 19th century to the end of World War I, with most migrating from Syria and Lebanon (Erickson & Al-Timimi, 2001). The second wave followed the creation of Israel in 1948. As a result, the majority of these individuals were Palestinian and primarily Muslim (Erickson & Al-Timimi, 2001). The third wave occurred in 1967, following the conclusion of the Arab Israeli War (Awad et al., 2019, 2025; Erickson & Al-Timimi, 2001; Zarrugh, 2016), and included individuals from Egypt, Lebanon, Palestine, Iraq, and Syria (Awad et al., 2022). This wave included both Muslim and Christian immigrants and continues today (Erickson & Al-Timimi, 2001).

These migration histories are not simply historical details; they shape this community's experiences. For many MENA individuals, migration is closely tied to war exposure, forced displacement, political violence, and intergenerational loss and trauma that often emerge in counseling work (Atari-Khan et al., 2025; Awad et al., 2019; Haboush, 2007). Understanding these contexts provides an important foundation for examining how identity, discrimination, and racialization shape mental health among MENA individuals.

Identity, Discrimination, and Racialization

Lack of Visibility

The lack of visibility of MENA individuals has significant structural, social, and clinical consequences. MENA individuals have historically not been recognized as a distinct category in U.S. census data (Awad et al., 2025). As a result, there has been minimal research on these individuals (Awad et al., 2025). This invisibility also has a hypervisibility element to it, in which, although these individuals are not considered different from White individuals, they are targeted and discriminated against differently than White individuals (Awad et al., 2021).

MENA individuals have been identified as non-White, White, and Asian or *yellow* in racial categorization systems (Zarrugh, 2016), despite the repeated evidence that MENA individuals do not consider or identify themselves as White (Awad et al., 2021). The instability of MENA individuals' identities may lead to increased distress and identity confusion (Awad et al., 2025; Zarrugh, 2016). This instability, coupled with the lack of ethnic minority status for MENA individuals, may have given rise to a lack of civil rights protection, as data collection is absent on hate crime statistics or racial disparities (Awad et al., 2025).

Within this context of invisibility, naming and self-identification have become complex and contested. The term Arab is commonly used interchangeably with MENA; however, individuals' preferences for this label vary. Awad et al. (2021) found that approximately half of individuals of MENA descent preferred the term Arab, while the other half preferred MENA and did not identify as either Arab or White. Those who rejected the Arab label often cited stigma associated with negative stereotypes or noted that the term did not accurately reflect their linguistic or cultural background (Awad et al., 2021). Additionally, some populations, such as Iranians, may identify as Persian rather than Arab or MENA (Awad et al., 2021; Erickson & Al-Timimi, 2001). These patterns underscore the limitations of relying on singular or externally imposed identity labels. However, identity labels alone do not fully capture the lived experiences of MENA individuals.

Beyond naming, many MENA individuals navigate persistent experiences of *othering*, in which belonging is shaped by sociopolitical narratives. The othering of MENA individuals may contribute to uncertainty about belonging and identity for many within this population (Awad et al., 2025; Khoury & Manuel, 2016; Samari, 2016). Zarrugh (2016) highlighted how inconsistent racial classification shaped MENA identities over time, noting that whenever a significant political event involving MENA individuals occurs, their White status is no longer recognized. Examples of these events include the Six-Day War of 1967, the Israeli war, the Iran Hostage Crisis, and the terror attacks of 9/11 (Zarrugh, 2016).

More recently, anti-MENA sentiment has been remarkably common because of the recent events in the Middle East, including the war in Gaza (Awad et al., 2025), the current Iran war, and the attack on Lebanon (PBS NewsHour, 2026; Sky News, 2026). MENA individuals can experience a tremendous amount of stress from discrimination as a result of the world events described above, despite being considered White (Awad et al., 2019, 2025).

MENA individuals' historical lack of visibility also means that many counselors have provided treatment that is similar to that of the majority. Such misalignment and lack of an individualized approach may lead clients to feel unseen or misunderstood in the counseling setting (Huang & Zane, 2016). Counselors who overlook these identity-related experiences risk reproducing the invisibility

clients experience in their day-to-day lives (Cho, 2018; Huang & Zane, 2016). Understanding how invisibility and marginalization shape MENA clients' experiences provides an important foundation for examining culturally responsive approaches to mental health services.

A notable shift occurred in 2024, when the Office of Management and Budget included a category for MENA individuals. Therefore, MENA individuals will be officially counted and documented separately in their own category in 2030 (Awad et al., 2025). This recognition in the U.S. Census may lead to increased documentation of MENA individuals and to the mitigation of discrimination faced by this community (Awad et al., 2025). In addition to structural invisibility, MENA individuals are impacted by persistent misunderstandings about identity, particularly the conflation of ethnic, regional, and religious identities (Awad et al., 2025; Erickson & Al-Timimi, 2001).

Conflation of Religion and Ethnicity

The terms Arab, MENA, and Muslim are often used interchangeably in public discourse and clinical settings, even though they refer to distinct ethnic, regional, and religious identities (Awad et al., 2019, 2021, 2025). This conflation has contributed to widespread misunderstanding, reduced visibility, and discrimination toward MENA individuals, many of whom do not identify as Muslim. In the United States, MENA individuals are overwhelmingly Christian, a reality that is frequently obscured by media portrayals and dominant narratives (Awad et al., 2025). For counselors, this conflation may contribute to inaccurate assumptions about clients' beliefs, values, and sources of support within counseling.

When MENA individuals are viewed primarily through a religious lens they do not identify with, important aspects of their cultural background, lived experiences, and sources of meaning may be overlooked. At the same time, Islam continues to hold cultural significance in many MENA communities, even for individuals who do not personally identify as Muslim (Cho, 2018; Erickson & Al-Timimi, 2001; Nassar-McMillan & Hakim-Larson, 2003). Recognizing this nuance is essential, as cultural influence does not equate to religious identification.

Treating MENA individuals as a homogeneous group and reducing them to a single identity obscures the diversity within this population (Awad, 2010; Awad et al., 2021). MENA individuals identify across a range of religious traditions, including Christianity, Islam, Judaism, Hinduism, and others, though accurate demographic data remain limited because of inconsistent data collection practices (Awad et al., 2021; Haboush, 2007). This lack of clarity reinforces the importance of approaching identity as self-defined and contextually grounded, rather than assumed. For counselors, attending to how clients describe and make meaning of their own identities can foster trust and reduce the risk of misattunement in the counseling relationship.

Identity Complexity and Acculturation

Identity development and acculturation among MENA individuals are shaped by intersecting factors, including religion, national origin, sociopolitical context, and migration history (Amer & Hovey, 2007; Awad, 2010). These processes are rarely linear and often involve navigating multiple cultural expectations simultaneously. Research suggests that Christian immigrants from countries such as Lebanon, often described as more Westernized, may face fewer challenges adapting to life in the United States (Haboush, 2007; Nassar-McMillan & Hakim-Larson, 2003). In contrast, MENA individuals who identify as Muslim and immigrate from countries such as Iran may face greater difficulty during acculturation, particularly when cultural norms, religious practices, or visibility increase vulnerability to discrimination (Haboush, 2007; Nassar-McMillan & Hakim-Larson, 2003).

These differences are clinically meaningful. Some studies indicate that Muslim-identifying MENA individuals experience higher levels of discrimination and acculturation-related stress than their Christian-identifying counterparts (Ikizler & Szymanski, 2018). However, acculturation experiences vary widely, even among individuals from similar national or religious backgrounds (Awad et al., 2025). For counselors, this variability highlights the importance of understanding acculturation as a personal and relational process rather than a fixed stage or outcome.

Acculturation has been associated with both increased and decreased psychological distress, depending on generational status and contextual pressures (Amer & Hovey, 2007). Individuals who immigrated to the United States as adults may experience less distress when not pressured to abandon their cultural norms, whereas first- and second-generation individuals often report more positive outcomes when they can integrate aspects of both cultures (Amer & Hovey, 2007). These patterns show how identity negotiation can be both a source of strain and a source of resilience. Despite the complexity of these experiences, public narratives and media portrayals frequently collapse MENA identities into simplified and stigmatized representations (Awad et al. 2025). Such portrayals can influence how MENA individuals understand themselves and how they are perceived by others, including within clinical settings.

Racialization, Media Portrayals, and Mental Health Outcomes

Historically, the media's portrayal of MENA individuals has primarily been negative. Depictions have often framed MENA individuals as "brute murderers, sleazy rapists, religious fanatics, oil-rich dimwits, and abusers of women" (Awad et al., 2019, p. 79). Positive portrayals of MENA individuals that are not rooted in stereotypes remain rare in mainstream media. Studies have shown that much of the knowledge about MENA individuals comes from popular media (Cho, 2018). These negative depictions, coupled with limited and inaccurate information, may contribute to identity confusion and foster critical misunderstandings of MENA individuals within broader society, including among helping professionals (Amer & Hovey, 2012; Cho, 2018; Erickson & Al-Timimi, 2001).

One of the most significant media-related events shaping perceptions of MENA individuals is the terrorist attacks of September 11, 2001 (Amer & Hovey, 2012; Zarrugh, 2016). A substantial body of literature has documented the negative impact of 9/11 on the racialization and portrayal of MENA individuals in the United States (e.g., Awad et al., 2019, 2025; Cho, 2018; Ikizler & Szymanski, 2018; Mechammil et al., 2019; Zarrugh, 2016). Although negative stereotypes existed prior to 9/11, the events of that day intensified and legitimized existing biases (Awad, 2010; Awad et al., 2025; Zarrugh, 2016). Scholars argue that even MENA individuals who previously identified as White were prompted to reconsider their racial identities following 9/11 because of heightened scrutiny and discrimination (Zarrugh, 2016). Given the scale and visibility of this event, media narratives following 9/11 played a central role in shaping public perceptions of MENA individuals in the United States (Awad, 2010).

As a result of persistent negative media portrayals and sociopolitical events, MENA individuals have experienced substantial discrimination in the United States (Awad, 2010; Mechammil et al., 2019). One prominent example is the enactment of the Patriot Act following 9/11, which disproportionately targeted individuals of MENA descent, particularly those perceived to be Muslim (Awad, 2010; Zarrugh, 2016). These policies and practices reinforced suspicion toward MENA communities and legitimized discriminatory surveillance and treatment based solely on identity. The cumulative impact of prejudice and discrimination has been associated with elevated stress and psychological distress among MENA individuals (Awad et al., 2025).

Research indicates that MENA individuals are at an increased risk for depression and anxiety linked to experiences of discrimination and marginalization (Amer & Hovey, 2012; Samari, 2016). Multiple studies document heightened vulnerability to mental health concerns within this population, with estimates suggesting that approximately 66% of MENA Americans may be at increased risk for depressive disorders (Mechammil et al., 2019; Samari, 2016). Given this heightened vulnerability, attention to how MENA individuals experience and express psychological distress is essential for understanding their mental health needs and presenting concerns in counseling contexts. These experiences also interact with broader cultural values and psychosocial factors that shape how MENA individuals understand mental health concerns and engage in help-seeking.

Cultural Values and Psychosocial Factors Influencing Help-Seeking

Many MENA communities can be incredibly family-centric and patriarchal (Haboush, 2007; Kira et al., 2014; Mechamil et al., 2019; Nassar-McMillan, 2003). Usually, the father is the head of the family; however, the oldest male sibling can also exert influence within the family system (Haboush, 2007). Like other ethnic communities, MENA individuals tend to come from collectivist cultures, which can manifest in decision-making that extends beyond immediate family and in prioritizing family harmony over individual needs (Cho, 2018; Haboush, 2007). These values may also contribute to multigenerational living arrangements, which reflect the central role of family in daily life (Erickson & Al-Timimi, 2001). Counselors may need to take a systems approach when working with MENA individuals, as their families' well-being may play into their goals of therapy.

MENA families can be incredibly supportive of one another, but they may not necessarily support seeking counseling services (Erickson & Al-Timimi, 2001). Although families may express care and support, they may not fully understand the extent of an individual's mental health concerns (Amer & Hovey, 2007). This mixed support can be seen in research as studies have shown that there can be a devaluing of mental struggles within the MENA family (e.g., Amer & Hovey, 2007; Mechammil et al., 2019). This stigma comes from an emphasis on family harmony and role. Concepts such as family honor may influence the decision to seek help outside the home, as doing so may be perceived as a sign of weakness or a threat to the family's reputation (Amer & Hovey, 2007; Awad et al., 2022; Erickson & Al-Timimi, 2001; Mechammil et al., 2019). Understanding help-seeking behaviors and stigma can aid counselors in conceptualizing potential barriers to treatment or perceived resistance.

Religion, as well as family, is deeply ingrained in MENA culture and thus can be seen as another counseling consideration; regardless of religious identity, there may be significant value placed on religion (Cho, 2018; Mechammil et al., 2019; Nassar-McMillan, 2003). The literature emphasized that many MENA communities view religion as both a cause of mental illness and a solution for it (Cho, 2018; Ikizler & Szymanski, 2018; Mechammil et al., 2019). For example, if an individual is experiencing difficulties, it is not uncommon for those within the MENA community to believe they have offended God or Allah (Mechammil et al., 2019). The other side of this belief is that by seeking penance or praying, they can be relieved of their affliction (Mechammil et al., 2019). Practices such as prayer, faith in a higher power, and religious coping have also been identified as sources of resilience that help individuals navigate psychological stressors (Manning et al., 2019; Mechammil et al., 2019).

A religious concept that counselors should be familiar with and that may shape how distress is understood within MENA communities is the Djinn, a common religious figure in this culture (Lim et al., 2018). The Djinn is defined as an invisible being capable of occupying the body and affecting psychological functioning (Nathan, 2005). Psychological distress may be interpreted as being *Majnoun*

or *indjinned*, meaning under the control of Djinn (Nathan, 2005). Djinn beings are commonly associated with possession, although they are not inherently evil and are understood as part of the natural or spiritual world (Nathan, 2005).

Awareness of these religious figures can help counselors understand how their clients make sense of the world and how they conceptualize their mental health issues. This knowledge can inform assessment for mental health issues and treatment planning among this population. In addition to shaping beliefs about mental health and help-seeking, these cultural values also influence how MENA individuals communicate distress and present symptoms in counseling contexts (Elshamy et al., 2023).

Communication Patterns and Symptom Manifestation

Language can significantly influence how MENA individuals present concerns within counseling settings. Individuals who speak Arabic or related languages (e.g., Persian) may communicate in ways that differ from dominant U.S. norms. Arabic, in particular, includes many regional dialects that shape meaning and expression (Versteegh, 2014). MENA individuals may communicate with high levels of emotional intensity and indirect phrasing, which can reflect cultural norms rather than psychological distress (Awad et al., 2022; Haboush, 2007). For example, indirect communication may involve using general statements rather than direct commands (e.g., “all good children make their bed” instead of “go make your bed”). In counseling contexts, indirect phrasing may also influence how sensitive topics are discussed, such as framing suicidal ideation as a wish for suffering to end rather than a direct statement of self-harm (Cho, 2018; Haboush, 2007). Attending to these communication patterns is important for accurate understanding and assessment.

In addition to verbal communication styles, nonverbal expression may also shape counseling interactions with MENA individuals. Emotional intensity, animated gestures, and louder vocal expression are common and culturally normative forms of communication in many MENA communities (Awad et al., 2022; Haboush, 2007). In counseling settings, these expressive behaviors may be misinterpreted as hostility or agitation, even when there is no such intent. Understanding these nonverbal patterns is important for accurately interpreting clients’ affect and emotional engagement within the therapeutic relationship.

The literature indicates that some MENA individuals, particularly those who speak Arabic, may describe distress through physical symptoms because of limited psychological terminology and stigma surrounding mental illness (Cho, 2018; Erickson & Al-Timimi, 2001; Zora et al., 2020). Distress may be communicated through complaints such as stomach pain or fatigue rather than verbalized anxiety or sadness (Erickson & Al-Timimi, 2001). In addition, culturally specific idioms of distress may be used, including expressions such as *attack of nerves*, *sadma* (shock), or *heartache* to describe emotional suffering (Bovey et al., 2025; International Organization for Migration, 2008). These somatic and linguistic expressions reflect culturally embedded ways of communicating distress and are relevant to understanding presenting concerns in counseling contexts. Recognizing how MENA individuals understand, communicate, and experience distress provides a foundation for culturally responsive counseling practices.

Culturally Responsive Practices

Given the limited empirical research with MENA populations, intervention recommendations are largely drawn from culturally informed clinical literature and practice-based sources. As such, evidence-based approaches may require thoughtful adaptation to ensure cultural congruence with

clients' lived experiences. Structured and directive approaches, such as cognitive behavioral therapy (CBT), have been identified as potentially congruent for some MENA individuals, particularly given preferences for clear guidance and the perception of the counselor as an expert (Barry, 2005; Erickson & Al-Timimi, 2001; Haboush, 2007; Kira et al., 2014). Although concerns may be communicated indirectly, many clients may value clarity and structure in addressing distress.

In contrast, insight-driven therapies such as psychoanalysis or psychodynamic therapy may be less congruent for some MENA individuals (Erickson & Al-Timimi, 2001). The lack of psychologically oriented vocabulary in Arabic may make it difficult to engage with and understand counseling concepts or to talk about one's feelings (Erickson & Al-Timimi, 2001). Counseling itself is uncommon in the Middle East and North Africa (Elshamy et al., 2023). Therefore, focusing on the somatic and adopting a directive approach are vital (Cho, 2018; Erickson & Al-Timimi, 2001; Haboush, 2007). Integrating body-based check-ins and attention to physical sensations may further support clients with somatic symptoms.

Psychoeducation can be an important component of culturally responsive approaches for MENA individuals, particularly in addressing stigma related to mental health issues (Mechammil et al., 2019). Internalized stigma and fear of being labeled Majnoun can create significant barriers to help-seeking (Erickson & Al-Timimi, 2001; Kira et al., 2014). Silence around emotional struggles may further delay engagement in counseling (Atari-Khan et al., 2025). Therefore, framing mental health concerns as natural responses to stress, trauma, or life challenges may help reduce stigma and support engagement.

Given the prevalence of migration-related stressors, discrimination, and identity-based marginalization, a trauma-informed lens is particularly relevant when working with MENA individuals (Atari-Khan et al., 2025). Trauma within this population may be cumulative and ongoing, shaped by experiences such as war exposure, displacement, political violence, and chronic societal marginalization (Atari-Khan et al., 2025; Awad et al., 2019). These experiences are not always articulated directly and may instead be normalized, minimized, or expressed through somatic symptoms, emotional restraint, or heightened vigilance (Kira et al., 2014). Counseling approaches that emphasize emotional safety, cultural humility, and sensitivity to power and trust align with trauma-informed principles and may support engagement with MENA clients whose trauma histories are embedded within broader sociopolitical and cultural contexts (Awad et al., 2019; Ratts et al., 2016).

Family-oriented approaches may be an effective and culturally congruent modality when working with MENA individuals (Cho, 2018; Erickson & Al-Timimi, 2001; Zora et al., 2020). Incorporating family involvement or acknowledging family influence can be beneficial when clinically appropriate (Nassar-McMillan & Hakim-Larson, 2003). Counselors should remain attentive to family dynamics, as directly challenging the head of the household in front of family members may be perceived as disrespectful in some contexts (Haboush, 2007; Nassar-McMillan & Hakim-Larson, 2003). Respecting and working within the family system can support rapport-building and engagement (Haboush, 2007).

Knowledge of these cultural norms allows counselors to adapt their approach to foster trust and relational safety. For example, allowing time for initial conversation before moving into formal therapeutic work may support rapport-building and reflect values related to hospitality and relational connection (Cho, 2018; Haboush, 2007). In some settings, small environmental gestures that convey care and respect (e.g., offering snacks and beverages) may help foster engagement, provided they align with ethical guidelines. Attending to these cultural patterns provides a natural bridge to considering the broader implications for counseling practice when working with MENA individuals.

Other Implications for Counseling

In clinical practice, allowing clients to communicate in their preferred language may support deeper emotional expression, enhance meaning-making, and improve diagnostic clarity (Cho, 2018; Sayed, 2003). When counselors do not speak a client's preferred language, the ethical use of trained interpreters can help maintain accuracy and confidentiality in clinical work (ACA, 2014; Sayed, 2003). Language also serves as a primary means of relational connection within communities, and shared language has been shown to facilitate trust and engagement (Bowker & Richards, 2004).

At the same time, counselors should be mindful that some MENA individuals may experience wariness toward outsiders or heightened concern about confidentiality, particularly when counseling occurs within close-knit communities (Haboush, 2007; Nassar-McMillan & Hakim-Larson, 2003). For individuals from regions with histories of political repression, fears related to surveillance or disclosure may further shape how openly clients express thoughts and emotions in counseling settings. For example, the Syrian phrase "*Whisper! The walls have ears*" reflects a broader cultural narrative emphasizing caution and self-protection when speaking openly (Pearlman, 2016). Such narratives may influence client engagement, disclosure in sessions, and comfort with therapeutic exploration. In practice, this highlights the importance of counselors explicitly addressing confidentiality, pacing disclosure, and building trust over time rather than assuming immediate openness.

Ethical Implications

ACA's (2014) *Code of Ethics* preamble identifies honoring diversity and embracing multicultural approaches as core professional values that support the worth, dignity, and uniqueness of individuals within their social and cultural contexts, as well as promote social justice. Multiple ethical standards (e.g., A.7.a., B.1.a, C.2.a, E.8, F.7.c, F.11.c) further emphasize the importance of multicultural competence and cultural knowledge in both training and clinical practice (ACA, 2014). Ethical work with MENA clients, therefore, requires intentional application of these principles within counseling relationships.

Counselors practicing within a social justice framework are expected to cultivate supportive attitudes and beliefs, understand key social justice concepts, develop culturally responsive skills, and engage in actions that promote equity and inclusion (Ratts et al., 2016). Given the historical marginalization and limited visibility of MENA populations, ethical counseling practice involves recognizing how systemic factors, cultural context, and identity-based experiences shape clients' mental health and access to care. Providing culturally informed services to underserved populations is an act of advocacy and a crucial ethical responsibility within the counseling profession.

Counselor Education Implications

Given the historical lack of visibility of MENA populations within counseling research and training, counselor education programs are uniquely positioned to help address this gap (Cho, 2018; Khoury & Manuel, 2016; Samari, 2016). Preparing counselors to work effectively with MENA clients begins with developing a deeper understanding of the cultural values, identity processes, and psychosocial factors that shape how mental health concerns are experienced, understood, and expressed within these communities. Counseling programs may benefit from intentionally integrating MENA-related content into multicultural coursework, including case examples that reflect the diversity and complexity of MENA identities.

Providing students with opportunities to practice indirect questioning styles, attend to somatic expressions of distress, and explore experiences of discrimination-based stress can help bridge the gap between theory and practice. Because MENA clients may not readily label these experiences as trauma, training that encourages curiosity and cultural humility in assessment may be especially valuable (Hosny et al., 2023). Exposure to culturally responsive approaches, such as directive interventions, trauma-informed care, and family-sensitive practices adapted to hierarchical family systems, can further support students' clinical development.

Training may also focus on helping future counselors explore the salience of MENA identities and acculturation processes in counseling relationships (Awad, 2010; Cho, 2018; Erickson & Al-Timimi, 2001). Counselor education can prepare students to recognize how identity labels, cultural self-identification, and acculturation stages influence clients' presenting concerns and comfort in counseling. Introducing culturally sensitive assessment tools, such as the Acculturation Rating Scale for Arabic Americans–II (ARSAA-IIA, ARSAA-IIIE; Jadalla & Lee, 2015), can help students learn to explore cultural explanations of distress in respectful and meaningful ways.

Finally, counselor education programs may benefit from addressing the role of media portrayals in shaping perceptions of MENA individuals. Reliance on popular media has been shown to contribute to stereotypes and incomplete understandings of this population (Awad et al., 2025; Cho, 2018; Erickson & Al-Timimi, 2001). Moreover, incorporating structured tools, such as the *DSM-5-TR* Cultural Formulation Interview (American Psychiatric Association, 2022), into training can further help students learn to contextualize symptoms and explore clients' lived experiences. Continued attention to MENA populations within counselor education represents an important step toward more inclusive training and an important area for future scholarship.

Recommendations for Future Research

Despite growing recognition of the mental health needs of MENA individuals, much of the existing literature remains conceptual, leaving important questions unanswered. Future counseling research should examine the effectiveness of the framework and treatment recommendations proposed in this paper using empirical designs. Cho (2018) noted that less than 1% of psychological research has historically focused on MENA populations, which indicates a longstanding gap that warrants continued attention. The inclusion of a distinct MENA category in the 2030 U.S. Census may help address this invisibility and create new opportunities for research that moves beyond narrow or stereotypical representations (Awad et al., 2025).

Further research is needed to better understand how experiences of discrimination, identity confusion, and racialization shape mental health outcomes among MENA individuals. Studies examining the effectiveness of different counseling approaches for this population would be particularly valuable. There is also a clear need to develop culturally responsive assessment tools and to validate commonly used mental health measures with MENA samples to reduce the risk of misdiagnosis and improve clinical accuracy. Finally, future research should explore racial trauma and intergenerational trauma within MENA communities, as these experiences are likely to play a significant role in mental health across generations (Atari-Khan et al., 2025).

Conclusion

The literature demonstrates that MENA individuals have been constantly underrepresented in research. Depictions of MENA individuals, when shown, were more than likely negative. The goal of this work has been to provide a basic framework for working with MENA Americans, given the longstanding lack of acknowledgment in the counseling literature. The recommendations and observations in this paper about the community are not intended to put these individuals into boxes. Instead, these are only suggestions and considerations for practice when working with MENA individuals. MENA individuals are a diverse group with significant levels of intersectionality and acculturation. They come with rich cultural traditions and strong family bonds, and have overcome years of adversity. They are a community whose experiences merit deeper understanding and acknowledgment. May they at last be recognized as a culture with its own beauty, strength, and voice.

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A Journey, Not a Destination: The Intersection of Trauma and Substance Use Recovery



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Research has consistently shown a link between substance use disorders and trauma; however, there is a need to explore the experience of dual recovery from these struggles. The purpose of this qualitative research study was to examine the lived experiences of individuals in recovery from both trauma and problematic substance use. This study involved semi-structured interviews with 10 individuals who identified as being in recovery from both trauma and substance use. A hermeneutic phenomenological approach was used to gain an in-depth understanding of the recovery experience. Emergent themes included the importance of social support, self-discovery, and that recovery is an ongoing process rather than a time-limited goal. Implications for understanding dual recovery and for counseling clients with dual trauma and substance use recovery experiences are explored.

Keywords: substance use, trauma, dual recovery, lived experiences, counseling

Research has established a link between addiction and trauma (Gidzgieir et al., 2023; Jacobsen et al., 2001; Kilpatrick et al., 2013). Approximately 97.4% of individuals diagnosed with a substance use disorder (SUD) have been found to have experienced a traumatic event (Gielen et al., 2012). Farrugia et al. (2011) also found the prevalence of childhood trauma to be significantly higher among individuals with an SUD diagnosis compared to the general population. Problems with substance use are categorized as an SUD based on impairment of functioning and significant distress (American Psychiatric Association [APA], 2022), while trauma is defined by an acute event threatening one's physical safety or complex, chronic experiences threatening one's mental and emotional well-being over time (May & Wisco, 2016; Wamser-Nanney & Vandenberg, 2013). LeTendre and Reed (2017) found that increased exposure to adverse childhood experiences, such as exposure to domestic violence or having a parent with a serious mental health struggle, accounts for a 34% increase in the likelihood of developing an SUD in adulthood. A recent study focused on comparing indirect and direct exposure to traumatic events found an increased risk for substance use and behavioral addictions with both types of exposure (Levin et al., 2021). Direct exposure in this study included combat and sexual assault trauma. Childhood trauma is linked to substance use, with more extensive trauma histories predicting earlier initiation and greater severity of substance use (Farrugia et al., 2011).

Based on the research demonstrating a correlation between trauma and substance use, dual recovery experiences warrant exploration. In clinical treatment settings, clients will present with a need to address these co-occurring struggles. To date, research has focused primarily on the correlated pathology rather than the co-occurring healing and recovery process. To address this gap, this study aims to explore the lived experiences of individuals who self-report dual recovery experiences.

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Understanding the Link Between Trauma and Addiction

Evidence suggests that individuals who have these co-occurring struggles have poorer treatment outcomes than clients with only one of these presenting issues (Brewerton & Brady, 2014). Although several explanations for the relationship between trauma and substance use exist, self-medication theory predominates (Hawn et al., 2020). Self-medication theory posits that substances are used to cope with and mitigate trauma-related symptoms. Despite offering a respite from unwanted hypervigilance, anxiety, or thoughts related to trauma, substances do not eliminate symptoms or resolve the underlying reactions. Self-medication suggests that a cycle of experiencing symptom distress and using substances to cope becomes problematic. Once the substances' effects subside, the cycle may begin again, often with exacerbated emotional distress and additional concerns about one's inability to control consumption.

Counter to self-medication, some theorists believe there is a relationship between post-traumatic stress disorder (PTSD) and the predisposition to substance use (Khoury et al., 2010; Van den Brink, 2015). Although not all individuals who identify as in recovery from trauma meet criteria for PTSD, research has often focused on creating sampling parameters to explore epidemiology and treatment protocols (Zrineh et al., 2026). Brewerton and Brady (2014) agreed that epigenetics and genetic predisposition may contribute to substance use vulnerability for people who have experienced significant traumas. Additionally, early trauma caused individuals in the study to feel abnormal and misunderstood, potentially leading them toward social groups involved in substance use (Brewerton & Brady, 2014).

Treatment Considerations

Traditionally, many treatment approaches have sought to disrupt this cycle via a sequential model of treatment, with substance use problems addressed first. This approach assumes that meaningful mental health treatment cannot be effective while a person is still impaired by regular substance use (Schumm & Gore, 2016). Newer evidence suggests that concurrently treating trauma and addiction shows promise in producing successful outcomes like reduced substance use and relapse, and improved quality of life (Flanagan et al., 2016). Concurrent treatment of trauma and substance use has become more widely accepted (Flanagan et al., 2016; Priester et al., 2016; Schumm & Gore, 2016). It remains unclear if this research has influenced treatment practices, especially in addiction programs not affiliated with research institutions (e.g., hospitals and universities). Scholars have recommended universal trauma screening for clients entering care for substance use (Van den Brink, 2015), and concurrent treatment is now seen as efficacious and safe (Flanagan et al., 2016). The National Institute on Drug Abuse (2014) recommends simultaneous treatment for these issues, acknowledging a correlation between substance use and underlying mental health struggles, including trauma.

Evidence that this concurrent approach leads to successful treatment for those who have experienced co-occurring substance use and trauma is accumulating. Studies have found that participants prefer an integrated approach to treatment, such as receiving treatment for both SUD and PTSD in the same treatment program (Brown et al., 1998; Gielen et al., 2016; Roberts et al., 2023). This, however, is not a common experience for individuals with co-occurring diagnoses (Gielen et al., 2016), as most substance use treatment programs do not include trauma-focused interventions (Giordano et al., 2016). The European Society for Traumatic Stress Studies utilized a systematic review of research and expert opinions to develop a list of nine assessment strategies and 21 treatment recommendations for co-occurring trauma and substance use (Roberts et al., 2023). These recommendations include: concurrent treatment, helping clients navigate logistical barriers to treatment (e.g., transportation), case management services, building a strong therapeutic relationship, and psychoeducation about the relationship between trauma and substance use. The current study

aims to examine the lived experiences of people identifying as in recovery from both trauma and substance use, with the intent to clarify the phenomena of dual recovery.

Purpose of the Study

Understanding the process of dual recovery for individuals who experience traumatic events and have struggled with substance use is vital for providing appropriate care. The current study aimed to examine the lived experiences of people identifying as in recovery from both trauma and substance use issues, with a focus on their recovery journey over time. The purpose was to build on prior research that focused on trauma and substance use by exploring intersecting recovery processes, rather than etiology, and investigating the phenomenon of recovery by exploring lived experiences. A qualitative study design and methodology was utilized and guided by the overarching research question: *What is the experience of recovery for someone who struggles with trauma and substance use?*

It is important to acknowledge that a variety of recovery definitions exist. There is disagreement among experts regarding the precise language to describe recovery, and individuals choose to identify for themselves when they are in recovery without precise criteria (Piat et al., 2009). According to Neale and colleagues (2015), individuals in active recovery find previously established definitions to be limiting and focused on a deficit-based mindset and framework. Conceptualizations that are strength-based consider social and context influences and acknowledge that individual differences are preferred. Recent studies have moved away from offering their participants a definition of recovery; instead lived experiences and individual definitions of recovery conceived by the participants themselves are now common in addiction research (Zemore et al., 2023). The current study did not provide a definition of recovery to participants but focused on eliciting participants' conceptualizations of what defines recovery to the individual.

Methods

In looking at the experience of recovery for someone who struggles with trauma and substance use, we intentionally sought a research methodology that would account for the depth and complexity of these life experiences. Given this focus, hermeneutic phenomenology was chosen as our research approach. Phenomenology aims to understand a phenomenon through the lens of those with direct experience (van Manen, 2016). Phenomenology prioritizes meaning making and attempts to get at the depth of experiences, as opposed to examining generalizable patterns across a broad range of perspectives (Hays & Singh, 2012). Through first-person accounts, phenomenology pulls together key descriptions to form a picture of an experience or phenomenon. Hermeneutic phenomenology was specifically chosen because it places participants as co-researchers (Hays & Singh, 2012). This means that participants are viewed as experts in the field of study, thus lessening the power differential between researcher and participant (Hays & Singh, 2012). Given the marginalization and stigma of those who experience substance use issues and trauma, it was important to utilize a method that recognizes power dynamics and attempts to diminish those between the researcher and the participants. This included asking participants to self-define their recovery status and what qualifies as being in recovery.

Reflexivity

Transparency regarding researcher perspective and positionality is essential in qualitative inquiry (Levitt et al., 2018). We are invested in advancing the understanding of recovery processes, especially among counselors who work with individuals with co-occurring trauma and substance use histories.

Through this research, we hope to help counselors use this information to better support those they serve, as well as enhance the awareness of educators and supervisors. Dana Ripley, Justin R. Jordan, and Jyotsana Sharma have been colleagues through their doctoral program, are licensed counselors, and hold doctoral degrees in counselor education and supervision. Ripley, Jordan, and Sharma are currently tenure-track professors in counselor education programs, with Ripley and Jordan consistently teaching addiction counseling courses to master's-level students. Taylor Allesch is pursuing licensure as a professional counselor and is a former student of Ripley. Ripley has a background in substance use and addictions counseling, which is also her primary teaching and research interest. She teaches at a public university in the Midwest United States. Jordan is a professor at a mid-sized public university in the southern United States. He has more than a decade of experience counseling individuals with trauma and substance use struggles in a public mental health agency and in private practice. Sharma is a professor at a large, research-focused university in the southern United States and has experience working with clients with trauma and other stress-related disorders. Allesch was a master's student in clinical mental health counseling who completed her degree during the data collection and analysis phases of our study. She has experience addressing trauma in private practice settings, predominantly with couples and individuals.

Beginning with the initial planning for this study, we discussed how academic, research, personal, and treatment-providing experiences with addiction and trauma would affect development of the research protocol. None of the team members identify as being in recovery from substance use, although multiple members have experienced traumas of varying severity and chronicity. We collectively lean toward wellness-based interventions and respecting personal autonomy in navigating healing from substance use or trauma. Throughout the study, we held reflective discussions about how our experiences influenced the development of interview questions and interpretations of the coding process and distillation of themes, and we kept reflexive journals, which were audited by Sharma, and conveyed results in writing. This included exploring: the influence of client issues and treatment systems we had worked in; personal experiences with substances, trauma, and the impacts on those we care about; and research and literature that had impacted our perspectives on recovery journeys. We were deliberate and consistent in acknowledging personal perspectives and biases while attempting to allow the voices of study participants to be captured accurately and fully.

Participants

After securing IRB approval from our three affiliated institutions, participants were recruited through contacting peer recovery specialist organizations via email. Peer recovery specialists are trained as helping professionals who identify as being in recovery from substance use/addiction, or having mental health struggles, including trauma, or both, which is why we targeted this population for recruitment. Purposeful sampling was used to identify appropriate candidates who were recruited directly through organizational websites and through connections to local communities in Kentucky, Ohio, and Virginia. Snowball sampling was also used, as participants recommended other peers who might be interested in the study. Participants were not required to be trained as peer recovery specialists, but all participants were recruited through these networks. Emails to peer recovery specialists and associated organizations were sent with a link to an online screening survey utilizing Qualtrics software, which clarified which prospective participants met inclusion criteria.

The three inclusion criteria for this study were that participants must: be 18 or older, self-identify as being in recovery from substance use issues, and self-identify as being in trauma recovery. Because definitions of recovery vary, participants were not asked about the length of time since their last use of specific substances or the timeline of their trauma symptoms. Participants were asked to describe

their recovery process from each struggle as part of the interview protocol; they were also asked how they define recovery. Although personal definitions vary, participants referenced government definitions, freedom from use or symptoms, normalcy in their lives, sustaining quality relationships, and having balance in their lives. Some participants referenced sustained abstinence from substances and reduction in trauma symptoms, while others spoke to the absence of chaotic behavior patterns and a sense of mental peace and calm. Potential participants who met eligibility criteria were contacted via email to schedule an interview. Each participant was sent a copy of informed consent documentation and gave verbal agreement to participate at the start of the interview.

Our final sample included 10 participants. Bartholomew et al. (2021) suggested that there is no specific range for sample sizes in phenomenological research, but 10 participants is within a normative range; larger samples often lose some of the essential qualities of this methodology. Other researchers have suggested three to 10 participants for phenomenological studies (Dukes, 1984).

In our study, participants' ages ranged from 23 to 61, with a mean age of 42.2. Participants were asked open-ended questions regarding how they identified their gender, race/ethnicity, and sexual orientation. Two participants identified as male, with the rest identifying as female. Three participants identified as Black or African American, one as Hispanic, two as mixed race, and four as White. One participant identified as bisexual, one as lesbian, and the rest identified as heterosexual or straight. Table 1 summarizes pseudonyms and pertinent demographic information.

Table 1

Participant Demographics and Pseudonyms

Participant	Age	Gender	Race or Ethnicity	Sexual Orientation	Pseudonym
Participant 1	61	M	White	Heterosexual	Jackson
Participant 2	46	F	Hispanic	Bisexual	Dedra
Participant 3	49	F	Black	Heterosexual	Erica
Participant 4	40	M	African American	Heterosexual	Levon
Participant 5	31	F	White	Heterosexual	Olivia
Participant 6	37	F	White/Colombian	Heterosexual	Kara
Participant 7	41	F	White/Puerto Rican	Heterosexual	Alecia
Participant 8	41	F	White	Heterosexual	Rhonda
Participant 9	53	F	Black	Heterosexual	Corva
Participant 10	23	F	White	Lesbian	Rosemary

Participant Background

The participants were thoughtful in sharing their unique experiences in recovery. Jackson is a 61-year-old heterosexual White man who spoke about an abusive father and his drug use causing him to miss time with his kids. He talked about self-forgiveness as a key part of his recovery. Dedra is a 46-year-old bisexual Hispanic woman who discussed being hit by a truck while intoxicated and the complications of receiving inpatient nursing care while being prescribed Suboxone for opioid addiction. Erica, a 49-year-old heterosexual Black woman, currently works in a harm reduction program and

talked a lot about people who died in active use and how Narcotics Anonymous (NA) was key in her early recovery. Levon is a 40-year-old heterosexual African American man who spent 18 years in prison on charges related to alcohol and prescription pill use. He described trauma recovery as very difficult, as he did not realize how his lived experiences had led to impaired functioning, even after achieving sobriety. Olivia, a 31-year-old heterosexual White woman, is currently pursuing a degree in social work and is employed as a peer specialist. She feels the cognitive behavioral therapy she received for trauma and 12-step fellowship for addiction were essential for the healthy relationships she has in her life now.

Kara is a 37-year-old heterosexual biracial (Columbian/White) woman who turned to alcohol and other drugs after the death of her brother. She says pregnancy and parenthood helped push her toward recovery and she is an advocate for improving Methadone access. Alecia is a 41-year-old heterosexual biracial (Puerto Rican/White) woman, who credits a supportive probation officer for helping her work toward recovery after 20 years of active addiction. She is a supporter of multiple interventions for recovery, including harm reduction, prevention, and diversion programs. Rhonda, also 41, is a heterosexual White woman. She supports many pathways to recovery, but for her, becoming involved in her church was the key to making progress. Corva is a 53-year-old heterosexual Black woman who talked about how her chaotic childhood led her to cope with alcohol, as well as having an unhealthy relationship with food and sex. Finally, Rosemary is a 23-year-old lesbian White woman. She was a college student who participated in a collegiate recovery program and has found substance recovery through harm reduction rather than abstinence.

Data Collection

Participants gave verbal consent at the beginning of each interview. Data collection included semi-structured interviews (see Appendix for the interview protocol). Interviews were scheduled for 1 hour, and participants were advised that they may receive contact for a brief follow-up if clarification was needed (no participants were contacted for follow-up). Questions focused on the participants' lived experiences of recovery from trauma and substance use. Zoom videoconferencing software was used to meet with the participants, and all interviews were video-recorded. The recordings were transcribed by Ripley, Jordan, and Allesch.

Data Analysis

Each transcript was read and coded by two members of the research team. Ripley, Jordan, and Allesch completed the coding. In reviewing the transcripts, each member used the selective or highlighting approach (van Manen, 2016). This approach requires several readings of the text, paying attention to statements that "seem particularly essential or revealing about the phenomenon or experience being described" (van Manen, 2016, p. 93). We highlighted these statements in the text, then copied and organized the data in an Excel spreadsheet with repetitive data being identified and deleted. Statements were synthesized into a phrase that encompassed the statement's meaning. Using cross-case analysis (Patton, 2015), the statements were grouped based on focus and perceived meaning (coding), leading to initial coded themes. In hermeneutic phenomenology, themes are used to describe a common aspect of the experience (van Manen, 2016). Collaborative analysis, or hermeneutic conversations, were then conducted by the three coders (van Manen, 2016). This entailed coding team meetings in which members discussed patterns and content, and preliminary ideas for themes emerging from the transcripts. Each coding review meeting included Ripley, Jordan, and Allesch.

Collaborative analysis assures "themes are examined, articulated, re-interpreted, omitted, added, or reformulated" as needed (van Manen, 2016, p. 100). Ripley, Jordan, and Allesch met several times

over 4 months for collaborative analysis to calibrate and reach consensus regarding emergent themes. They examined lines of text that seemed to capture the essence of the recovery phenomenon and experience. We generated ideas for thematic groupings and descriptions; some themes were dropped because of inconsistency or lack of consensus, including a theme focused on “giving back” in recovery, which did not have the same amount of participant endorsement as the other themes. These dialogues included examining potential biases in interpreting transcripts, exploring overlaps and distinctions between themes, and ensuring each theme was evaluated and agreed upon amongst us. Once consensus was reached, themes were audited by Sharma. Sharma checked each coded statement to ensure its match to the assigned theme and then reported potential mismatches or poorly fitting codes to Ripley, Jordan, and Allesch. Further meetings and dialogues were held to work through different interpretations until consensus was met for all themes and coded statements (sometimes, a vote was held, requiring a majority to move forward). Themes were considered sufficiently refined when we all agreed that the essence of the interviews had been captured and no additional themes were needed to understand the participants’ experiences.

Trustworthiness

Our research team engaged in several strategies to enhance the trustworthiness of our findings. Researcher bias was addressed using reflexive journals (Hays & Singh, 2012). Reflexive journals were kept by Ripley, Jordan, and Allesch. After each interview, the interviewer would write a reflexive journal documenting thoughts, assumptions, feelings, and reactions to the interview. The reflexive journals were read and examined for influence on code/theme generation by Sharma while auditing the themes. Sharma spoke about the journals and inquired about biases during meetings. Based on this feedback, the coding team was able to talk through and mitigate biases that affected data analysis, including transference related to personal and professional experiences.

Trustworthiness was also ensured using triangulation with multiple analysts (Patton, 2015). Ripley, Jordan, and Allesch conducted interviews and coded the transcripts, thus helping to “reduce the potential bias that comes from a single person doing all the data collection” and analysis (Patton, 2015, p. 665). Additionally, Sharma did not participate in conducting interviews or the initial coding process. Sharma audited the coding and themes without prior exposure to the data, with the intent of remaining objective.

Findings

Interviews with 10 participants were analyzed via a hermeneutic phenomenological approach. Six themes emerged from the interviews and subsequent coding process: *recovery is hard*, *recovery includes structured support services*, *recovery is an ongoing process*, *recovery is relational*, *recovery is self-discovery*, and *substance use and trauma recovery are interconnected*. These themes encompass defining characteristics of the dual recovery journey for the 10 participants in our study.

Recovery Is Hard

Participants discussed how working toward and living in recovery comes with many challenges, especially related to stigmas and navigating systemic barriers in receiving help. Looking for support early in their substance use recovery process, Dedra highlighted, “Even if I’m an addict, I still deserve the proper treatment and proper care and proper empathy, and I didn’t get that.” She elaborated that, “I had to fight for myself; nobody else was doing it so I just had to fight hard.” Rhonda talked about multidimensional challenges that led to being overwhelmed in early substance use recovery, stating, “The hardest thing for me to get over in that first year is changing absolutely everything.”

Another common difficulty that participants expressed was finding a place to “fit in.” After experiencing traumas related to homelessness during pregnancy while simultaneously managing a chronic blood illness, Kara described, “I think some of the hardest parts for me were just sort of like learning how to reintegrate in society, and I think that continues to be hard for me, like ‘where do I fit in here?’” Kara felt that finding a sense of belonging was essential for healing, given the disconnection from supports she experienced before pursuing recovery. In pursuing formal treatment for co-occurring struggles, Kara indicated that she encountered “all these wait lists,” and shared, “if you want to go to a program . . . you can’t get in right away.” Olivia also described substance use and trauma having “such a stigma on it already anyway, receiving any kind of mental health service . . . it just seemed so unobtainable.” Dedra discussed judgment within the substance use recovery community because of being prescribed Suboxone, a medication used to treat opioid use disorder: “I experienced a lot of stigma because I was an opiate user and they had to put me on Suboxone. I just had all this weird treatment toward me that was so uncomfortable, so embarrassing, and really degrading.” Participants had a lot to overcome in order to receive support in pursuing recovery and sustaining their efforts amidst treatment barriers and social stigma. Some participants reported that they had to learn how to advocate for themselves because of the lack of support and barriers they encountered trying to seek support.

Recovery Includes Structured Support Services

Most participants emphasized the necessity of structured support such as mental health and substance use treatment programs, mutual self-help groups (AA and NA), and other systems (e.g., church) as essential to their recovery journeys. The theme of *recovery includes structured support services* encompasses the importance of treatment programs, groups, and organizations that provide help to participants. Participants talked about the importance of these support systems to help people work toward change early on in pursuing recovery. Olivia benefited from both mutual self-help and professional therapy, sharing:

I personally worked a 12-step program [for substance recovery], and so, in that, [my counseling] was really based more on my trauma than it was actual substance use and I, I went to counseling and just a lot of things like that. . . . cognitive behavioral therapy is really what helped me work through those childhood traumas that I had, and the trauma that I added on to it as an adult, and it was difficult.

She elaborated about positive experiences working on trauma in formal treatment: “When I went into that treatment setting, the people there were already so well equipped to handle the kind of things that I needed to talk about, that I wanted to talk about.” Speaking more broadly, Olivia shared the importance of having multiple systems for support in dual recovery, saying, “I also think it’s really important to be able to connect people to a lot of different services, kind of like the wraparound services.” Jackson also benefited from both mutual self-help groups and formal treatment, stating: “When I got out [of incarceration], I did kind of dive into AA, which was integral, in my early recovery, and, you know, continued to see my therapist [for trauma counseling].”

Kara found out that she was pregnant while she was incarcerated and did an intensive 3-year program for women who were prescribed Methadone and pregnant. She reported this as an important step for her recovery. That group meant a lot to her. When asked about her trauma recovery process, Alecia talked about a peer specialist being a role model when she entered

treatment, saying, “I can do this. If she can do it, I can do it,” as well as participating in SMART [Self-Management and Recovery Training] Recovery meetings. She expressed that this specialist helped her feel understood as someone who had been incarcerated and using substances to subdue childhood trauma symptoms. Overall, this theme showed that participants felt that they could not achieve sustained recovery on their own and benefited from programs, services, and mutual help spaces in healing from trauma and addiction.

Recovery Is an Ongoing Process

Another theme that emerged from the interviews was that *recovery is an ongoing and continuous process*. Participants described their recovery from trauma and substance use as continuing to unfold, rather than a destination where they had already arrived. This process was discussed as an individual journey because, as they recovered, each person had to make choices about what resources to utilize and what changes fit their lives. Several participants explicitly identified that their co-occurring recovery is a continuous process. In characterizing her journey in dual recovery as being unique, Rosemary stated: “It took time for me to learn that recovery is a spectrum, and there’s not one right way to do this.” Alecia agreed with this theme and made similar statements, including: “I know this is a process that I’ll go through for the rest of my life.” In speaking primarily to substance recovery, Rhonda had similar sentiments, sharing her belief that “everybody’s not the same, and there’s so many different paths out there now. It’s just finding the right path in the right way for you.” She added, “Yes, I went to treatment, but I don’t use that as my recovery. My recovery was honestly therapy and going to church.”

This theme encompasses descriptions of making broad lifestyle changes and continuing to grow as a human, while still acknowledging the influence of substance use and trauma in one’s life journey.

Recovery Is Relational

All participants spoke to relationships as they related to their recovery journeys. This theme is given more attention here, as it was the most frequently coded and consistent theme. *Recovery is relational* focuses on the importance of bonding and human connection in the recovery process. This theme is distinct from the theme of *recovery includes structured support services*, which focuses on therapy/counseling, education, or tangible resources, such as medications or financial assistance, rather than the general importance of interpersonal relationships.

Specifically, participants highlighted how relationships facilitated recovery, which included connections to individuals in the mutual self-help community, professionals, and treatment providers, but also support from their families, friends, and community. These connections helped participants cultivate hope and accountability as they progressed in healing from substance use and trauma. The sense of being understood and accepted through the challenges of recovery was impactful and motivating.

Jackson described the importance of his relationship with his 12-step sponsor, a high school teacher that “really got me.” His sponsor worked the steps with Jackson, trying to understand Jackson’s unique perspectives on the steps and recovery. He described his sponsor as patient and intelligent. The sponsor was able to repackage the AA message in a way that fit for Jackson, who said that “if I hadn’t had somebody like that, I wouldn’t have stopped.” Kara and Erica similarly shared the importance of relationships in the 12-step community, including not feeling alone in pursuing recovery.

Sources of support varied widely in our study. Olivia described the important relationship she had with her children's foster parent. Not only did the foster parent take care of her children, but she became an integral part of Olivia's life; she described her as "my absolute biggest supporter." This foster parent helped her build back community and showed her that it is possible to live the kind of life she had always wanted.

Other participants also emphasized the benefits of community and support broadly. Olivia shared that she had to learn new ways of living and building relationships within her community. Her local community has been essential to her success in recovery. She detailed how this support facilitated recovery from trauma and substance use:

I spent almost an entire year just digging through those things and opening up and sharing about them, and that's also where I built that first sense of community of speaking on those traumas with like-minded people who had been through similar situations.

Alecia spoke about the significant support she received from her probation officer. She stated that having a probation officer who really understood her and wanted to see her succeed was "a game changer." The probation officer's investment in her was a turning point for Alecia. Corva felt that recovering from both issues has given her relationships authentic connection: "Being around people who really know us and know us at our depth and, you know, and that's what life is truly about. So, for me, that's what recovery is about. And it's given me a family."

Participants were consistent in pointing to relationships boosting their success in recovery, which included building back bonds with people they had lost touch with or been cut off from during active use, as well as building a new network of support. The theme of *recovery is relational* had the highest number of identified codes from participants supporting the theme.

Recovery Is Self-Discovery

Participants identified the development of self-awareness and connecting with themselves as part of their recovery. This theme of *recovery is self-discovery* included emphasizing new personal growth since confronting trauma and addressing substance use struggles, including reconnecting with prior values and aspects of their identity. Additionally, participants described self-awareness as a key component of their life in recovery, including being honest with themselves and processing emotions that they may have avoided previously. Epitomizing this theme, Jackson stated:

So much of my recovery is about finding my place in the world — that sense of comfort and connection and stuff. A lot of my trauma that I experienced entails me forgiving other people. This, you know, is forgiving myself for the mistakes I've made, which I still struggle with, but also is letting go of resentments.

When asked about critical points in his recovery, Levon also spoke about personal development, saying that he started to see how to present a stronger version of himself, knowing internally that he was courageous and could fight through obstacles. Olivia added that she had created walls that served the purpose of protecting her but had to "chip away" at those protections for her true self to emerge in recovery.

In terms of confronting emotions and suppressed thoughts, Dedra shared that trauma recovery required “this ability, which only came to me late in life, to just be objective with my own self, and to be honest and objective about what [trauma is] doing, and who I am, and what’s happening to me.” In connecting this to substance use recovery, both Dedra and Rosemary agreed that self-awareness and honesty are key to recovery and that secrets can continue the cycle. Multiple participants alluded to increased self-awareness, understanding, and reconnection with their true self as being an important part of the recovery process.

Substance Use and Trauma Recovery Are Interconnected

The theme of *substance use and trauma recovery are interconnected* was described in multiple ways by participants, often referencing trauma being an underlying aspect of substance use struggles. Participants spoke about realizing the connectedness of trauma, mental health issues, and substance use in recovery. Erica acknowledged the close connection between substance use and trauma recovery, saying that “they just kind of overlap and intersect, and it’s kind of hard to differentiate where one ends and one begins.” Dedra spoke about trauma being the underlying issue, explaining, “Trauma is the root for me, and you know, with other people it might be that, you know, once they quit drinking, things get better, but I’ve always had to struggle with trauma.” Levon also described that he was unaware of how affected by trauma he was, recounting: “Trauma drove the substance use in that sense . . . because the trauma had certain effects on me that I didn’t [recognize].”

Additionally, participants noted that addressing trauma, including associated mental health concerns, along with substance use, was an essential part of recovery. Jackson spoke about the importance of getting help with mental health diagnoses, which he didn’t start until 10 years after engaging in substance use recovery. He had experienced multiple hospitalizations related to suicide attempts, which eventually spurred him to address his mental health:

But it was at that point I kind of really took my mental health issues as seriously as I took my substance use issues because it was easy to see that my substance use issues were killing me, were going to kill me. It’s harder to see that with mental health issues.

Alecia used similar language, describing that “addiction is just one of the symptoms of trauma, and . . . you can’t get to the root with the symptoms still there.” The direct relationship between trauma healing and substance use recovery was consistent in the interviews. Participants were directly asked if these recovery processes were related, and all participants replied affirmatively and elaborated on the reasons for this connection. Although many responses highlighted the trauma as an underlying cause of substance use, the responses showed that in conceptualizing the recovery process, healing from each was interconnected.

Discussion

Six themes emerged from the phenomenological analysis of these 10 interviews focused on the experience of trauma and substance use recovery: *recovery is hard*, *recovery includes structured support services*, *recovery is an ongoing process*, *recovery is relational*, *recovery is self-discovery*, and *substance use and trauma recovery are interconnected*. Taken as a whole, these themes demonstrate that the lived experience of dual recovery from substance use and trauma is an individual, holistic journey supported by personal and formal relationships. There is an inherent connection between trauma

and substance use recovery for these participants. This type of dual recovery includes hardships on the path to healing for both trauma and substance use. Among our participants, there were multiple pathways to recovery, and yet there were parallels in how they described essential elements of long-term recovery. Recovery is a forward-focused endeavor rather than a cure for pathology (Witkiewitz et al., 2020), which is a useful perspective for laypersons and professionals who offer guidance to people working to overcome trauma symptoms and substance use addictions.

This study deepens the understanding of dual recovery from these correlated struggles, which counselors commonly address. Acknowledging the ongoing nature of recovery reduces the focus on acute symptom management and shifts the focus toward lifestyle factors such as relationships. These themes support an individualized self-exploration process for discovering a new sense of self within substance use and trauma recovery. All participants indicated that these two recovery processes were correlated. This finding supports a simultaneous approach to healing substance use and trauma, as opposed to a historical emphasis on sequential treatment.

These findings call for a focus on development and wellness congruent with counselor professional identity (Woo et al., 2014), in contrast to a medical model framework. Conceptualizing recovery as an ongoing purpose, rather than a destination, supports the benefits of counselors embracing holistic wellness and developmental perspectives. Participants described a long-term process enabled by relationships and structured support, calling on counselors to be responsive to recovering clients' ongoing healing journeys. This aligns well with how counselors join clients in pursuing meaningful, multidimensional changes in their lives (Woo et al., 2014) rather than focusing solely on symptom reduction. Trauma and substance use are correlated, but each individual navigates unique challenges in pursuing a better life in recovery. This healing is not just alleviating symptoms but rather finding new identities and maintaining wellness daily. These findings demonstrate that counselors benefit from recognizing that there is no one-size-fits-all approach to dual recovery. Long-term support is needed in recovery and that care should target both trauma and substance use in order to be successful. The participants acknowledged that addressing the trauma at the root of their struggles would benefit both their mental wellness and ability to avoid harmful substance use. Our participants have given us evidence in their own voices to help clarify what the phenomenon of co-occurring recovery looks like.

Refining the understanding of recovery as a process advances the pursuit of better supports for survivors persevering through trauma and substance use that has negatively impacted their lives. Recognizing that trauma and substance use recoveries are intertwined calls for services designed to support the long-term healing process. This recognition also discredits siloed treatments that do not address co-occurring needs. The importance of relationships and support networks was clear, as was the individualized nature of the recovery process over time. Counselors are trained and equipped to meet clients where they are by matching interventions to individual needs. This means cultivating recovery based on clients' unique strengths rather than using cookie-cutter prescriptive approaches to support sustained recovery.

Implications for Counselors

Counseling, being defined as a relationship that facilitates growth and healing (Kaplan et al., 2014), is a fitting intervention for people pursuing recovery. Emphasizing holistic wellness, supporting development through the lifespan, and honoring the specific needs of the client are all aspects of professional counselors' duty (American Counseling Association [ACA], 2014). Counselors are uniquely

equipped to provide holistic and development-focused support for individuals in dual recovery, given that these approaches are congruent with counselor professional identity (Woo et al., 2014).

Historically, addiction treatment has relied on a prescriptive, sequential approach to substance use recovery, usually involving the pursuit of sobriety before addressing mental health concerns. Recent research supports concurrent treatment as best practice for treating trauma and substance use (Garland et al., 2015; Roberts et al., 2023; Schumm & Gore, 2016). This approach to co-occurring treatment supports the holistic approach emphasized by leaders and researchers in the counseling profession (Dollarhide & Oliver, 2014; Fickling, 2023; Kaplan et al., 2014). Valuing client autonomy and personal preferences in navigating recovery is necessary for counselors, which aligns with the individuality of recovery journeys found in our study. This research demonstrates that for many individuals, trauma struggles were not addressed until after they managed substance use effectively, which likely inhibited progress and overall wellness. Additionally, counselors integrating wellness, prevention, and developmental perspectives can help these individuals thrive long after the pathology of acute addiction or trauma symptomology is relieved.

Motivational interviewing and principles of trauma-informed care embrace this stance, including focusing on empowering the individual on their own terms and assuming a natural tendency toward growth (Miller & Rollnick, 2023). Addiction treatment, specifically, has traditionally been confrontational and behaviorally focused (White & Miller, 2007). This contradicts a trauma-informed approach to recovery and is particularly concerning given the high rates of co-occurrence between these struggles (Dore et al., 2012; Giordano et al., 2016). Harm reduction is another approach that fits for dually recovering individuals based on these findings. One of the main hardships that participants described was the experience of stigma because of their substance use. This approach mitigates stigma by focusing on wellness without judgment (Collins & Clifasefi, 2023). Harm reduction is a humanistic and pragmatic approach that prioritizes autonomy and the holistic well-being of the individual. Harm reduction is uniquely suited to co-occurring trauma and addiction, given its emphasis on collaboration with those being helped, a trauma-informed approach, and avoiding retraumatization through power-over dynamics. This philosophy has been adapted as an approach to psychotherapy by multiple scholars (Collins & Clifasefi, 2023; Tatarsky & Kellogg, 2012). Some participants had awareness, knowledge, and experiences receiving or providing harm reduction care and expressed their support for harm reduction within the continuum of services supporting substance use recovery.

With trauma, counselors may wish to engage with post-traumatic growth phenomena, as well as validating the natural tendency toward self-improvement, wellness, and growth. With substance use, counselors can draw from motivational interviewing, harm reduction, and self-guided changes to empower clients to take responsibility for personal change and respect their autonomy in the process. In supporting the dual recovery process, professional counselors can honor the unique strengths and meaning created through relationships, self-discovery, overcoming barriers, and the unfolding pursuit of growth in their clients.

Limitations

The current study did not differentiate the types of substances participants were recovering from, nor did it focus on specific types of trauma. Our research team intentionally focused on self-defined experiences with these struggles and the phenomena of recovery rather than the etiology of the struggle. It is difficult for these themes to be applied to substance use or trauma separately, as most

interview questions focused on the participants' experiences in co-occurring recovery. Sometimes, there was a clear distinction in which process, or sequential experience with recovery, they were referring to; those are noted in the Findings section. However, by design, most of the time, they were speaking about the dual recovery process. It is likely that complex trauma recovery may have phenomenological differences from acute event traumas. Similarly, recovery from different types of substances includes unique needs and experiences, such as medication treatment for opioid use recovery. During the coding and theme development process, our researchers may have been influenced by prior definitions of recovery in the literature. Despite this influence, our research team was diligent in focusing on giving voice to the participants as they reviewed coded statements from the interviews in clustering emergent themes.

Broadly, our study provides nuance in conceptualizing the phenomenon of dual recovery from trauma and substance use, but it cannot be generalized given that it is a qualitative study. Our study was limited geographically and by purposeful sampling. It is noteworthy that peer recovery specialists may have received education or exposure as helpers that has influenced their conceptualizations of recovery, which may differ from the broader population of individuals recovering from trauma and substance use. Finally, recovery as an experience extends to many other struggles beyond trauma and substance use issues, and it is unclear if the themes found in the current study would apply to other medical or mental health recoveries.

Future Research

These findings build on prior studies examining how substance use and trauma experiences are correlated and provide an in-depth look at the phenomenon of recovery with 10 individuals. Future studies may utilize quantitative methodology to determine if the themes found in this study are generalizable to people in recovery from trauma and substance use. Research is also needed to explore the specific experiences of peer recovery specialists in dual recovery. Additionally, further research may also explore factors that differentiate trauma recovery from substance use recovery experiences, both for individuals with co-occurring recoveries and those who only identify as being in recovery from one or the other. The current study adds to the research in a significant way but also reinforces a need for more studies looking at subtleties of recovery experiences.

Conclusion

Recovery is a multidimensional process that is defined by wellness and improved overall functioning (Witkiewitz et al., 2020). The current study examined the experience of recovery for 10 individuals identifying as in recovery from both substance use and trauma using hermeneutic phenomenology. Six themes emerged that conceptualize recovery from trauma and substance use as an ongoing, interconnected, individualized process that includes hardships and self-discovery and is facilitated by relationships and formal services. These findings support existing research calling for a concurrent and holistic approach for counseling individuals pursuing recovery from substance use and trauma-related symptoms.

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Appendix

Interview Protocol

Research Question: What is the experience of recovery for someone who struggles with substance use and trauma?

1. When I say the word “recovery,” what comes to mind? How do you define “recovery”?
2. Tell me about the process of your recovery from trauma.
3. Tell me about the process of your recovery from substance use.
4. Do you feel your recovery process from substance use and trauma are related? If so, can you describe how?
5. What are some of the critical moments or turning points in your recovery?
6. Describe in as much detail as possible what you struggled with the most during recovery and how you managed those struggles.
7. How has being in recovery influenced your life and what have you learned from those experiences?
8. If you could go back and change anything about the process of your recovery, what would it be?



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