Success is not final, failure is not fatal: it is the courage to continue that counts.
– Winston S. Churchill
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FROM THE CO-EDITORS

We are pleased to present you with Volume 35 of the Virginia Counselors Journal (VCJ). We want to take this opportunity to thank the many authors who have contributed to the Volume’s content and our Editorial Board members for their work over the past year and a half to ensure that the content of the Volume is relevant and of the highest possible quality.

More manuscripts were received for Volume 35 than were received for any previous volume during our years as co-editors, and we hope that this is an indication that the VCJ is being increasingly recognized as a desired publication venue. Our receipt of submissions from authors across the country seems to be another indication of the Journal’s growing visibility and recognition among professional publications.

As with any professional journal, the ongoing existence and quality of the VCJ is dependent upon the willingness of individuals to serve as Editorial Board members. Typically, VCJ Editorial Board members will be asked to review two to three manuscripts per year and to make recommendations regarding the suitability of those manuscripts for publication. Having a sufficient number of editorial board members ensures that the review process can be completed in a timely manner and that individual board members are not overtaxed with excessive requests for manuscript reviews. If you have interest in serving as a member of the VCJ Editorial Board, we encourage you to contact the Editor at vcjeditor@gmail.com.

Volume 35 will be the last volume of VCJ to be published under our co-editorship. As we depart, we want to thank all of the authors, Editorial Board members, and the VCA Board and staff (Vicky Wheeler) for their ongoing support of our efforts for over five years to maintain and build upon the positive standing as a state journal that VCJ had enjoyed for many years. We are also grateful to long-time Editorial Board member, Nadine Hartig, for her willingness to step up and assume the position of VCJ Editor beginning with Volume 36. Given Nadine’s Editorial Board experience and demonstrated commitment to the quality of the VCJ, we depart with confidence that the change in editorship will be a seamless one. We look forward to the publication of Volume 36!

Rip McAdams
Victoria Foster
Co-Editors, The Virginia Counselors Journal
Error Correction

An error was brought to our attention the publication of Volume 32 (Summer 2012) of the Virginia Counselors Journal. Article # 1-28-12 entitled The Relationship Between Social Support, Depression, and Income Level was erroneously published naming Dixie Meyer (the corresponding author) as the sole author, when there were actually multiple authors that should have been listed as follows: Meredith Haskins, Regent University; Dixie Meyer, Saint Louis University; Cynthia Harrell, E. O’Neill Hunter, & Nikki Pickett, Regent University. We apologize for this error and ask that VCJ readers to be apprised of the correct authorship of this article.

— Rip McAdams & Victoria Foster, Co-Editors, Virginia Counselors Journal
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An Interview with Eleanor Saslaw

Kevin Doyle, Longwood University

Abstract
Eleanor Saslaw has been a longtime leader in the counseling profession in Virginia, working as a school counselor and director of school counseling at several high schools in Northern Virginia during a distinguished career. She served as President of the Virginia Counselors Association in 1991-92 and has been recognized by VCA with both the John R. Cook Award (2011) and the Humanitarian and Caring Person Award (1995). In this interview she reflects on her career in the counseling profession, changes she has observed over the years, and future directions for counselors.

Introduction
Eleanor Saslaw sat down for an interview on July 22, 2015 at her home in Northern Virginia. Now retired from a distinguished career as a school counselor, she served as President of the Virginia Counselors Association (VCA) in 1991-92 and has been recognized with most of VCA’s highest awards. Her career spanned the decades that saw the counseling profession come into its own.

The Interview
KD: I’d like to start at the beginning, so let’s start with a little about your childhood and your upbringing.

ES: I was born in San Francisco, California, one of three children to Horace and Florence Berman. We came from a family that was always interested in activism and doing the best for the most people, and it just kind of became a part of me as I was growing up. We were transferred here because of my father’s profession in 1957, and I lived in Maryland until I got married in 1968, and have lived in Virginia ever since that time. I went to the University of Maryland and majored in social studies education with a minor in psychology and sociology, and I enjoyed all three. I was always particularly interested in how human behavior affected social trends and history and how human behavior could actually influence and change the course of history in many instances. I taught in Prince George’s County Maryland—taught social studies and math. At nighttime I went and got my Master’s (degree) in Counseling at the University of Maryland and then decided I’d really like to be in Fairfax County, so I applied for a counseling job in Fairfax County and got my first counseling job at Herndon High School. Herndon was a pretty new school at that time and very rural, and then from Herndon I went to Annandale High School, which was more suburban and becoming very diverse. From Annandale I went to Thomas Jefferson, a regional school emphasizing science and technology, and then to West Springfield (High School), another urban/suburban Fairfax County school, as Director of Student Services. So, I feel like I worked with the most limited students and the very brightest students, and I don't find a difference in the need for counseling in any of those groups. I find that intellectual capacity has very little influence on the amount of emotional support students may or may not need.

KD: Interesting. So your CV indicates you were a school counselor from 1973 to 1995, although in those days I guess you were probably referred to as a guidance counselor before we started using the school counselor term?

ES: Yes, in Fairfax County, that was actually true. They did not refer to it as a Guidance Director, but as Director of Pupil Personnel or Student Services. I enjoyed all my jobs and would not have changed my career for anything. It was very fulfilling, and I made a lot of contacts in a lot of places. Those contacts still occupy me today in working to make education better. Some of the people that I worked with then, I am still working with now in various organizations. At first I was active in the Fairfax Education Association and became their government relations chair, and that’s where I learned how to lobby for educational issues, because they have a wonderful, wonderful training program. Later, I felt the need to concentrate on counselor issues because they didn’t have the time to, and it wasn’t as much of a priority for them as it was for me, so I switched my priority to the Virginia Counselors Association and the Northern Virginia Counselors Association. I began to get into Government Relations there and was government relations chair for both the Virginia Counselors Association and the Northern Virginia Counselors Association, and then President of the Virginia Counselors Association.
KD: Going back to the beginning, what was it that led you to consider counseling as a career and to become a counselor?

ES: Because when I first started teaching, I was very young and like everybody else, didn't know much and learned on the job that it wasn't the intellectual ability that determined success or determined academic achievement. There were many other emotional, environmental, and social issues that were affecting my students, and I realized that you had to essentially support the whole child. I felt like I had to concentrate on supporting those students who were handicapped to be able to academically achieve, but when I went into counseling at Herndon High School, I was in for a rude shock. One of my students was both an alcoholic and a diabetic, and when dealing with his family I discovered that they were all alcoholics. There were so many issues that precluded this young man from being able to be successful! I knew there were issues, but the shock of this one particular student as a first-year counselor was amazing, and I just began to delve more deeply into the counseling profession.

KD: I remember Herndon very well at that time, as I was in high school—I was at Madison from 1974 to 1978 and there was a big sign on the Herndon gym wall that said “Big Red Country.” It seemed like we were way out in the sticks or something when we went out there.

ES: Yes, and at the time it seemed like you had to drive and drive and drive, and there was nothing there. Now there are shopping centers and things on both sides of the road—there was nothing but farms and trees back then.

KD: Farms back then?

ES: Yes, farms and that type of thing. Being brought up in the city and a pretty urban neighborhood, that was a new experience for me.

KD: What are your recollections of the counseling profession itself back in those years?

ES: Different than today. All of the people I worked with on the staff were very well meaning, but did not receive the education that we give counselors today. And I think I myself didn't receive that education but had to continue taking courses and educating myself and just realizing what some of the underlying principles should be in terms of supporting students. Diversity was just beginning to be an issue, because it wasn't really too long after schools had integrated in Virginia, and there were a lot of black-white issues we had to deal with. I would have to say that for the most part, they (the counselors) did well, and the attitudes were productive. The counselors involved the students in the planning and structuring the [integration] process but there were some fights, and there was some jealousy over dating. There were a lot of students who came from a very rural background, a rural farm background, who had very different attitudes from what students in Fairfax County have today. It was very interesting, and when the social workers, who were called “home visitors” or something like that, used to go out to these homes, the conditions were not what those of us coming from the middle class imagined. A lot of them did not even have running water or electricity or that type of thing; it was really rural. These kids would come to school, and we would expect them to be where the middle class kids were. They just weren't—they just hadn't been exposed.

KD: So, it was a different world then?

ES: Yes, a different world.

KD: How did you become involved in VCA?

ES: I had been active in the Fairfax Education Association as I told you earlier. I had been their government relations chair, and we did a lot of lobbying on educational issues for the school board, the Board of Supervisors on the state level, and even some national issues, and I just decided there needed to be more concentration on counselor issues. There was very little activity in the counselors association up until we started mobilizing more. I had gotten active when I first became a counselor. I was at Annandale at the time, in the Northern Virginia Counselors Association, and they did have an interest in issues, especially establishing the LPC. That was established, and we were very happy with that. One of the first issues we worked on at the state level was mandatory reimbursement for LPCs. Before that you had to go and get a doctor's signature to be able to practice, and that limited the profession substantially as you might imagine.

KD: Some of the previous interviewees have commented on that also.
ES: Yes, that was huge step, and we got mandatory reimbursement while I was Government Relations chair for VCA. That was a statewide issue, and I can still remember going before the House Committee. I wasn’t supposed to speak, but the person who was supposed to speak did not show up, and I got up and spoke very extemporaneously. They got it right away, and the bill passed—it absolutely passed!

KD: So moving through the 80s, you were the VCA President in 1991 and 1992. When licensure happened in the mid-70s what were some of the issues as the profession advanced that became prominent during your time in the leadership?

ES: Well, actually the first issue that became prominent and that I think galvanized the VCA was elementary counseling. At that time you have to remember, we had many different divisions in VCA, and we all worked together—the clinical counselors supported the school counselors’ issues and vice versa. So, everybody would lobby for everybody else’s issues, and it was a very positive and motivating environment. I think we created that environment by giving workshops explaining, for instance, what the state can do for your profession. The state writes all the rules and regulations and determines your salaries, and so these are the people we need to see. Well, the elementary counseling issue came up because it began to be a need in schools for various reasons. We were definitely becoming much more urbanized, and the issues that come along with urbanization were now coming along. We did research statewide, and there were some counties and some places that had already had elementary counseling for a period of years—Roanoke was one of them. We asked them [Roanoke] for their studies, because when we presented national statistics to the state legislature, they said, “Go back and show us success in Virginia.” So, we used the areas that had established elementary counseling programs and got testimonials and research statistics of how achievement improved. They (the legislature) didn’t want to hear about emotional support or anything like that—they wanted to hear that elementary counseling improves achievement, and we were able to document that. One of the people who I worked with was Libbie Hoffman, who was a former VCA President and who has now passed away, Suzee Leone, Gaynelle Whitlock, and KD: [the late] Pete Warren were all active in that effort. So when we got our stuff together, we went to the legislature, to particular legislators in the House and Senate first, who we knew were going to supportive like Jim Dillard and my husband [KD: Eleanor’s husband is Virginia State Senator Richard [Dick] Saslaw], and we presented them with the materials, and said, “What do you think?” They said, “Go for it.” And so we did, and they helped us. We also had people go to their own legislators, and we had workshops on how to lobby, how to address people, how to present information, how to be specific, and how to be focused. A lot of the legislators saw the elementary counseling issue as a money issue, and their response to anything that was as a money issue was just “Forget it” – that was kind of the way Virginia was on a lot of things at that time—“Why do we need it anyway?” But Governor Baliles was elected, and Governor Baliles had a history of losing his parents, and going through, what I would imagine, was a lot of turmoil when he was a child and then all this happened, and he was 100% in favor of it. He instructed his Secretary of Education, I think at that time it was Finley [KD: former Virginia Secretary of Education Donald Finley], to find a way to be able to fund having one elementary counselor per 500 students in every school in Virginia. The way they did it was to take one teacher position and make it an elementary counselor position. You can imagine that the principals and the teachers and everybody else were furious and were lobbying against that, but mainly because of the governor, I think, it happened. And then over a period of time, they [KD: elementary counselors] were phased in, and after my presidency, it became a part of the SOQ [KD: Standards of Quality]. It was really a long fought battle starting in the early 80s, and by the time that it actually became a part of the SOQ we were into the latter 90s. I remember Fairfax County called them [elementary counselors] “crisis resource teachers”—they didn’t even call them counselors. I can remember one of my friends who lobbied with me, Marjorie Bleweis. She is still doing mediation now; she was one of the crisis resource teachers, and she had a degree in elementary counseling. She was one of the first ones to have her title changed to elementary counselor. We introduced her everywhere. We’d say “Margie is an elementary school counselor.” Very quickly principals recognized the value of the position, and as a result, within a couple of years they did not want to give up their counselors. We had some further battles in terms of what exactly was the job of the elementary counselor,
and so another issue that we had to lobby for and got was the protection of the 60% counseling time [assurance that the majority of counselor time was used for counseling], and we got it. I couldn’t believe during this time, that we were getting all this stuff, because a lot of principals wanted to use them [KD: counselors] as clerks or administrators or, but the 60% protection of counseling time was another big step forward. Later the counselors’ time was divided into personal counseling vs. guidance lessons vs. group counseling, and counselors actually had to document their time to verify that they were actually doing what they were supposed to do. But I think these were battles well won. Except in particular counties, I did not see counselors having to fight them statewide anymore.

KD: And the 1:500 counselor to student ratio has stayed in effect?

ES: Yes, that has stayed in effect. It depends on the areas of the state, but I know in my county, they try to reduce that ratio when possible, but of course that depends on funding and other issues.

KD: Switching gears just a little bit…who were some of the major influences in your career?

ES: I had some good principals even when I was a teacher, who let me do anything I wanted. Of course you have to remember, we did not have Standards of Learning and that type of thing; everything wasn’t quite as structured. I remember my first year teaching my department chair wouldn’t let me do some things, so I went to my principal and I said “You, know, these kids don’t all need the same thing, they need different things.” I was teaching mostly 8th grade U.S. history at that time and some math. You have to remember, at that time we had the track system [separating students by academic ability]. I had 8.1, [KD: tracking the “really bright kids”] and also 8.12 [KD: tracking students who were largely illiterate], so I went to him and I said, “I need different materials for these classes.” I showed him what I wanted because I had done the research. One set of materials was for two very bright [8.1] classes. This was in Prince George’s County (Maryland), and learning history was a tough skill for 8th graders. I gave one class a textbook that was essentially original documents in U.S. history, and then I gave the other class a regular textbook that said this happened, then this happened, etc. And after the test I said “See how close you were? [KD: to writing history correctly based on reading the original documents as opposed to a traditional textbook]. You able to gleam what happened by actually reading the original documents” And they were! They complained, but they did it. For my very slow ones [the 8.12 track students], we used a different approach. We had numbered paragraphs and read it [KD: the textbook] out loud. Everything was very structured, and we explained each paragraph. You talk about times being different; these kids came from rural Prince George’s County and had very, very few advantages. So I had principals that let me do things like that when I went to them. They let me do stuff, and as a result I think I developed the idea that you have to start where your children are and teach to where they are and counsel to where they are. I think that became the basis for my going into counseling and trying to give as much support to kids as possible, which led to my interest in the association in elementary counseling and very many other things that I continued to do during the years. The other thing is when I became active in the Fairfax Education Association as well as the counseling associations, I just met very sincere, like-minded people. When I became active in VCA, some of the people who you have already interviewed, Bob Pate, Fred Adair, and of course, Pete Warren were really strong influences. Libbie Hoffman, Gaynelle Whitlock, Suzee Leone, and Leslie Kaplan were other ones. Leslie was really good on research, and she kind of structured us and helped the counselors learn how to document what they had done. There are a lot of counselors who don’t have that skill and don’t like to do that, just by the nature of their interest. My friend Marge Bleweis was also very, very active, and she got me interested in mediation later on. Then going from school to school and experiencing different populations, I realized that they could have very different needs, and I am realizing the same thing in a lot of what I am doing today on the community college board [KD: Eleanor has served on the board of the Virginia Community College system since 2014].

KD: How would you say that the profession has changed in your view and where do you see it heading?

ES: Well, I think people used to look at the school counselor kind of only for college prep students. When I went to high school, I saw my counselor only once a year, and she said “you are doing great”
and went over my transcript, and I didn't see her again until the next year. If you had an academic problem counselors might help you change your classes or teachers—that type of thing. There was not the scope or the understanding of what we see as the counselor doing today. I think that began to change probably in the early 80s or maybe late 70s, and it has continued to expand. I think it is just a much broader profession. You know, the thing I don’t like to see, and we had touched upon this earlier, is this separation [among the different counseling emphases]. I think we’re all on the same trajectory, and I think working together we can accomplish great things. I think if we splinter ourselves, we lose a lot of power and a lot of understanding. We [school counselors] have always had a relationship with clinical counselors. School counselors were able to recognize when a child needed to be referred for more extensive counseling, and we always had that give and take relationship. Now I don’t see that relationship being the same way it was before. I am not sure they [KD: school counselors] know the people that they refer to, and I think that knowing the people is very valuable. For example you know when a student really needs a male counselor, or a female counselor, for certain issues. It’s very valuable to know that person [KD: to whom you are referring students] and what they’re especially good at.

KD: It just struck me in listening to you that students seeing counselors probably is now a pretty universal experience. If you ask someone “have you ever been to see a counselor?” the person might say no, but in reality everybody over a certain age has at least interacted with a counselor in the school setting, at minimum at the end of the high school years as you prepare for that transition. So, everybody over a certain age has probably seen a counselor at some point, and then of course there are those with a diagnosed mental health condition who might have seen a clinical counselor.

ES: But often they see a school counselor first!

KD: Yes, behavioral problems might be starting to show up in the school setting.

ES: Behavioral problems and clinical depression are very observable—that’s a referral that is immediate and can be very effective. That happens over and over and over in the high school setting. Actually, even in the middle school setting you being to see it [depression], but once puberty hits it becomes more evident.

KD: I have a couple of more questions. What role do you see technology having in the evolution of the profession?

ES: I see it being a wonderful support. It can be very informational. I’ve seen the wonderful tools that Virginia uses to help children research career pathways and professions, find colleges, and use Face Time to connect with people in professions to help that research. I think taking the Myers Briggs and similar instruments can be very valuable. I know when I was at West Springfield, I had my staff, including the secretaries and the ADP operators, take the Myers Briggs, and we put together work groups as a result of it. We had all the 9th graders take the Myers Briggs, and we did Myers Briggs workshops with them to explain what it meant and how they could work with some people and why they might have conflicts with others. You could see the light go on when they developed an understanding. I think those kinds of tools can be an incredible support to counselors and other professionals. I think we would have to go back to the 19th century if we didn’t use them. They can just provide so much information.

KD: What advice do you have for those new members of our profession as counselors?

ES: The first advice I have is to really listen on the job. You know, sometimes a counselor’s day is so demanding and so busy that it’s just hard to take the time to pick up on the cue that could save a child’s life, and I have had that experience happen to me. So, listening would be the first thing in working with students. If this kid comes to you and he says he needs to talk, just really look and listen to the body language before you give them a pass to class and have them come back (later). You can prevent things like suicide by doing that. That’s the first thing I would say is to take that time. The second thing I would say is to become involved in everything that you can that relates to your profession, because it is so broadening—your experiences make you a much wiser person in the long run. Never stereotype or jump to conclusions, because a lot of times you can see something on the surface, or you think you see it, and there is so much possibility and so much depth by looking more closely. I am thinking
of students who, because of their background, had no understanding of their potential. They just lived in this world, that has told them what they are, and you have to take them out of that world and let them see what they can be. That covers a lot of territory. The other thing is to become involved in the associations, because they are as much a part of your growth as day-to-day experiences are. They are so incredibly broadening and a lot of fun. You know, you meet colleagues and just have experiences that you just don't get by coming to work every day.

KD: That’s good advice. The last part of this interview is really just to open it up to any further thoughts or reflections you have upon your career and the counseling profession—really anything that you feel like you haven’t touched upon already.

ES: Well, my career as a counselor and then as a counselor administrator, taught me a lot of skills. Also, because I was in a leadership position in the (professional) association and would work with people outside the counseling profession, I became known in the areas outside the counseling profession, and that projected me into positions where I could do more about things that affected counseling and counselors. I guess I am referring to my eight years on the Board of Education and two years as President of that Board. You talk about “fighting for your goal”—I had to do that there, too, because there are not always people who think what you think is important. So finding the right person for your issue is key. Only your experience and knowledge that you have gained over the years will let you know who the right person is; part of it is getting rid of your political naiveté, and part of it is realizing people whom you think hold very lofty [influential] positions. Those people often really do what to hear from you, and they really are interested in what’s going on at the very grassroots level, because they want to have an understanding, and they want to do the right thing. I’ll give you a very specific example. In 1992, Governor Wilder [KD: Virginia Governor L. Douglas Wilder] put me on as the Chair of this Committee on Girls and Education, because there was kind of a gender divide in terms of expectations and pathways. I had been doing workshops for quite a long time on that issue [KD: the divide between expectations for girls and boys] for parents in my county and for VCA. The people that I worked directly with were Jim Dyke and Suzette Denslow. Well, we put forth a whole series of recommendations…a lot of the things that we put in there became part of just general knowledge related to school systems. People, particularly parents, became very interested in their daughters’ education…because they realized by that time that their daughters were likely to do more than just get married, you know. So my association started then with Suzette Denslow, who was the Assistant Secretary of Education, and she later went and became part of [KD: Governor Mark] Warner’s staff and then [KD: Governor Tim] Kaine’s staff. When I was on the Board of Education, I said to Suzette, “We are getting all these SOL [Standards of Learning] statistics back, and no one looks at them—nobody uses them, except for a very few teachers for educational planning.” I said that schools should be using them for planning their curricula to support certain groups of students who are not doing well and for devising a curriculum for those students to approach their needs. Well, she just went right to the Governor and the Governor said “Absolutely, why the heck are we doing these SOLs if we don’t do that?” I had tried to create a position of coordinator to put all of that together with the principals when I was on the State Board but, again, money was an issue. They asked: “How are we going to fund it?” So, then, Suzette said, “Come talk to the Governor,” so I did. I also called two other colleagues, and they were also in support of it. Well, lo and behold, they created two tech positions, one for fixing the technology that was coming into the school and the other to educate teachers. Well, I could have talked to my superintendent ’til I was blue in the face, and nothing would have happened, so contacting Suzette and she then contacting the governor is a perfect example of going to the right person. You only develop that knowledge after years of participating, and it’s only due to the fact that I lobbied in the 80s, led some things in the first part of the 90s, got on to the State Board of Education in 2004, and had been lobbying for issues since the late 70s on education issues. You can then talk to others and say, “this is who you need to go to.” People with the experience can say, “Ok, that’s a great idea, but this is who you need to go to,” and then get your idea across. You need people who have some institutional know-how and knowledge to guide the others. That’s a key part, I think, for continuing your education and keeping people involved in your associations. Counselor educators have a key role in that, also. I think you have to...
begin to see your profession as very broad. I wanted the counselors association involved in the political process, and I finally did this through Suzee [KD: Leone, held leadership of the Virginia Counselors Association at that time], I said to Suzee, “The reading resource teachers are here and lobbying the board, the L.D. teachers are here lobbying the Board,” and I went through the list and I said, “Where are the counselors?” So, with a few jumps and starts, the counseling board hired a lobbyist, Pete Warren. You have to hire someone, because you can’t expect someone who is full-time employed to do that [lobbying]. There were lots of issues coming up that concerned counselors—that the counselors needed to weigh in on—otherwise people think the issues are not important.

KD: Right, you have to have a voice and be at the table.

ES: Exactly, so Suzee was the one I think who said to counselors: “Hey, Eleanor wants to know where you are?” [in terms of lobbying for counselor issues] VCA listened, and now we have Becky Bowers-Lanier [KD: VCA’s current lobbyist], and I think she does a very reputable job. At one point the Virginia school counselors met with me and said they wanted to accomplish this, this, this, and this, and I said “It’s already done!” It turns out that they were not involved enough [politically] to know we had already done the things they wanted just before they came to see me. I can’t be too tough on them though, they would have to have been at the meeting to know! It just shows how important being aware is. The other thing is that under my [VCA] presidency we established our first executive director, who was also Pete Warren, and he was wonderful! He was wonderful because he had so much knowledge and such a good heart that when things came up that needed to be handled by an Executive Director, he knew exactly what to do. I had followed him into the presidency, so I knew when we got that funding [for the Executive Director position], which was not very much, at that time, he did it because of his heart, not because of the money. I knew I wanted Pete in that position. Then we hired clerical staff, and we also hired our first lobbyist at that time. Vince Callahan [KD: the late former Virginia Delegate] recommended someone to us and we hired him [as the first VCA lobbyist]. The other thing we instituted was the Challenge Fund, which essentially is a PAC [KD: Political Action Committee], and we realized the necessity of contacting and supporting especially those who supported our issues. I think in terms of the whole metamorphosis of elementary counseling, our lobbying efforts have been successful; the 60% requirement for counseling time (for school counselors) was key. I think lobbyists are not that helpful in going to see people on your behalf, but they are so helpful in educating counselors on the issues in saying: “well, now is the time to do this, now is the time to contact this person.”

KD: Well, thank you so much. This is a wealth of information, and I am looking forward to transcribing it. It’s been a great follow-up to the previous interviews.

ES: I think we [the interviewees] are all of a like mind.

KD: They do complement each other nicely. It is good to trace the evolution of the profession, and I hope to continue to do these interviews as we move forward. Thank you!

Final Interviewer Reflections

Eleanor Saslaw was an engaging interviewee and retains her enthusiasm both for the counseling profession and for service in general. Although retired from her professional role as a school counselor, she continues to serve the greater good in many ways, including her current role as a board member for the Virginia Community College System. We can all learn from her tenacity, her dedication, and her cooperative spirit.

Author Note

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An Investigation of Perceived Ethical Infractions Among Peers and Supervisors in the Counseling Profession

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Abstract
Research on the ethical culture of the counseling profession has emphasized ethical infraction prevalence rates based on formal complaints and self-report measures, which is problematic given failures to report and/or sanction ethical infractions and social desirability biases. A survey design was utilized to examine a national sample (N=131) of counselors’ perceptions of ethical infractions committed by peers and supervisors. Results indicated that 35.1% of participants perceived ethical infractions committed by peers within the last six months, 27.5% by supervisors. Considering the effects of ethical infractions on clients and the profession broadly, implications for counselor preparation and further research are suggested.

Keywords: professional ethics, ethical infractions

Ethical behavior is a core component of counselors’ professional identity and refers to “making responsible decisions every day in every context” (Rowe & Kellam, 2011, p. 55). As outlined by the American Counseling Association’s Code of Ethics (ACA, 2014), the “primary responsibility of counselors is to respect the dignity and to promote the welfare of clients” (A.1.a). Unethical behavior can undermine the counseling process, damage the therapeutic relationship, and have negative repercussions for clients (Gregorie, Yungers, & White, 2012; Moleski & Kiselica, 2005).

Counselors have multiple resources to help navigate ethical complexities and dilemmas, including professional ethical codes, ethical decision-making models, and clinical supervision (ACA, 2014; Bradley & Hendricks, 2008; Forster-Miller & Davis, 1996). Professional organizations and state licensing boards protect the public by conducting formal investigations and sanctions (Neukrug, Milliken & Walden, 2001; Welfel, 2012). In order to protect the public and the client, counselors are required to intervene through informal resolution or report concerns to specified governing bodies when unethical behaviors are suspected in self or others. Informal resolutions might consist of speaking to the peer about the concerns, validating the existence of the issue, or offering a remediation plan (ACA, 2014). If an informal remediation does not alleviate the problematic behavior or is not deemed appropriate due to the severity of the alleged infraction (e.g., client romantic relationships), an ethical grievance complaint is filed with a governing body (e.g., ACA, state licensure board) (Welfel, 2012). An investigation then occurs to determine the veracity of the alleged ethical breach. If the accused is found in violation, then the incident and ethical findings become public knowledge (Neukrug et al., 2001).

Ethical culture refers to ethicality from an organizational standpoint across different dimensions including the visibility of (un)ethical behavior, role modeling of superiors’ behaviors, and reinforcement of ethical behavior (Kaptein, 2011). Historically, understanding of the status of ethical culture within the counseling profession has relied on reports of formal ethical complaints resulting in a determination of a violation. However, this means of understanding provides a limited perspective, as suspected ethical violations are not always publically reported or filed (Neukrug et al., 2001). In addition, ethical infractions are typically reported to a specific professional/governing organization, thus rendering a comprehensive national snapshot of ethical culture within the counseling profession difficult. Ultimately, this partial picture of (un)ethical culture in the profession may leave the profession ill prepared to intervene.

Enhanced knowledge of current ethical culture in the counseling profession may better equip the profession to more proactively intervene on ethical violations, address potential trends, and ultimately,
safeguard clients and the profession broadly. The purpose of this research was to explore perceptions of ethical culture within the counseling profession. A national sample of counseling practitioners completed a descriptive survey assessing rates of peers’ alleged unethical infractions. Due to social desirability response bias, utilization of peer perspectives (versus self-report) is particularly warranted when investigating ethical perceptions and culture (Randall & Fernandez, 1991). Social desirability relates to the effect of one conforming to social norms, through deception of actual facts in favor of self-reports that are considered to be socially acceptable (Randall & Fernandez, 1991). Through peer assessment, this study aimed to understand perceived unethical prevalence rates, grounding future research and substantiating interventions congruent with a professional counseling identity that honors client care/rights.

Method

Sampling

A convenience sample was used, with participants recruited through the distribution of a research survey via online list-serves specific to the counseling profession; social media sites established with a counseling theme (e.g., LinkedIn and Facebook counseling groups and pages); and, through participant word of mouth. Criteria for participants included: (a) professional association with the counseling profession as evidenced through current enrollment or graduation from a graduate level counseling program, (b) completion of a graduate level counseling ethics course or related training, and (c) current clinical practice in the field of counseling as defined through practicum/internship or fieldwork experience.

A total of 146 participants attempted to participate in this study. Of these 146 attempts, 131 (89.7%) surveys were deemed usable for research purposes. Unusable surveys consisted of participants not meeting inclusion criteria, submitting blank surveys, and omitting responses to relevant data fields. Due to blank surveys (n=9), the extent to which participant demographics of omitted surveys differed from the rest of the sample could not be determined. Additionally, while the participation rate is ascertainable for those who attempted the survey, participation rate at the individual level is unknown as information about those who received the instrument and elected not to participate was not collected.

Participants

Demographic information from the total sample (N=131) indicated that 78.6% of participants identified as female (n=103), 19.1% as male (n=25), and 0.8% (n=1) as transgender, with 1.5% (n=2) “preferring not to answer.” Participants’ ages ranged from 22-73 years, with a mean age of 37.9 years and a median age of 33 years. Over eighty-percent (n=105, 80.2%) of the participants identified as Caucasian, 8.4% (n=11) as African American, 3.8% as Asian (n=5), 3.8% as Latino/a (n=5), 3.1% as Bi-Racial (n=4), and 0.8% as Indian (n=1). Participants reported on all applicable specialized areas of training/practice (N=131), identifying with one or more of the following: 62.6% in community mental health (n=82), 34.4% in marriage and family counseling (n=45), 24.4% in addictions counseling (n=32), 19.8% in counselor education and supervision (n=26), 19.8% in school counseling (n=26), 13.0% in inpatient mental health (n=17), 8.4% in rehabilitation counseling (n=11), 7.6% in career counseling (n=10), 4.6% crisis/trauma counseling (n=6), 3.1% in counseling children and adolescents (n=4), 3.1% in play therapy (n=4), 1.5% in college counseling (n=2), and 0.8% in Christian counseling (n=1).

The Survey Questions

Two main survey items and two continuation items were developed to examine the prevalence of alleged unethical peer behaviors considering the research objectives (Creswell, 2009) and using recommendations set forth by Fowler (1995); survey questions were designed to be answerable, specific, and measurable. A methodologist expert with over 30 years of experience then reviewed the survey items, resulting in the following two main questions: (a) In the last six months, have you witnessed or been aware of a work-peer engaging in perceived unethical behavior?; and (b) In the last six months, have you witnessed or been aware of a work supervisor/boss engaging in perceived unethical behavior? Responses were provided on a binary scale of either “yes” or “no.” As to determine the frequency of the perceived ethical infractions, responses of “yes” triggered a continuation item to appear after each main question; responses of “no” did not include these additional items. The continuation item was answered.
using a text response in which the participant answered the following item: *approximately how many infractions have you witnessed or been aware of in the past six months.*

**Procedures**

A call for participation and an online Qualtrics link was distributed via the aforementioned online recruitment channels. Prior to data analysis, inclusion criteria were compared to participants’ noted demographics, verifying that represented participants met the inclusion criteria (e.g., counselors training and working in the field). Contact information was provided for ACA's ethical consultation division; participants were encouraged to contact ACA if they had questions or concerns related to potential witnessed ethical infractions.

**Analysis**

The Statistical Package for the Social Sciences (SPSS) was used to analyze descriptive data of participants and the survey items. Percentages and frequencies were calculated for participant demographics. Survey item analysis included each item's percentage, range, mean, and standard deviation scores.

### Table 1. Descriptive Statistics for Peer and Boss/Supervisor Unethical Infractions

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Response</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <em>In the last six months, have you witnessed or been aware of a work-peer engaging in perceived unethical behavior?</em></td>
<td>Yes (1)</td>
<td>46</td>
<td>1.65</td>
<td>0.48</td>
</tr>
<tr>
<td></td>
<td>No (2)</td>
<td>85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.a. <em>If “yes” approximately how many infractions have you witnessed or been aware of in the past six months?</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>43</td>
<td>4.70</td>
<td>3.76</td>
</tr>
<tr>
<td>2. <em>In the last six months, have you witnessed or been aware of a work supervisor/boss engaging in perceived unethical behavior?</em></td>
<td>Yes (1)</td>
<td>36</td>
<td>1.73</td>
<td>0.45</td>
</tr>
<tr>
<td></td>
<td>No (2)</td>
<td>95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.a. <em>If “yes” approximately how many infractions have you witnessed or been aware of in the past six months?</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>34</td>
<td>4.74</td>
<td>3.92</td>
</tr>
</tbody>
</table>

**Note**: N = 131; For items 1.a. and 2.a., only numeric text responses are considered in the above table analyses

**Results**

An exploratory survey was designed to assess practitioners' perception of ethical culture in the counseling profession. Specifically, participants provided perceptions of potential unethical behaviors of work peers and supervisors/bosses over the last 6 months. Survey results are presented below and summarized in Table 1.

### Perceived Unethical Behaviors Among Work Peers

For survey item one (i.e., work peer infractions), 35.1% of participants (n=46) stated “yes” and 64.9% of participants (n=85) reported “no” when asked of being aware of a work-peer acting unethically, (M=1.65, SD=0.48). For participants answering “yes,” a continuation item appeared to gauge ethical infraction frequency. As a text response was used for this item, not all answers were numerical, including one participant reporting “not sure” and another stating “too many to count.” From participants who numerically reported the incidents (n=43), the frequency of perceived ethical infractions ranged from one to 20 (M=4.70, SD=3.76).

### Perceived Unethical Behaviors Among Work Supervisors or Bosses

When reporting on item two (i.e., boss/supervisor infractions), 27.5% of participants (n=36) stated “yes” and 72.5% of participants (n=95) reported “no” when asked of being aware of a boss/supervisor acting unethically, (M=1.73, SD=0.45). For participants answering “yes,” the text response continuation item appeared and one participant did not answer numerically; one response of “many” was given. From
participants who numerically reported the incidents (n=34), the frequency of perceived ethical infraction ranged from one to 20 (M=4.74, SD=3.92).

Discussion
The results of this study indicated counselors frequently perceive that their peers and work supervisors are committing ethical violations. The prevalence of perceived unethical behaviors is alarming considering the short- and long-term implications ethical infractions can have on clients. The negative impact of counselors’ unethical behaviors on clients may include emotional and physical repercussions, such as: client exploitation, degradation of client autonomy, decline of client interpersonal abilities (Moleski & Kiselica, 2005), shame, depression, isolation, and self-harm (Gregoire et al., 2012). Though consequences vary contingent on contextual factors (e.g., severity, frequency, client perceptions), they almost certainly undermine therapeutic processes, leading to disengagement (Gregoire et al., 2012; Moleski & Kiselica, 2005). A client whose therapist allegedly exhibited non-professional boundaries (i.e., inappropriate self-disclosure) reported that he/she felt “there were moments when it seemed like my therapist was crazier than I was” and as if “I was the therapist and she was the patient getting everything off her chest” (Audet, 2011, p. 95).

Further, in addition to harming clients, violation of ethical codes represents an affront to the integrity of the counseling profession itself. Acting with ethical intent represents a core philosophy of the counseling profession (ACA, 2014). Moral principles serve as pillars for specific ethical codes and standards in the mental health field (Welfel, 2012) and can be seen ubiquitously throughout counseling professional ethical codes, including those of the American Association for Marriage and Family Therapy (AAMFT, 2012), ACA (2014), American Mental Health Counselors Association (AMHCA, 2010), American School Counselor Association (ASCA, 2010), and National Board for Certified Counselors (NBCC, 2012) Ethical Codes. A counselor’s duty is to do no harm (i.e., non-maleficence) and “promote the welfare of the client” (ACA, 2014, A.1.a). Results of this study support the assertion that, although ethical codes “may be enormously important…we must also be attentive to the shortcomings” (Gergen, 2001, p. 2). Beyond codes of ethics, internalized professional ethical identities seem essential to uphold the daily enactment of the professional ethical responsibilities and commitments of counselors (Houser & Thoma, 2012).

Limitations of the Study
Several limitations of the study should be considered when interpreting the results. First, a convenience sample was utilized, with participant recruitment transpiring through venues most likely requiring Internet access; such participant samples can impact representativeness of the desired population. The self-report nature of the survey questions also may have contributed to an over- or under-estimation of prevalence rates of perceived ethical violations. Specific details on the types of alleged infractions were not gathered due to the exploratory nature of this study; hence infraction ethicality could not be verified. In addition, participants may have been exposed to an unethical behavior but not reported it due to a lack of knowledge of such exposure. Finally, the exploratory nature of this study led to limited questions on alleged unethical infractions with the justification of: (a) increasing participation rates, (b) determining if this is indeed a potential issue within the profession, and (c) substantiating a need to investigate this phenomenon in a more detailed fashion.

Implications for Counselor Preparation and Training
Several implications for enhanced counselor preparation and training emerge from this study. Though additional research is indicated to examine the specific nature of perceived ethical infractions and the effects of ethical culture on professional counselors, a common occurrence of ethical infractions (perceived or actual) has been substantiated. The ACA Code of Ethics (2014) clearly reflects a responsibility that professional counselors, including counselors-in-training, recognize and address problematic ethical behavior among others. However, enacting this responsibility may be easier said than done. Counselors may be reluctant to discuss or report ethical misconduct among peers with whom they also have a personal relationship. Additionally, addressing perceived ethical misconduct among supervisors is complicated by power dynamics and potential negative implications on an individual’s status and safety within the work place.
Given that more than one-third of participants observed recent ethical infractions among peers and more than one-quarter of participants among supervisors/bosses, greater attention to specific facets of ethical culture counselors may encounter is needed. More explicit integration of honest and realistic discussion of these realities is suggested. Toward this, counselor educators and supervisors are well served to share experiences from their own practice related to the perceived ethical misconduct of others. Counselor educators and supervisors may enumerate steps involved in recognizing the misconduct, identifying internal or external conflicts that may have been present during their consideration of necessary actions, and examining implications of choosing to address or not address perceived misconduct. Integration of panel-based discussions of professionals from a variety of work settings including legal and human resources personnel is recommended. Strategies for seeking mentorship and guidance outside of one's work setting may also be generated through in-class and supervision discussions.

**Training tools.** Targeted utilization of ethical decision-making models and role-plays may help bridge indicated gaps in counselors' ethics training. Within ethics courses and professional development settings, ethical decision making models are often discussed as tools that assist counselors in navigating ethical challenges that may arise with clients. Extending the application of ethical decision-making models to also include navigating the ethical culture of work settings seems beneficial. Coursework and professional development trainings may also consider greater attention to workplace concerns within ethical dilemmas used for instruction.

The use of role-plays is suggested to facilitate practice enacting professional responsibilities related to recognizing and addressing the ethical misconduct of others. Role-play scenarios may attend to how to identify an ethical infraction, moving through the steps of an ethical decision making model, and broaching conversations with peers and supervisors. Role-plays provide counselors with the opportunity to receive feedback on how to have more difficult conversations, as well as the opportunity to discover potential challenges or nuances that may emerge within discussions.

**Implications for Future Research**

Despite the aforementioned limitations, this study adds to the counseling literature by delineating potential areas for concern within the ethical culture of the counseling profession. Greater understanding is necessary to mitigate ethical concerns and safeguard clients, as well as the profession more broadly. Results of this study suggest the following areas for further research: (a) nature of ethical infractions, (b) response to ethical infractions, (c) effects of an unethical culture, and (d) supervisors and alleged ethical infractions.

**Nature of ethical infractions.** Not collecting information about the specific nature of perceived ethical infractions was a noted limitation of the current study. Knowledge about the type of perceived ethical infractions would assist the profession in understanding the prevalence, as well as suggested areas of focus for ethics courses, continuing education, and other professional development opportunities. While extant literature does address common ethical infractions investigated by state licensing boards (Even & Robinson, 2013; Neukrug et al., 2001), it is important to note that not all ethical infractions are reported/investigated. Understanding ethical culture as conceptualized in the frontlines seems to provide a more realistic and proactive picture that can better inform prevention efforts. Future researchers may consider assessing the nature and veracity of alleged infractions through the use of follow-up interviews or survey specific questions.

**Response to ethical infractions.** Along with understanding the nature of ethical infractions, the response (of lack of) to these behaviors warrants consideration. Counselors have an ethical obligation to “take appropriate action” when they possess “knowledge that raises doubts” about others' ethical behavior (ACA, 2014, H.2.a). Required actions vary and may encompass internal/informal resolution or may eventually lead to reporting the behavior to the appropriate agencies if unresolved (ACA, 2014; NBCC, 2012). Considering that more than one-third of participants (35.6%) reported awareness of peers' engagement in potential ethical infractions, the question arises of how/if these situations are being addressed? Are counselors fulfilling their ethical obligations and taking some type of intervening action? This area of research becomes even more urgent if it is revealed counselors are not intervening, as failure to act on a known ethical infraction is an
ethical infraction in and of itself (ACA, 2014; NBCC, 2012). Interviews or survey questions may be fruitful in future research to assess participants’ emotional and behavioral reactions to others’ ethical infractions.

**Effects of unethical culture.** Normalization of behaviors within one’s environment is a concept rooted in social learning theory (Bandura, 1977). Research indicates that exposure to unethical activities by work peers and supervisors may contribute to an increased magnitude of ethical infractions within organizational contexts by creating normative effects (Kaptein, 2011; Mumford et al., 2009; Randle, 2003). However, a gap exists in the current literature, as unethical cultures and their subsequent ramifications have not fully been studied within the context of the counseling profession. Further consideration to social learning theory and ethical culture becomes substantiated, considering that over a third of participants in this study reported awareness of peer alleged infractions. Future research may explore how participants’ ethical identity is affected and shaped when exposed to unethical role modeling by peers.

**Supervisors and alleged ethical infractions.** Prior research has highlighted the negative impact of supervisors’ unethical behavior on supervisees, including the potential for unethical role modeling in organizational contexts (Kaptein, 2011) and causing supervisee moral distress within counseling contexts (Nuttgens & Chang, 2013). Within the counseling profession, a supervisor takes on a specific role in which he/she is bound to behave ethically and also serve as a role model for the supervisee (ACA, 2014; Bernard & Goodyear, 2009; NBCC, 2012).

Considering that 27.5% of participants reported awareness of perceived unethical behavior from their supervisor or boss, subsequent ramifications of such unethical cultures warrants attention. Particularly, within the context of counseling, how does an unethical supervisor impact supervisees and/or the ethical culture of the work organization? Given the power differential between the supervisor and supervisee, research also may investigate this phenomenon from the perspective of the supervisee. As previously discussed, counselors have an ethical obligation to intervene when cognizant of others’ unethical behaviors (ACA, 2014; NBCC, 2012); however, the power differential might muddle, complicate, and thwart the appropriate course of action if the alleged perpetrator is one’s supervisor/boss (Bernard & Goodyear, 2009). Ultimately, more research is needed that examines the relationship between these role dynamics and the supervisee’s subsequent actions/perceptions.

**Conclusion**

Counselors have an obligation to understand and apply the profession’s ethical codes (ACA, 2014). Ethical violations negate the moral pillars that ground ethical codes, resulting in potential client and professional harm. Necessary professional attention to ethical infractions extends beyond behaviors formally reported and sanctioned. Emphasis should be given to barriers to ethical decision-making, and also to reporting ethical infractions. The findings of this study are a reminder that ethical behavior extends beyond reasoning to also include abilities to recognize and act on ethical and moral violations (Rest, Narvaez, Bebeau, & Thoma, 1999). It is only with this comprehensive understanding of ethics that counselors are optimally positioned to protect the welfare of the clients and professional field they are entrusted to uphold.

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References


Compassion Fatigue and Satisfaction among Critical Incident Stress Management (CISM) Providers: A Study on Risk and Mitigating Factors

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Abstract
Critical incident stress management (CISM) providers experience indirect trauma exposure due to their invaluable work with trauma survivors but have received little attention on their risk for compassion fatigue and potential for compassion satisfaction. International Critical Incident Stress Foundation members (N = 473) were administered the compassion fatigue, burnout, and compassion satisfaction subscales of the Professional Quality of Life Scale R-V. Data analysis examined nine risk factors including gender, age, years of experience in CISM, dose of trauma exposure, personal trauma history, education level, leader type, personal debriefing, and emotional separation (Maintenance of Emotional Separation Scale). Results indicated low levels of compassion fatigue and high levels of compassion satisfaction in this sample. The model of nine risk factors significantly predicted compassion fatigue, burnout, and compassion satisfaction in regression analyses. Emotional separation and debriefing were the two strongest predictor variables and may be key factors in compassion fatigue prevention training programs.

Keywords: compassion fatigue, emotional separation, CISM

Events that cause physical, mental, and emotional pain are unfortunately part of human life. These traumatic events may produce a ripple effect of symptomology among individuals who directly experience the trauma as well as the support network around them. According to the DSM-V, repeated exposure to aversive details of a traumatic event is a criterion for Post-traumatic Stress Disorder (PTSD), which includes the indirect exposure of listening to the stories of trauma survivors (APA, 2013). Indirect trauma exposure may lead to the same degree of post trauma symptoms as an exposure to the event itself (Baranowsky, Gentry, & Shultz, 2011). Consequently, trauma workers, who are frequently engaged in trauma narratives, may experience the same emotions and symptoms as primary victims (Pulido, 2012).

Although trauma workers offer an invaluable service to primary and secondary trauma victims, there exists a potential cost of providing this level of care. Poignantly described, “When traumatologists enter their clients worlds, it is no longer possible to deny the potential for trauma in their own lives” (Myers & Wee, 2005, p. 115). Indirect exposure to trauma can lead to emotional, behavioral, physical, relational, spiritual, and cognitive changes for trauma treatment providers (Bride, Radey, & Figley, 2007; ICISF, 2010), and these symptoms may lead to a form of secondary PTSD also known as Secondary Traumatic Stress (STS).

Figley (2002b) coined the term compassion fatigue, as a more user-friendly name for STS. Compassion fatigue is characterized by depressed mood, fatigue, intrusive thoughts, disillusionment, and feelings of worthlessness as a result from working directly with traumatized individuals (Circenis & Millere, 2011). The disorder is commonly defined in the literature as “the trauma suffered by the helping professional” (Conrad & Kellar-Guenther, 2006, p. 1071). Figley’s (2002a) compassion fatigue etiology model includes identified risk factors (empathy and trauma exposure), protective factors (emotional separation and compassion satisfaction), and posttraumatic stress symptoms (intrusive thoughts and impairment in functioning). The emotional energy and connectivity that extending compassion necessitates must operate within boundaries and limitations to prevent PTSD symptoms in the treatment provider. A key concept in Figley’s model is the use of emotional separation in trauma treatment as a mitigating factor in compassion fatigue development.

Emotional Separation

The term emotional contagion is defined as “the degree to which a person is vulnerable to ‘catching’ and sharing the emotion experienced by another” (Siebert, Siebert, & Taylor-McLaughlin, 2007, p. 47). Emotional contagion differs from empathy and countertransference in that it only refers to a transfer of mood and not a re-experience
of a traumatic situation. However, a distinguishing feature in effectively managing emotional contagion, empathy, and countertransference may be emotional separation.

Emotional separation is the ability to form appropriate boundaries between treatment provider and client while maintaining empathy and a therapeutic alliance. In his seminal work, Corcoran (1989) concluded that the correlation between empathy and burnout became insignificant after controlling for emotional separation. Additionally, a study by Badger, Royse, and Craig (2008) demonstrated emotional separation as one of the strongest predictor variables of compassion fatigue, however, emotional separation has received minimal attention in the literature. Badger et al. (2008) proposed that failure to emotionally differentiate from the trauma clients may be the critical pathway to the development of compassion fatigue.

If emotional separation is indeed a critical determinant of compassion fatigue vulnerability, then education on the topic is imperative for all professionals who work with trauma survivors. Trauma workers and clinicians may not have been sufficiently instructed as students on the personal hazards of empathy and how to self-regulate this emotion (Jacobson, 2012; Salston & Figley, 2003). Education on effective emotional separation may significantly reduce the risk of compassion fatigue (Figley, 2002a). Professional training programs such as graduate schools, supervision programs, continuing education classes, and trauma-related conferences offer the opportunity to prepare trauma workers for real-world practice. Cunningham (2004) suggested providing counseling students a framework to understand their own personal responses to trauma would improve their ability to emotionally differentiate from their clients.

Critical Incident Stress Management

One population who may experience traumatic stress resulting from indirect trauma exposure is critical incident stress management (CISM) providers. CISM is a comprehensive response system to traumatic events that consists of multiple crisis interventions covering the temporal spectrum of a crisis (Guenthner, 2012). CISM providers include both professional mental health clinicians and trained peers (paraprofessionals such as firefighters and chaplains) on the front lines of assisting individuals after critical incidents and receive training through the International Critical Incident Stress Foundation (ICISF) or other organizations such as the Green Cross Academy of Traumatology. Gentry, Baranowsky, and Dunning (2002) included CISM providers in their list of professionals who work closely to trauma and may be at high risk for developing compassion fatigue.

The primary goals of this study are to (a) better understand the impact of indirect exposure to trauma on a sample of CISM providers, (b) investigate the variables that may increase the risk of compassion fatigue development as a result of CISM trauma work, and (c) explore potential compassion fatigue risk reduction factors such as emotional separation and compassion satisfaction.

Previous Research on Compassion Fatigue

Evidence of compassion fatigue risk has been found in various trauma treatment providers and emergency response populations. Craig and Sprang (2010) studied compassion fatigue, compassion satisfaction, and burnout among a large number (N = 532) of mental health providers in the United States. A high level of indirect exposure (large number of PTSD clients on their caseload) was a significant predictor of compassion fatigue. Additionally, Badger et al. (2008) examined factors contributing to STS in hospital social workers, and results indicated that emotional separation and occupational stress accounted for approximately half of the variance in scores on the Secondary Traumatic Stress Scale (Bride, Robinson, Yegidis, & Figley, 2004). These two variables were strong predictors of STS and reflect the need for emotional boundaries and management of job stressors when working with trauma survivors.

Compassion fatigue was examined among 53 social workers that worked in two major hospitals in Israel (Cohen, Gagin, & Peled-Aram, 2006). Results indicated very low levels of compassion fatigue among the hospital social workers despite the fact that they were each exposed to an average of four terrorist attacks and provided direct care to victims of these attacks. The researchers attributed these lower levels of compassion fatigue to clinical supervision and to debriefings after each terrorist attack.
Wee and Myers (2003) administered Figley’s (1995) Compassion Fatigue and Compassion Satisfaction Scale and the Critical Incident Stress Management Provider Questionnaire for demographic information in one of the few studies examining compassion fatigue in the CISM population. Over half of respondents (58%) reported experiencing psychological distress as a result of providing CISM services, and 40% were at moderate to high risk for compassion fatigue. While the distress from working with primary and secondary trauma victims was evident, the vast majority of respondents reported low burnout and high compassion satisfaction. The researchers concluded that the CISM work was so rewarding that it mitigated the effects of burnout.

Compassion Fatigue as an Occupational Hazard

Compassion fatigue is now considered an occupational hazard and may significantly reduce an individual’s ability to function at home, at work, and in relationships (Adams, Boccarino, & Figley, 2006; Bride, 2007; Gentry et al., 2002). Compassion fatigue has also been shown in previous studies to lead to burnout and result in job attrition (Cunningham, 2003). Job attrition could be especially damaging considering that most CISM providers, both peer and mental health, are volunteers who sacrifice their own time to help others. Losing trained volunteers may be detrimental to trauma victims, their families, and their communities. However, despite Figley’s work in bringing compassion fatigue to the forefront in the last two decades, there is still a lack of sufficient studies that evaluate the effects of trauma exposure and what variables contribute to the transmission of traumatic stress to trauma workers (MacRitchie & Leibowitz, 2010).

Methods and Procedures

This study examined the potential risk factors of compassion fatigue in the CISM provider population including gender, age, years of experience in CISM, amount of trauma exposure, personal trauma history, education level, leader type (mental health or peer), personal debriefing, and emotional separation as predictor variables. Personal debriefing in this study included individual one-to-one processing with a peer, group interventions, and supervision after providing trauma services. The criterion variables were the three subscales of the Professional Quality of Life Scale (ProQOL R-V): STS, burnout, and compassion satisfaction. The design of this study was a descriptive quantitative design utilizing a cross-sectional survey with a convenience sample of the CISM international population.

Participants

Participants were members of International Critical Incident Stress Foundation (ICISF). ICISF members provide CISM services worldwide as individuals and teams from a variety of professional backgrounds. Categorically, there are two types of CISM providers: mental health professionals and peers. Mental health providers included master’s and doctoral- level mental health professionals who received specialized training in working with crisis situations and the first responder community. Peers included professionals from the first responder community such as fire, EMS, law enforcement, and 911 dispatch as well as chaplains and other clergy. Peers received training in crisis intervention alongside the mental health professionals and are both paid and volunteer individuals, and it is assumed that all participants utilize the various components of the Mitchell model of CISM due to the fact that the Mitchell model is the foundation of ICISF training. This study includes only participants who stated on the demographics questionnaire that they had provided CISM services within the last 2 years.

Instruments

Demographics questionnaire. The demographics questionnaire included background information for the predictor variables such as age, gender, and frequency of providing CISM services.

Maintenance of Emotional Separation Scale. The Maintenance of Emotional Separation Scale (MES), developed by Corcoran (1982), measures the degree an individual is able to emotionally differentiate self from others. The MES consists of seven items intended to measure emotional separation and is scored by summing the items. Item number four was reversed for the purpose of scoring. Therefore, the higher scores represent lower ability to maintain emotional separation. The scale demonstrated construct validity by establishing a significant negative relationship with empathy scores. The internal consistency reliability is acceptable, Cronbach’s alpha = 0.71 (Badger et al., 2008).
Professional Quality of Life Scale. The ProQOL-R-V is a standardized instrument intended to measure how well an individual feels in response to their professional position as a “helper” to others. The concept "quality of life" reflects both the positive and negative aspects of the helping professions (Stamm, 2010). The ProQOL is a 30-item self-report scale divided into three subscales: STS (compassion fatigue), burnout, and compassion satisfaction. Respondents are instructed to answer questions according to how they have experienced the item in the past 30 days. Each item is scored on a 0 to 6 Likert scale (0 = never, 1 = rarely, 2 = rarely, 3 = sometimes, 4 = often, and 5 = very often). The ProQOL is an appropriate instrument for measuring the occupational hazard of providing trauma work (Bride, Radey, et al., 2007).

Data Collection

Data was collected from the ICISF member email distribution list from January 29, 2013 to March 1, 2013. The email was sent to 2,194 email addresses; 56 bounced back due to invalid information, leaving a total of 2,138 possible respondents. There were 62 participants who only answered the demographics questionnaire and not the MESS or ProQOL instruments. These cases were considered missing data and were eliminated from the database resulting in a total sample of N = 473. This represents a 22% response rate. A sample size of at least 135 participants was necessary to meet the multiple regression criteria of at least 15 participants per nine independent variables (Mertler & Vannatta, 2010). Participants followed a link to Survey Monkey, an online survey vehicle.

Findings

A total of 473 participants in this study, approximately 42% were female and 57% female. Participants reported age in 10-year brackets, and 58% were over the age of 55 years old. The average number of years they provided CISM services was 13 years, and services were usually provided either monthly or quarterly. The vast majority of participants (83%) provided CISM services in the United States, and 74% of participants provided these services on a voluntary basis. Approximately 40% of participants were mental health professionals, and the other 60% were peer providers. The most common profession of peer providers was chaplain followed by clergy and pastors. While most participants reported that they had not experienced childhood abuse (70%), 12% of the individuals reported physical abuse, 21% reported mental abuse, and 13% reported sexual abuse. The vast majority of participants were Caucasian (94%) and had completed some graduate-level education (73%). On the MESS, approximately 66% of the participants scored in the middle range (scores between 2.0 and 3.0).

Normative statistics of criterion variables were tested prior to data analysis to ensure that assumptions were met for regression tests. Mahalanobis distances were compared with critical Chi-squared values and an alpha level at .05. The nine predictor variables were used to determine the degrees of freedom. Chi-squared values were compared to cut-off values in Mertler and Vanatta (2010) for all three dependent variables, and no outliers were found. The subscales showed normal distributions on histograms and P-P plots. Linearity was acceptable, and skewness and kurtosis were within reasonable limits. Bivariate correlations were calculated between variables. Multicollinearity was determined to not be a concern due to the fact that no correlations were r = .85 or greater.

Overall, compassion fatigue and burnout scores were relatively low as indicated on the STS. The mean raw scores on the compassion fatigue and burnout subscales on this assessment were 17.89 (out of a possible 50) and 17.75 respectively, suggesting low risk. Additionally, the compassion satisfaction scores were high for these CISM providers with a mean raw score of 43.63 (out of a possible 50), and this mean score falls above the cut off score (42 or above) for high compassion satisfaction.

Regression results indicated that the overall model significantly predicted compassion fatigue (on the STS subscale) $R^2 = .29$, $R^2_{adj} = .27$, $F(9,427) = 18.99$, $p < .001$. This model accounted for 27.1% of the variance in compassion fatigue scores. Within the model, the respondents’ frequency of providing services, $B = -1.32$, $\beta = -.15$, $p < .001$, and maintenance of emotional separation, $B = 8.7$, $\beta = .48$, $p < .001$, were the strongest predictors of compassion fatigue. Frequency of providing services, classification of CISM provider, education level, and MESS scores were the variables that significantly contributed to the model. Further analyses indicated that STS was highest in participants who conducted CISM services.
more frequently, higher among college graduates compared to high school graduates, and higher in peer providers compared to mental health providers.

Regression results indicated that the overall model also significantly predicted burnout, $R^2 = .21$, $R^2_{adj} = .19$, $F(9,427) = 12.46$, $p < .001$. The nine predictor variables combined to significantly account for 19% of the variance in burnout scores. Within the model, the respondents’ maintenance of emotional separation, $B = 6.549$, $B = .359$, $p < .001$, and whether they had a form of debriefing for their CISM services, $B = -3.919$, $B = -.176$, $p < .001$, were the strongest predictors of burnout. Frequency of providing services, education, history of childhood abuse, debriefing, age, and MESS scores were the significant variables in the model. Further investigation revealed that burnout was higher among individuals who provided services more frequently, who did not receive any form of debriefing for their work, had completed higher levels of education (completed college compared to high school), had a history of childhood abuse, and among younger providers.

Regression results indicated that the overall model also significantly predicted compassion satisfaction (on the STS subscale) $R^2 = .111$, $R^2_{adj} = .092$, $F(9,427) = 5.927$, $p < .001$. The model of nine predictor variables significantly accounted for 9% of the variance in compassion satisfaction scores. Within the model, the respondent’s age, $B = 1.523$, $B = .153$, $p < .01$, and whether they had a form of debriefing for their CISM services, $B = 3.469$, $B = .151$, $p < .01$, were the strongest predictors of compassion satisfaction. The predictor variables that significantly contributed to the model were frequency of providing services, debriefing, gender, age, and MESS scores. Further analyses indicated that compassion satisfaction was higher in individuals who provided CISM services more often, who had debriefings following their work with trauma survivors, who were female compared to male counterparts, and who were older in age.

The final assumption that MESS scores would be a strong predictor of compassion fatigue, burnout, and compassion satisfaction was confirmed by the results of this study. For compassion satisfaction, the beta weight was $\beta = -.117$, $p < .05$, indicating a negative relationship with MESS scores. The lower the MESS score (or higher ability to maintain emotional separation), the significantly more likely the participant was to experience satisfaction. For burnout, the beta weight was $\beta = .359$, $p < .001$, indicating a positive relationship with MESS scores. In other words, the lower MESS scores (or higher the ability to maintain emotional separation), the significantly less likely the participant was to experience burnout. For STS, the beta weight was $\beta = .475$, $p < .001$, also indicating a positive relationship with MESS score. The lower MESS scores (or higher the ability to maintain emotional separation), the significantly less likely the participant was to experience STS. Conversely, the higher participants scored on the MESS (indicated less ability to maintain emotional separation), the higher their STS and burnout and the lower their compassion satisfaction.

**Limitations**

Although care was taken to reduce reliability and validity concerns, there were several limitations to the conclusions and generalizability of the results. This study was a convenience sample of CISM providers who volunteered their participation to complete the surveys. CISM providers represent a heterogeneous population that varies in background, training, and other characteristics that may impact whether these results are representative of the broader ICISF population. There were also some challenges to using the ProQOL instrument. Although many studies have used the ProQOL, there is currently no uniform measure for compassion fatigue (Badger et al., 2008). Within the ProQOL instrument, the concept of compassion fatigue was defined by the combination of STS and burnout subscales. In other literature, compassion fatigue and STS were used interchangeably to describe one phenomenon and burnout was considered a separate concept. One final limitation is the fact that there may also be additional factors that predict the occurrence of compassion satisfaction and compassion fatigue that were not included in this study and should be considered for future research studies.

**Discussion**

Debriefing, emotional separation, and compassion satisfaction were three key variables in reducing compassion fatigue risk in this study. Determining which form of debriefing worked best was beyond the scope of this investigation but is an option for future research. Debriefing is a type of countertransference review as well as a discussion of the feelings, thoughts,
beliefs, and conclusions that come from providing compassion care to others (Wicks, 2012). This processing allows for appropriate evaluation of the events, adds language to emotional material, and may even decrease the potential for cognitive distortions. Wee and Myers (2003) recommended briefings before CISM assignments and debriefings after the assignments. Regardless of the specific method of debriefing, reflection and processing trauma materials are a necessary component to CISM services.

The ability to maintain emotional separation proved to be the strongest variable in this study in predicting compassion fatigue and compassion satisfaction scores. Participants maintaining higher levels of emotional separation were at lower risk for compassion fatigue and burnout and higher potential for compassion satisfaction. Emotional separation is the ability to maintain boundaries between oneself and the level of compassion and empathy extended toward clients. Setting healthy boundaries requires trauma workers to achieve as close a connection as possible for empathy and as distant as necessary for self-preservation. “The inability to modulate emotional proximity to the client’s situation and the failure to emotionally differentiate may contribute to the social worker’s vulnerability to secondary traumatic stress (STS) and may represent a critical pathway for development of STS reactions” (Badger, Royce & Craig, 2008, p. 65).

Emotional separation may be considered a form of metacognition, a mental processing or actively thinking about one’s own thoughts (Sperling, 2012). Cognitively detaching from the emotionally charged material of a client reminds trauma workers’ brains that their exposure is indirect (the trauma did not happen to them personally) and that their bodies should not respond with traumatic stress symptoms as they would in direct exposure. This emotional distancing enables trauma care providers to sit with client after client and hear a multitude of painful stories while mitigating the impact the exposure has on them personally. Most importantly, counselor educators should consider that emotional separation may be a teachable skill used in training and preparing counselors, CISM providers, and other trauma workers.

Figley’s (2002a) recommendations for coping with indirect trauma exposure include learning ways to maintain emotional separation and to increase the potential for compassion satisfaction. Compassion satisfaction acted as a moderator to compassion fatigue in this exploratory study and appears to be an important factor in reducing the risk of compassion fatigue development. According to Radey and Figley (2007), compassion satisfaction may be maximized by an increase in self-care, a positive attitude, and an increase in the resources available to deal with job-related stress. Figley’s model for treatment of trauma workers who have already developed compassion fatigue includes education/awareness of the risk factors that lead to traumatic stress symptoms, desensitization and relaxation exercises, limiting the exposure of all forms of traumatic material (including media and recreational activities), and maintaining strong social support networks.

This study found that the sample of CISM providers were at low risk for compassion fatigue, which may be due to a number of factors. According to Wee and Myers (2003), CISM providers have a CISM worldview that may serve as a protective factor against compassion fatigue and burnout. This worldview is based on the foundation of knowledge taught in the CISM model training, which emphasizes the importance of early intervention following indirect exposure to trauma, adequate processing of thoughts and feelings that were reactions to the indirect exposure, and connecting with others in individual or group settings to reflect on these experiences. The findings of this study affirm that trauma workers such as CISM providers may decrease their risk of compassion fatigue and increase their potential for compassion satisfaction by applying components of Figley’s compassion fatigue model (2002a).

Adequate research in compassion fatigue risk, prevention, and treatment is imperative for trauma workers, such as CISM providers. The CISM community provides essential services to both primary and secondary trauma victims, and compassion fatigue could deplete trauma victims of this therapeutic resource. Continued attention must be dedicated to the risk variables as well as an ongoing practice of nurturance towards the mitigating factors associated with compassion fatigue and burnout.
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References


Knowledge and Practice: Exploring the Integration of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Clinical Internship Settings in Virginia

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Abstract
Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive public health approach for individuals with risky alcohol and drug use and is considered an evidence-based practice for intervention with high-risk substance use (Babor, et al., 2007; Saitz, 2007). This study examined how SBIRT is being integrated into community practice settings by surveying clinical supervisors of counseling and/or social work interns in the Hampton Roads region of Virginia. Results indicate that, although participants view screening, brief intervention, and referral to specialty services for clients engaging in high-risk substance use as important, actual practice of these skills is inconsistent and knowledge of SBIRT as an evidence-based practice is limited among participants. Implications, limitations, and recommendations for future research are also included.

Keywords: SBIRT, substance abuse, internship, alcohol use, counseling

According to the Substance Abuse and Mental Health Services Administration’s (SAMHSA) 2014 National Survey on Drug Use and Health (NSDUH), 60.1 million Americans age 12 and over reported engaging in binge drinking within the month prior to being surveyed (SAMHSA, 2015). Among the same survey sample, 24.6 million Americans age 12 and older reported current illicit drug use (SAMHSA, 2015). Despite the prevalence of high-risk substance use reported by survey respondents, only 2.5 million Americans who participated in the 2014 NSDUH survey reported receiving treatment for substance use disorder at a specialty treatment facility (SAMHSA, 2015).

To better understand the context of these data, SAMHSA (2015) also compiles data from the NSDUH into a Behavioral Health Barometer for all 50 states. This report shows that alcohol use in Virginia, though comparable to national averages, is still concerning. For example, past-month binge alcohol use in 2012-2013 among people aged 12-20 was reported as 14.3% in Virginia compared to 14.7% nationally. During the same time, the percentage of alcohol dependence or abuse among individuals aged 12 or older in Virginia was 7.4%, not far from the national average of 6.7%. Finally, past-month heavy alcohol use among adults aged 21 or older (2012-2013) in Virginia was 6.9%, nearly the same as the national reported data of 6.8% (SAMHSA, 2015). With regard to illicit drug dependence or abuse, in 2012-2013 Virginia's percentage among individuals aged 12 or older was 2.6%, similar to the national rate of 2.7% (SAMHSA, 2015).

Excessive alcohol use, from which alcohol-related problems stem, is a preventable behavior consistently associated with a myriad of health concerns including cardiovascular disease, unintended pregnancy, sexually transmitted disease, depression, anxiety, suicide, injury, and violence (Bouchery, Harwood, Sacks, Simon, & Brewer, 2006). Likewise, use of illegal drugs such as heroin, marijuana, cocaine, and methamphetamine, is associated with increased rates of accidents, crime, domestic violence, and loss of productivity (Office of National Drug Control Policy [ONDCP], 2014).

Mental health providers can play an integral role in prevention, early identification, and the treatment of substance use disorders. In the last decade, greater emphasis has been placed on strategies to address individuals who engage in risky levels of consumption or who are at moderate risk for developing further drug and alcohol problems (Marlatt & Witkiewitz, 2002). One of the most cost-effective prevention and early intervention initiatives available is the use of screening and brief intervention for alcohol misuse (Babor, et al., 2007; Saitz, 2007).

Screening, Brief Intervention, and Referral to Treatment

SBIRT has been identified by SAMHSA as an evidence-based practice to support early intervention
and treatment services for persons with substance use disorders, as well as those at risk of developing these disorders (SAMHSA, 2015). SBIRT is a method by which practitioners first screen patients to assess substance use, then, based on the results, provide an appropriate follow-up intervention (Agerwala & McCance-Katz, 2012).

The use of a brief screening tool focused on high-risk substance use allows the practitioner to determine the client’s level of risk and proceed accordingly. For clients with low- to moderate-risk substance use, a brief, education-based discussion integrating feedback on these risks coupled with the use of motivational interviewing to help the client identify areas where he or she may desire to make changes occurs. This brief intervention typically extends for no more than four to six sessions (Goplerud & McFeature, 2011). For clients who present with high-risk substance use, the practitioner uses motivational interviewing and provides information and referrals to help the client obtain appropriate treatment for his or her substance use disorder (Goplerud & McFeature, 2011). In 2008, SAMHSA awarded 17 five-year grants for SBIRT in medical settings (Pringle, Kowalchuk, Meyers, & Seale, 2012). Outcome data from select SAMHSA grant programs offer some of the most compelling support for the impact of SBIRT. For example, 41% of individuals reported abstinence from drugs and/or alcohol six months after the intervention, compared to 16% at baseline (Pringle et al., 2012; SAMHSA, 2015). In addition to decreasing overall use, quality of life measures were also positive. Such measures include employment/education status, housing stability, and arrest rates. For example, 95% of individuals reported no arrests 30-days after the intervention compared to 88% at baseline (Pringle et al., 2012; SAMHSA, 2015).

Reimbursement for screening and brief intervention is available through private insurance, Medicaid, and Medicare. Virginia is one of 10 states in 2008 that activated the new substance abuse prevention and treatment health codes for SBIRT for Medicaid – eligible patients, including MEDALLION and FAMIS Plus enrollees (Virginia Department of Behavioral Health and Developmental Services, 2014). The Virginia Department of Medical Assistance Services (VaDMAS) recognized the established codes for reimbursement to providers who complete a structured substance abuse screening and provide a related brief intervention (VDBHDS, 2014).

Although not new, its flexible approach, adaptability to a range of settings, and recent approval for healthcare insurance reimbursement has SBIRT making a strong presence among tools used by mental health professionals (Saitz, 2007). Even so, research has found few health care professionals outside of medical settings consistently provide alcohol screening or intervention in practice (Pringle, et al., 2012). While the literature on SBIRT is growing, little is known with regard to how comprehensively it is being used in practice and if internship supervisors are integrating it into their supervision of students.

Community Based Internship Supervision

As earlier indicated, the prevalence of substance use and misuse has been well established, making it likely for practitioners to encounter clients who engage in high-risk substance use in community-based agencies servicing the mental health and wellness of their citizens. Likewise, students preparing for careers in mental health will inevitably be exposed to clients with varying degrees of substance use disorders during their internship experience. Therefore, it is important that clinical supervisors are able to share best practices such as SBIRT with students in training.

According to Cheon, Blumer, Shih, Murphy, and Sato (2009), “supervision has been defined as a continuous relationship in which a qualified supervisor monitors the professional development and competency of a therapy intern as he or she gains practical experience” (p. 52). One of the key goals of student internships is to use the supervised learning experience to enhance their understanding of the application of theories and skills from the classroom to practice, as well as to expand their framework on relevant health issues likely to be encountered.

Students engaged in practicum and internship training experiences are supervised on-site by individuals with diverse educational training and licenses, including counselors, social workers, psychologist, and other health care disciplines. The 2016 Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards specifies site supervisors have “a minimum of a master’s degree preferably in counseling, or a related profession” (CACREP standards section 3: Professional Practice), while the Council on Social
Work Education (CSWE), educational policy and accreditation standards (EPAS) 2015 requires instructors to hold a MSW or for undergraduate training programs the education program subsumes this responsibility. (CSWE 2015, Standard M2.2.9)

Whitley (2010) identified an unrecognized professional cultural divide among clinical supervisors and supervisees within the field of substance use disorder treatment. Supervisees entering the field, specifically those with addictions training, bring with them their own professional history, ascribed theories, and skills used for practice (Whitley, 2010). At the same time, other students may have little knowledge or experience with substance use disorders. Supervisors who can link their clinical training and background to the student’s level of development can bridge this divide. Community-based agencies where student internship training occurs play a key role in identifying substance use issues at earlier stages and facilitating links to treatment. In order to accomplish this goal, it is critical that internship supervisors who oversee student learning are well-prepared and keep abreast of new, emerging, and best practices in the field of addictions.

**Purpose of Study**

This study examines if and how SBIRT is currently integrated into community-based practice through the use of a survey of social work and counseling student internship supervisors in Virginia. The purpose of this study is to understand how SBIRT is being implemented, including the scope and level of entrenchment at the organizational level. The goal of the study is to ascertain how familiar internship supervisors are with the SBIRT framework, how or if they use it in practice, in what ways they are training students and future practitioners on the use of this approach, and if they would like more information on this topic.

**Method**

**Participants**

Sampling was purposive and targeted individuals who previously or currently supervised students in their work setting. Participants were selected based upon their role as site supervisors of record for one or more students completing a practicum or internship in counseling or social work at the undergraduate or graduate levels. All participants were working in Virginia at the time of data collection.

A total of 48 potential participants were provided with the online survey link via email. A total of 26 social work practitioners, 6 school counselors, and 16 clinical mental health counselors who serve at site supervisors for practicum and/or internship students were included in the potential participant list. From these 48 potential participants, a total of 15 completed the survey, yielding a response rate of 31.3%.

Ninety-three percent of respondents were female and seven percent were male. Among respondents, 67% were white and 40% were Black, with one respondent reporting membership in both racial groups. Thirteen percent of respondents reported they were of Hispanic/Latino origin, while 87% reported they were non-Hispanic/Latino. All 15 participants were over the age of 26, and a majority of participants (67%) reported they were age 46 or older.

The majority of participants reported they have been in practice for at least 20 years (53%), with 40% reporting 26 or more years of work experience in their field. Twenty percent of respondents had between six and 10 years of experience, and an additional 20 percent had between 11 and 20 years of experience. Among respondents, 80% reported they currently work with clients. Eighty-seven percent of respondents reported they worked with adults, and 47% of respondents reported they worked with pediatric, adolescent, or geriatric clients, with some participants reporting working with more than one category of clients. Sixty percent of respondents described their work location as suburban, while 27 percent reported they worked in an urban setting. Thirteen percent of respondents described their work setting as rural.

Participants reported a variety of fields of practice and current professional roles representing school counseling/psychology (20%), social work macro (7%) and micro (20%) practice, community-based social services (13%), rehabilitation counseling (7%), and substance use specialization (20%). Participants reported a range of professions, including psychologist (7%), professional counselor (7%), social worker (60%), marriage and family therapist (7%), and other roles (47%), including
school counselor, agency director, human services counselor, substance abuse therapist, qualified mental health professional (QMHP), and supervisor.

Participants were evenly distributed between community-based public agencies (27%), non-profit private agencies (27%) and other settings (27%). In addition, participants reported working in medical treatment facilities (7%), medium-sized group practices (7%), and solo private practices (7%). All participants reported that they were supervising at least one student at the time of data collection. A majority of participants reported their agency or work setting supervised between one and five students per year (60%). Twenty percent of respondents indicated their work settings supervised between six and 15 students. An additional 13% of respondents reported their agencies supervised more than 20 students annually.

Materials and Procedures

The researchers used a survey developed by researchers conducting the New York Screening, Brief Intervention, and Referral to Treatment Survey of Primary Care Practitioners (Yu, Harris, DeStafeno, & O'Grady, 2015). Permission to use the survey without modification was provided by the principal investigator for this study (J. Yu, personal communication, September 29, 2015). This research was deemed exempt from formal examination through any Institutional Review Board as it does not meet the criteria for human subject research. Participants who accessed the survey were provided with information related to the risks, benefits, and purpose of the study and were required to agree to participate given this information in order to access the survey. The survey contained a total of 40 questions; items included response formats including Likert scales, open-ended responses, binary responses, and multiple-selection responses. The survey focused on SBIRT knowledge, training, and practice in order to better understand the needs for integrating SBIRT into clinical practice where students are placed for internships. The survey used response-based item presentation; this meant that participants who responded that an item was not applicable were presented with the next survey item, while participants who reported the applicability of the item to them were presented with follow-up questions before moving on to the next item.

For example, if supervisors indicated they were not familiar with SBIRT, a short description was provided and follow up questions were asked about their interest in learning more. Demographic questions related to personal and professional demographic characteristics were also collected via the online survey to allow researchers to describe the sample characteristics.

Between January and February 2016, the electronic survey was sent to affiliated internship supervisors in the Hampton roads area of Virginia. The researchers created and distributed the online survey via Survey Monkey. Potential participants were contacted via email on January 12, 2016 with a first call for participation in the survey. A second email call for participants was distributed on January 27, 2016. A final call for participants for the study was distributed via email on February 12, 2016. Participants who completed the survey had the option of providing their name and contact information within a separate Survey Monkey survey link that appeared after submitting the research survey to enter a drawing for one of three $20 gift cards as an incentive for participation. Prize drawing data were not connected to survey response data in any way and no personally identifying information was collected in the research survey to support participant confidentiality.

Following data collection, data were downloaded from Survey Monkey into Microsoft Excel for analysis. Given the descriptive nature of the present study, data obtained were analyzed for frequency and percentage of total responses for each item presented on the survey. Tables containing aggregate data by item were then created in Microsoft Excel.

Results

Participant responses provided information on a variety of perspectives related to working with clients who use mood-altering substances and their use of SBIRT with their clients. These responses fall into the following categories: attitudes, personal responsibility, and perceptions of effectiveness working with substance use; SBIRT knowledge, training, and skills; and interest in SBIRT resources and training. More detailed information on participant responses within these three categories is provided in the following sections.
Survey respondents were presented with items asking about the degree to which they agreed with 10 statements related to high-risk substance use, associated clinical services, and professional attitudes related to substance use. Items were presented with response options ranging from 1/strongly disagree through 5/strongly agree. Over 86% of participants reported they agreed or strongly agreed that the prevalence of high-risk substance use warrants systematic screening. Regarding the impact of screening for risky substance use on clients, 80% of respondents agreed or strongly agreed that screening for high-risk substance use can promote early intervention and over 73% of respondents agreed or strongly agreed that screening can improve client outcomes. One hundred percent of participants disagreed or strongly disagreed that substance use is not an important issue in therapy, although only 67% agreed or strongly agreed that therapists should discuss substance use with all patients. Over 73% of respondents reported their workplace has a responsibility to provide services to clients with substance use problems.

In terms of perceptions of other professionals, over 73% of respondents disagreed or strongly disagreed with the statement that “therapists have a disease model view of substance use and they don’t think about prevention,” while only 13% of respondents agreed with this statement. Eighty-seven percent of respondents disagreed or strongly disagreed with this statement that preventative health is the client’s responsibility rather than the responsibility of the therapist; only 7% of respondents agreed with this statement.

Among participants, 80% reported they believe they know enough about substance use problems to work with individuals who use substances. Over 73% of respondents also reported they believe they can appropriately advise clients who use substances. Detailed responses to each item are presented in Table 1.

Table 1. Participant Attitudes toward Substance Use Disorder Treatment (N=15)

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risky substance use in clients is common enough to warrant screening for in a systematic way.</td>
<td>1 6.7</td>
<td>0 0.0</td>
<td>1 6.7</td>
<td>8 53.3</td>
<td>5 33.3</td>
</tr>
<tr>
<td>Screening for risky substance use can result in early intervention.</td>
<td>1 6.7</td>
<td>0 0.0</td>
<td>2 13.3</td>
<td>4 26.7</td>
<td>8 53.3</td>
</tr>
<tr>
<td>Screening for risky substance use can lead to improved client outcomes.</td>
<td>1 6.7</td>
<td>1 6.7</td>
<td>2 13.3</td>
<td>6 40.0</td>
<td>5 33.3</td>
</tr>
<tr>
<td>I feel I know enough about substance use problems to carry out my role when working with risky substance users.</td>
<td>0 0.0</td>
<td>1 6.7</td>
<td>2 13.3</td>
<td>10 66.7</td>
<td>2 13.3</td>
</tr>
<tr>
<td>I feel I can appropriately advise my clients about substance use and its effects.</td>
<td>0 0.0</td>
<td>2 13.3</td>
<td>2 13.3</td>
<td>9 60.0</td>
<td>2 13.3</td>
</tr>
<tr>
<td>Therapists have a disease model training and they don't think about prevention.</td>
<td>3 20.0</td>
<td>8 53.3</td>
<td>2 13.3</td>
<td>2 13.3</td>
<td>0 0.0</td>
</tr>
<tr>
<td>Therapists think that preventive health should be the client’s responsibility not theirs.</td>
<td>5 33.3</td>
<td>8 53.3</td>
<td>1 6.7</td>
<td>1 6.7</td>
<td>0 0.0</td>
</tr>
<tr>
<td>Substance use is not an important issue in therapy.</td>
<td>10 66.7</td>
<td>5 33.3</td>
<td>0 0.0</td>
<td>0 0.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td>Therapists should discuss substance use with all patients.</td>
<td>2 13.3</td>
<td>2 13.3</td>
<td>1 6.7</td>
<td>5 33.3</td>
<td>5 33.3</td>
</tr>
<tr>
<td>My work place has a responsibility to provide services to clients with substance use problems.</td>
<td>1 6.7</td>
<td>1 6.7</td>
<td>2 13.3</td>
<td>4 26.7</td>
<td>7 46.7</td>
</tr>
</tbody>
</table>
In a second set of survey items, participants responded to six statements related to their perception of personal responsibility to conduct clinical activities related to client substance use. Item response options ranged from 1/strongly disagree through 5/strongly agree. Perceptions of personal responsibility related to working with clients who use mood-altering substances generally demonstrate respondents’ sense of responsibility for initiating conversations about substance use, screening clients for substance use using a standardized screening instrument, and assessing clients’ readiness to change high-risk substance use, with over two-thirds of respondents agreeing or strongly agreeing that these were personal responsibilities for them. Almost 87% of respondents reported they believed it is their personal responsibility to both advise clients to change high-risk substance use and to refer clients with substance use disorders to specialty treatment facilities. Over 93% of participants agreed or strongly agreed it was their personal responsibility to document any assessment, intervention, or referral. Detailed response data are provided in Table 2.

### Table 2. Perceived Personal Responsibility to Address Client Issues Related to Substance Abuse (N=15)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask clients about substance use.</td>
<td>1</td>
<td>6.7</td>
<td>1</td>
<td>6.7</td>
<td>8</td>
</tr>
<tr>
<td>Screen clients for substance use using a standardized tool.</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>6.7</td>
<td>4</td>
</tr>
<tr>
<td>Assess clients’ readiness to change their risky substance use.</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>6.7</td>
<td>4</td>
</tr>
<tr>
<td>Advise clients to change their risky substance use.</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>6.7</td>
<td>1</td>
</tr>
<tr>
<td>Refer clients with substance use problems to specialty treatment.</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>Document my assessment, intervention, and referral.</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
</tbody>
</table>
Participants also rated their confidence in their ability to engage in six SBIRT-related clinical activities rated on a scale from 1/strongly disagree to 5/strongly agree. Participants generally felt confidence in their ability to engage in processes to implement interventions for clients who use mood-altering substances. Slightly over half of participants agreed or strongly agreed they could assess readiness to change high-risk substance use patterns with clients. Sixty percent of respondents reported they agreed or strongly agreed that they could screen clients using a standardized screening tool for high-risk substance use. Eighty percent or more of participants reported they agreed or strongly agreed that they could ask clients about substance use, advise clients regarding high-risk substance use, refer clients to specialty treatment, and document assessments, interventions and referrals. Detailed response data are presented in Table 3.

Table 3. Participant Confidence in Ability to Address Client Issues Related to Substance Abuse (N=15)

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask clients about their substance use.</td>
<td>1 6.7</td>
<td>0 0.0</td>
<td>1 6.7</td>
<td>7 46.7</td>
<td>6 40.0</td>
</tr>
<tr>
<td>Screen clients for risky substance use using a standardized tool.</td>
<td>0 0.0</td>
<td>4 26.7</td>
<td>2 13.3</td>
<td>6 40.0</td>
<td>3 20.0</td>
</tr>
<tr>
<td>Assess clients’ readiness to change their risky substance use.</td>
<td>0 0.0</td>
<td>4 26.7</td>
<td>3 20.0</td>
<td>5 33.3</td>
<td>3 20.0</td>
</tr>
<tr>
<td>Advise clients to change their risky substance use.</td>
<td>0 0.0</td>
<td>2 13.3</td>
<td>1 6.7</td>
<td>6 40.0</td>
<td>6 40.0</td>
</tr>
<tr>
<td>Refer clients with substance use problems to specialty treatment.</td>
<td>0 0.0</td>
<td>1 6.7</td>
<td>2 13.3</td>
<td>5 33.3</td>
<td>7 46.7</td>
</tr>
<tr>
<td>Document my assessment, intervention and referral.</td>
<td>0 0.0</td>
<td>1 6.7</td>
<td>1 6.7</td>
<td>5 33.3</td>
<td>8 53.3</td>
</tr>
</tbody>
</table>

Participants were asked to rate their degree of effectiveness in working with specific client concerns rated on a scale from 1/very ineffective to 5/very effective. Over 53% of participants reported they feel effective in working with clients who engage in alcohol consumption. Sixty percent of participants reported they feel effective working with clients who use illicit drugs. Participants generally report feeling comfortable working with clients who use alcohol or illicit drugs, with 93% of respondents reporting they feel comfortable or very comfortable working with these issues.

SBIRT Knowledge, Training, and Skills

Participants were asked to report whether they participated in any training related to SBIRT model elements in the previous five years. Over half of participants reported they participated in training on screening for high-risk substance use and referring clients with substance use disorders to specialty treatment in the past five years. Over 73% of respondents also reported they participated in training on advising clients about high-risk substance use during the past 5 years. Despite this, only 13% of participants reported they were somewhat or very familiar with SBIRT.

Participants were asked to indicate which of the following SBIRT Model elements they personally practice in their clinical setting via a checklist within the survey. Among respondents, 60% reported they did not use any SBIRT Model elements in their practice. Twenty percent reported they engaged in screening, 13% reported they engaged in brief intervention, and over 33% reported they provided referral to specialty treatment for clients who have a substance use disorder. Some respondents reported they engaged
in more than one SBIRT Model element. Among respondents, 80% reported they did not practice SBIRT, while 20% of participants reported school training influenced their use of SBIRT. Additional influences on use of SBIRT reported by participants included internship training, conversations with colleagues, organizational policies, and professional literature. Some respondents reported more than one influential factor in their use of SBIRT practices. Given that 60% of participants reported not using any SBIRT Model parts while 80% of participants reported they did not practice SBIRT, it is possible that some participants’ limited knowledge of SBIRT impacted participants’ perceptions of their performance of SBIRT elements in clinical practice.

Participants were asked to describe the frequency with which they engage in specific SBIRT-related practices in their clinical settings on a scale of 1/never to 5/all the time. Between 20% and 27% of respondents reported they asked clients about substance use, including frequency and quantity of use, formally screened clients for substance use using standardized assessments, assessed readiness to change high-risk substance use, and discussed high-risk substance use with clients all the time. Fifty-three percent of participants indicated they never formally screen clients using a standardized assessment, and 20% of respondents reported they never assess client readiness to change or discuss high-risk substance use with clients. Eighty percent of respondents reported they sometimes, often, or always refer clients who have substance use disorders to specialty treatment, and 40% of participants reported they document their screening, intervention, and referral all the time. Detailed item response data are provided in Table 4.

Table 4. Frequency of Conducting Clinical Practices Related to Client Substance Abuse (N=15)

<table>
<thead>
<tr>
<th>Practice</th>
<th>Never %</th>
<th>Rarely %</th>
<th>Some times %</th>
<th>Often %</th>
<th>All the time %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking clients about their substance use.</td>
<td>1 6.7</td>
<td>1 6.7</td>
<td>6 40.0</td>
<td>3 20.0</td>
<td>4 26.7</td>
</tr>
<tr>
<td>Asking clients about quantity and frequency of their substance use.</td>
<td>2 13.3</td>
<td>3 20.0</td>
<td>3 20.0</td>
<td>3 20.0</td>
<td>4 26.7</td>
</tr>
<tr>
<td>Formally screening patient for risky substance use using a standardized tool.</td>
<td>8 53.3</td>
<td>1 6.7</td>
<td>2 13.3</td>
<td>1 6.7</td>
<td>3 20.0</td>
</tr>
<tr>
<td>Assessing clients’ readiness to change their risky substance use.</td>
<td>3 20.0</td>
<td>1 6.7</td>
<td>5 33.3</td>
<td>2 13.3</td>
<td>4 26.7</td>
</tr>
<tr>
<td>Discussing/advising clients to change their risky substance use.</td>
<td>3 20.0</td>
<td>0 0.0</td>
<td>6 40.0</td>
<td>2 13.3</td>
<td>4 26.7</td>
</tr>
<tr>
<td>Referring clients with substance use problems to specialty treatment.</td>
<td>3 20.0</td>
<td>0 0.0</td>
<td>9 60.0</td>
<td>1 6.7</td>
<td>2 13.3</td>
</tr>
<tr>
<td>Documenting your assessment, intervention, referral</td>
<td>3 20.0</td>
<td>1 6.7</td>
<td>3 20.0</td>
<td>2 13.3</td>
<td>6 40.0</td>
</tr>
</tbody>
</table>

Participants were asked to indicate what actions they usually take when they suspect a client has a substance use problem by selecting one or more options from a checklist on the survey. Fifty-three percent of participants reported they counseled clients on high-risk substance use when they perceived the client was engaging in high-risk substance use. Sixty percent of participants reported they provide clients with educational materials. Forty-seven percent of participants reported they encouraged clients to stop engaging in high-risk substance use, and 40% of respondents reported they make referrals to other counselors or specialty outpatient programs. Additional intervention strategies reported by participants included referral to inpatient treatment (27%), contacting family (20%), and referral to a physician (13%). Some participants indicated they intervened with more than one strategy when working with clients.
Participants indicated what reasons, if any, prevent them from discussing substance use with their clients by selecting one or more reasons listed on a checklist within the survey. Among respondents, 47% reported they always discuss substance use with their clients and, as such, they do not have any reasons for not discussing substance use concerns with clients. Among the most prevalent reasons participants provided for not discussing substance use concerns with clients were lack of training (20%) and the perception that substance use is less important to screen for than other conditions or problems (20%). Over 13% of respondents reported they did not discuss substance use concerns with clients due to the belief that clients are not honest about substance use, that screening for substance use is the function of other personnel, or that there are not enough staff to do so. Other reasons reported by participants included uncertainty regarding effectiveness of available treatments (7%), lack of funds to make system changes (7%), and lack of ability to bill for these services (7%). Some participants indicated that more than one reason influenced their choice not to discuss substance use concerns with clients.

**Interest in SBIRT Resources and Training**

Participants were asked what types of SBIRT resources or training, if any, they were interested in. Eighty percent of participants reported they were interested in receiving SBIRT resources; over half of participants reported they are interested in receiving clinical training in SBIRT, 40% of participants reported they were interested in technical assistance in SBIRT implementation, and 20% of respondents reported they were interested in receiving “other” information related to SBIRT. Some participants indicated an interest in more than one type of resources.

**Discussion**

The discrepancy between participants’ perceptions of personal responsibility for assessing and intervening with clients engaging in high-risk substance use in clinical practice and the participants’ reported actual practices in screening, intervention, and referral processes underscores a gap between perceptions and practice. While over 86% of participants reported that the prevalence of substance use warrants systematic screening of clients, only 20% of respondents reported they screened clients using a standardized tool all the time. Similar findings are reflected in a recent statewide study. Although 86% of primary care physicians provided annual substance abuse screening for adolescents, only one in three reported using a validated screening tool (Harris, Louis-Jacques, & Knight, 2014).

Previous research offers insight into the barriers leading to inconsistent use of screening, including lack of time, lack of referral sources, lack of mentors, concern regarding the patient response, and lack of belief by practitioners in its effectiveness (Bernstien, et al., 2007; Chossis et al., 2007; Pringel et al., 2012). In the current study, over 86% of participants reported it was their professional responsibility to provide feedback and/or referrals for clients who are engaging in high-risk substance use. Despite this, only 27% of respondents reported they discussed reducing high-risk substance use with clients all the time, and only 13% reported they made referrals for clients with substance use disorders all the time. Perhaps most surprising is the discrepancy between perceived responsibility for documenting assessment, intervention, and referral, with 93% of respondents indicating they perceive they have a personal responsibility to do so, and the finding that only 40% of respondents reported they engage in these practices all the time.

The discrepancy between perceptions and practice is also highlighted in participants’ responses regarding comfort and effectiveness in working with clients who are using alcohol or illicit drugs, as participants’ comfort level in working with these clients was greater than participants’ perceived ability to work effectively with these clients. Similarly, participants indicated they perceived they have the knowledge necessary to work with individuals who use mood-altering substances, with 80% of participants reporting confidence in their knowledge of substance use and 73% reporting confidence in their ability to intervene with high-risk substance use. These results stand in contrast to the 27% of respondents who reported they ask clients about their substance use or discuss high-risk substance use with clients all the time.

Despite this contrast there is room for optimism. Just as screening for lifestyle behavioral changes in diet and exercise have become more consistently integrated into standards of care practice, so too has the growth in screening and brief intervention for alcohol and other drugs (Agerwala & McCance-Katz,
& Bernstein, et al., 2007). This is evident in the support of National Alcohol Screening Day established in 2000 and in policies established by NIAAA to promote SBIRT (Bernstien, et al., 2007).

An important finding of the study lies in the variability of participants’ responses related to their practice in screening, intervention, and referral to treatment for substance use depending on the terminology used. While 80% of participants reported they do not use SBIRT, only 60% of participants reported they did not use any of the elements of the SBIRT model, and a majority of participants reported they sometimes, often, or all the time practiced elements of SBIRT such as asking about frequency and quantity of substance use, assessing readiness to change, and providing feedback on high-risk substance use. Most interestingly, the majority of participants reported receiving training on screening, brief intervention, and/or referral to treatment in the past five years despite their lack of familiarity with the SBIRT Model. It appears the concepts of SBIRT are known to practitioners, but universal and consistent integration of SBIRT takes time (Bernstien et al, 2007). For those agencies not fully integrating SBIRT, NIAAA recommends a single question screening for all: “How many times in the last month have you had 4 or more drinks on one occasion (for a female, or 5 or more for a male)?” (Bernstien, et al., 2007).

Implications

Implications of these findings have an impact on clients and supervisees alike. Clinical supervisors, such as those who participated in the present study, are charged with the task of advising, supporting, and modeling for students best practices in client care. Given the prevalence of high-risk substance use nationally, the work settings of the supervisors in the present study, and the influence that supervised practice may have on supervisees' future work with clients, participants' limited awareness of the overall SBIRT Model coupled with the discrepancy between beliefs and practices related to working with clients who use mood-altering substances is concerning. If students are expected to develop knowledge, skills, and competencies in evidence-based practice during their practica, internships, and field experiences, it is necessary that these practices are supported, modeled, and articulated effectively in the settings in which students are undertaking supervised practice. If students are unfamiliar with practices related to screening, brief intervention, and referral to treatment, and if they are unaware that the term SBIRT encompasses all of these tasks, they may be less likely to initiate systematic SBIRT model elements independently upon completion of their academic program. Without consistent transmission of this knowledge and skill set from supervisor to supervisee, inconsistent screening, intervention, and referral practices may have a negative impact on clients whose high-risk substance use may go unaddressed.

Given that participants indicated participation in professional development that presented information on the SBIRT elements in the previous five years, it is necessary to wonder whether the term SBIRT was included throughout these professional development sessions, to what degree implementation was spearheaded and supported by agencies and organizations for which participants work, and in what ways engaging in these practices was incentivized for the clinicians and for the agencies alike. If terminology is not shared, if implementation is not supported, and if funding and workload limitations prohibit effective integration of SBIRT into practice, current and future practitioners will continue to struggle to integrate this evidence-based practice consistently into their work with clients.

Limitations

The current study’s findings, in light of the small and relatively homogenous sample, should be considered tentative. Future research studies would benefit from a larger sample size with more diversity related to geographic region, demographics, employment settings, and area of practice. Future studies should also consider the possibility of including sites who have and who have not benefitted from SAMHSA support for training faculty, site supervisors, and students in SBIRT practices to determine whether these programs have influenced site supervisors’ practices related to SBIRT implementation. Finally, the results should be considered within the context of the realities of the work of site supervisors, who often see clients, supervise one or more interns, complete paperwork, and carry a clinical caseload with diverse clients and presenting concerns, all within the scope of an eight- to ten-hour workday.
Conclusion

An important finding of this study is the identification of gaps between supervisor perceptions and practices related to working with clients engaging in high-risk substance use and using SBIRT-related practices. More important are the implications of these findings that suggest the need to support site supervisors in finding ways to consistently engage in practices they believe are effective, both for the benefit of clients and for the benefit of students under their supervision. In addition to replicating these findings with a heterogeneous sample of site supervisors, future researchers would be wise to consider analysis of work tasks to determine if and how SBIRT might fit into a variety of work settings, client demographics, and clinical positions and how resources can be allocated to make consistent SBIRT practices feasible and effective across these settings with a wide variety of clients.

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References


The Impact of Emotional Intelligence on Counselor Burnout

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Liberty University

Abstract
Research on the relationship between mental health counselors’ burnout and emotional intelligence has been limited. This article highlights the role of burnout for counselors-in-training and the impact of emotional intelligence, bringing needed attention to the ways in which mental health professionals can utilize emotional intelligence practices as a potential buffer against burnout.

Keywords: emotional intelligence, counselor burnout, TEIQue

Burnout has been a concern in the field of clinical mental health, with rates being highest during the first three years of practice (Maslach, 2003). The American Counseling Association’s Code of Ethics (ACA, 2014), and the Council for Accreditation of Counseling and Related Education Programs’ 2016 CACREP Standards (CACREP, 2015) include codes and/or standards addressing the importance of self-care and wellness, ensuring ethical care for clients while preserving the wellbeing of the counselor. The present study was designed to address the gap in the literature calling for further investigation into the phenomenon of burnout and factors that may predict or reduce it such as emotional intelligence (EI) (Lent & Schwartz, 2012). Other researchers have stated the need to investigate the relationship between burnout and EI at different stages of counselor training programs such as practicum and internship (Testa & Sangganjanavanich, 2016). Counselor burnout and EI were studied using the Schutte Self-Report Emotional Intelligence Test (SSEIT; also known as SSREIS) (Schutte et al., 1998), the Trait Emotional Intelligence Questionnaire – Short Form (TEIQue-SF; Petrides & Furnham, 2006), and the Counselor Burnout Inventory (CBI; Lee et al., 2007). The present study examines the correlations between these factors in a sample of 167 counselor trainees in a practica experience.

Emotional Intelligence Models

According to Petrides, Pita, and Kokkinaki (2007) EI is defined as traits or self-perceptions related to emotion. The research literature contains competing models on conceptualizing EI: the trait-based model (Petrides & Furnham, 2000) and the ability based model (Mayer & Salovey, 1997). Mayer, Caruso, and Salovey (2000) define EI as an individual's ability to recognize, reason, and problem-solve in personal relationships based on the meanings of emotion. Petrides et al. (2007, p. 273) conceptualize the difference between ability-based and trait-based models primarily by the method of measurement; they indicate “Trait EI (or trait emotional self-efficacy) concerns emotion-related dispositions and self-perceptions measured via self-report, whereas ability EI (or cognitive-emotional ability) concerns emotion-related cognitive abilities measured via performance-based tests.” For this study, EI is defined as: one’s self-perception of a set of 15 attitudes and abilities that are associated with the regulation of emotions and sub-divided primarily into four factors including: 1) wellbeing; 2) self-control; 3) emotionality; and 4) sociability (Petrides & Furnham, 2003).

Burn-out

One of the challenges of the helping profession has been referred to as burnout, which is defined as a multifaceted occurrence observed across three dimensions: emotional exhaustion, reduced personal accomplishment, and depersonalization (Maslach, Jackson, & Leiter, 1996), and manifesting in feelings of helplessness, powerlessness, inflexibility, and/or being emotionally exhausted (Lee et al., 2007). According to Oser and colleagues, burnout not only impacts the counselor, but his/her place of employment and clients also suffer (Oser, Biebel, Pullen, & Harp, 2013). Counselors who experience burnout suffer from mental and physical health problems such as anxiety, depression, headaches, insomnia, low self-esteem, and lower quality of life. For counseling agencies, this leads to low productivity, higher interpersonal conflict, nonattendance, and turnover resulting in the spending of financial resources to recruit and train new counselors. For clients, this translates into premature termination, dissatisfaction with care and service, and lower levels of commitment to treatment and recovery (Oser et al., 2013).
Burnout and EI

Research by Platsidou (2010) on special education teachers found that those reporting high scores in the four trait EI dimensions and overall EI perceived themselves as doing well and moderately well in: (a) managing self-relevant information; (b) regulating emotions; and (c) managing others’ emotions. However, burnout has ethical implications for counselors who are unable to meet the psychological needs of their clients due to a depletion of their own emotional reserves (Maslach et al., 1996). The ACA Code of Ethics states, “counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired” (ACA, 2014, p. 9).

EI & Clinical Mental Health Counseling

Clinical mental health counselors use emotions to inform their work on a daily basis in therapy (Eatough & Smith, 2006). EI is a construct that may act as a protective factor helping counselors regulate emotion as other helping professionals, such as teachers, have found it useful (Platsidou, 2010). Resilient clinicians have a firm sense of self and faith, exhibiting clinical expertise, being confident, flexible, insightful, willing to advocate for others, empathic, humanistic, and engaging in self-care practices (Edward, 2005).

People in helping capacities, particularly counselors, continue to struggle with problems related to the regulation of emotion such as burnout (Lent & Schwartz, 2012; Sangganjanavanich & Balkin, 2013). Blankertz and Robinson (1997) reported that 50% of mental health workers surveyed were between “somewhat” and “highly likely” to leave the field within the next two years, and turnover rates in professions such as community mental health, social work and child welfare consistently range from 30% to 60% in any given year. High turnover rates prevent agencies from providing the services that are required to fulfill state mandates to prevent institutionalization of individuals and protect the communities in which they live (Paris & Hoge, 2010). A leading cause of job dissatisfaction for mental health professionals is related to the increasing difficulty of interpersonal interactions with clients and the lack of positive feedback in regard to competency and outcomes (Rössler, 2012). More so, researchers (Lent & Schwartz, 2012; Sangganjanavanich & Balkin, 2013) have commented on factors leading to burnout, including but not limited to: (a) stress, (b) introversion, (c) neuroticism, (d) being a new counseling professional, (e) poor health practices, (f) unrealistic expectations, (g) working long hours, and (h) difficult work settings.

Burnout can also impact counselors-in-training leading to a reluctance engaging with clients on multiple levels, including a hesitancy to see clients, struggling to build rapport, avoidance of emotionally charged issues, and an unwillingness to experience high levels of affect in relation to the client’s therapeutic process (Romero & Pinkney, 1980). Research conducted by Potter (2006) indicated that there are significant correlations between EI, measured by the Emotional Judgment Inventory, and burnout, as measured by the Maslach Burnout Inventory sub-scales. However, Potter also indicated more research is needed to replicate and clarify the relation between these variables using participants in their work environment. This study extends Potter’s research by examining EI using a sample of clinical mental health counselors-in-training participating in a practica experience. It also employs a measure of burnout specifically designed for those in the counseling field rather than a more general measure of burnout. Bogs (2011) also confirmed the need for more studies on EI and burnout in metal health workers who constantly experience high stress based on their work environment and clientele. Bogs advocated for educating mental health workers on the impact of stress and the use of EI to lower stress. The work of Lent and Schwartz (2012) further illustrates this gap. They investigated the correlations among burnout, clinical work setting, demographic characteristics and personality factors and found that counselors with higher levels of certain traits such as agreeableness and conscientiousness experienced lower levels of some dimensions of burnout (such as depersonalization and emotional exhaustion). They also emphasized a gap in the literature and stated that, “because burnout is a common phenomenon affecting clinicians and secondarily their clientele … further investigations of this phenomenon can help predict and possibly reduce burnout through increasing the awareness, knowledge, and skills of clinicians, supervisors, and educators” (Lent & Schwartz, 2012, p. 369). Testa and Sangganjanavanich (2016) indicated that more research is needed to investigate burnout among counseling students; thus, empirical research explaining the correlation between burnout and
emotional intelligence among mental health professionals and counseling students remains sparse and more research is needed (Bogs, 2011; Lent & Schwartz, 2012; Testa & Sanggananavanich, 2016). The purpose of this study is to examine perceived emotional intelligence (EI; trait-based) and its relationship with counselor burnout among 167 counselors-in-training. The variables are EI as measured by the TEIQue-SF (Petrides & Furnham, 2006), the SSEIT (Schutte et al., 1998), and counselor burnout as measured by the CBI (Lee et al., 2007).

The researchers’ hypotheses are as follows: (a) Hypothesis one: There will be a statistically significant positive correlation between trait-based EI and self-reported ability-based EI; (b) Hypothesis two: There will be a statistically significant negative correlation between self-reported ability-based EI and counselor burnout; (c) Hypothesis three: There will be a statistically significant negative correlation between self-reported trait-based EI and counselor burnout using the dimensions of counselor burnout and trait-based EI; (d) Hypothesis four: There will be a statistically significant negative correlation between the factors of trait-based EI and counselor burnout; (e) Hypothesis five: The four factors of trait EI and global trait EI will have statistically significant negative correlations with the five dimensions of counselor burnout.

Method

Participants

Participants were recruited through online announcements and were participating in practica experience, which included conducting practice-counseling sessions in triads with two other students. Approximately 320 students were invited to participate in the study using a convenience sample. Of those invited, 167 completed the study. The 167 participants were counselors-in-training (e.g., graduate students) enrolled in a private, mid-sized university. Participants included 39 male and 128 female counseling students, between the ages of 20-69 years old; the average age range was 30-39. There were 104 Caucasian, 48 African American, five Latino, one Asian-American, and eight Other Ethnicity. From the sample of counseling students available, 90 participants identified as being employed full-time, 47 participants identified as being employed part-time, and 30 participants were unemployed.

Measures

Participants completed the Schutte Self-Report Emotional Intelligence Test (SSEIT; also known as SSREIS) (Schutte et al., 1998), the Trait Emotional Intelligence Questionnaire – Short Form (TEIQue-SF; Petrides & Furnham, 2006), and the Counselor Burnout Inventory (CBI; Lee et al., 2007). The use of the aforementioned assessments was based on the fact that they were psychometrically sound, and freely accessible to the public.

SSEIT. A 33-item self-report trait EI tool with a five-point Likert scale (1-strongly disagree to 5-strongly agree). The SSEIT is said to have an internal reliability alpha coefficient of .87, and a test-retest reliability of .78 (Schutte et al., 1998, p. 186).

TEIQue-SF. A 30-item self-report questionnaire on a seven-point Likert scale (1-completely agree to 7-completely disagree). It provides a global trait EI score, and scores for each of its four factors; higher scores indicate higher trait EI (Petrides, 2010). The alpha internal reliability ranges from .81 to .89 (Petrides & Furnham, 2006).

CBI. A 20-item self-report measure using a five-point Likert type scale (1-never true to 5-always true); higher scores indicate higher levels of burnout. It has an internal reliability of .88-.94, a test-retest reliability of .81, and convergent validity of .73 with the Maslach Burnout Inventory-Human Services Survey Emotional Exhaustion subscale (Lee et al., 2007).

Procedures

Participants were recruited through an announcement made in each of the five sections of the counseling practica intensive class. This online announcement was followed-up by an email to each student, which included a secure link to Google Surveys. Willing participants completed an informed consent form. Of the 320 students invited to participate, 167 completed the study, resulting in a response rate of approximately 52%. Once the survey was completed, data was de-identified and statistical analysis was performed using IBM SPSS Statistics version 23.
Results

In order to evaluate Hypothesis One, a Pearson’s $r$ correlation was performed between levels of self-reported EI measured using the SSEIT (Schutte et al., 1998) and TEIQue-SF (Petrides & Furnham, 2006). The correlation between SSEIT and TEIQue-SF was positive and statistically significant, $r(167)= +.70$, $p<.01$ (one-tailed) in support of the researcher’s Hypothesis One. The $p$ value for this study was set at .05. Overall, there was a strong positive correlation between self-reported ability-EI (SSEIT) and trait-EI (TEIQue-SF), i.e., increases in self-reported ability-EI (SSEIT) were correlated with increases in trait-EI (TEIQue-SF). The reliability coefficients for the 33-item SSEIT and the 30-item TEIQue-SF were calculated to be $\alpha = .84$ and .89, respectively, meeting alpha values similar to initial studies of these assessments.

In order to address, Hypothesis Two, Pearson’s $r$ correlations were performed between EI measured by SSEIT (i.e., SSEIT Total) and counselor burnout using the CBI (i.e., CBI Total), and its five subscales (Lee et al., 2007). All six correlations were negative, and statistically significant, particularly, the correlation between SSEIT Total and CBI Total, $r(167)= -.36$, $p<.008$ (one-tailed), supporting researchers’ Hypothesis Two. The CBI subscales correlations were: -.22; -.22; -.34; -.25; -.25, $p<.008$ (one-tailed) for Exhaustion, Incompetence, Negative Work Environment, Devaluing Client, and Deterioration of Personal Life, respectively. This means that as self-reported ability-EI (SSEIT) score increased, counselor burnout (CBI) scores on each of the CBI dimensions decreased. The Bonferroni approach was used to control for Type I error across the six correlations, a $p$ value of less than .008 (.05/6 = .008) was required for significance. All six correlations were statistically significant, $p=.001$. In general, the correlation matrix results suggest that if an individual has a low burnout score in one domain, they tend to also have low burnout scores in other domains.

Hypothesis Three was addressed using Pearson’s $r$ correlations between EI measured by TEIQue-SF (i.e., TIEQue Total) and counselor burnout using the CBI (i.e., CBI Total), and its five subscales (Lee et al., 2007). The six Pearson’s correlations are reported in Table 1.

<table>
<thead>
<tr>
<th>CBI Dimensions</th>
<th>Correlations with TEIQue Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score on CBI</td>
<td>-.561**</td>
</tr>
<tr>
<td>CBI Exhaustion Total</td>
<td>-.409**</td>
</tr>
<tr>
<td>CBI Incompetence Total</td>
<td>-.340**</td>
</tr>
<tr>
<td>CBI Negative Work Environment Total</td>
<td>-.426**</td>
</tr>
<tr>
<td>CBI Devaluing Client Total</td>
<td>-.354**</td>
</tr>
<tr>
<td>CBI Deterioration of Personal Life Total</td>
<td>-.480**</td>
</tr>
</tbody>
</table>

Note: **: Correlation is significant at the 0.008 level (1-tailed) and N=167.
The Bonferroni approach was used to control for Type I error across the six correlations, a $p$ value of less than .008 (.05/6 = .008) was required for significance. All six correlations were negative, and statistically significant, particularly, the correlation between TEIQue Total and CBI Total, $r(167) = -.56$, $p < .008$ (one-tailed), supporting Hypothesis Three. The variables had an inverse correlation, this means that as self-reported trait-EI (TEIQue-SF) increased, counselor burnout (CBI) decreased. The results of Hypothesis Two and Three led the researchers to conclude that EI measured by TEIQue-SF has a stronger relationship with counselor burnout than EI measured using SSEIT.

Hypothesis Four was evaluated by examining the relationship of each of the four TEIQue-SF factors and Global Trait EI with CBI Total. The five Pearson’s $r$ correlations are reported in Table 2.

<table>
<thead>
<tr>
<th>CBI Dimensions</th>
<th>Correlations with TEIQue Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-being Trait EI Factor</td>
<td>-.440**</td>
</tr>
<tr>
<td>Self-control Trait EI Factor</td>
<td>-.523**</td>
</tr>
<tr>
<td>Emotionality Trait EI Factor</td>
<td>-.370**</td>
</tr>
<tr>
<td>Sociability Trait EI Factor</td>
<td>-.318**</td>
</tr>
<tr>
<td>Global Trait EI Factor</td>
<td>-.459**</td>
</tr>
</tbody>
</table>

*Note: ** Correlation is significant at the 0.01 level (1-tailed) and $N=167$.*

All five correlations were negative, and statistically significant, indicating that as participants’ scores on each Trait EI factor increased their CBI Total Score decreased. Using the Bonferroni approach, all five correlations were identified as being statistically significant, i.e., having a $p$ value of less than .01 (.05/5 = .01). This suggests that if an individual has a low EI in one domain, they tend to also have low EI scores in other domains.

In order to examine Hypothesis Five, the researchers analyzed the TEIQue Factors and Global Trait EI, with each of the CBI sub-scales/dimensions. Pearson’s $r$ correlations were performed; all twenty-five correlations were negative, and statistically significant. The Self-Control Factor had the largest correlations with three of the five CBI sub-scales/dimensions (Exhaustion Total: $r(167) = -.48$, $p < .002$; Negative Work Environment Total: $r(167) = -.34$, $p < .002$; and Deterioration of Personal Life Total: $r(167) = -.48$, $p < .002$; all one-tailed). The exceptions being the CBI Incompetence Total, which correlated highest with the Global Factor EI, $r(167) = -.40$, $p < .002$ (one-tailed), and Devaluing Client Total, which correlated highest with the Emotionality Factor, $r(167) = -.31$, $p < .001$ (one-tailed). Therefore, as participants’ scores on each Trait EI factor increased their scores on the CBI dimensions decreased. Using the Bonferroni approach, out of 25 correlations, 23 were identified as being statistically significant, i.e., having a $p$ value of less than .002 (.05/25 = .002). The two that were not significant include CBI Exhaustion with Sociability Trait EI, and CBI Incompetence with Emotionality Trait EI. The highest negative correlations were among Deterioration of Personal Life and Self-Control and the second highest was the negative correlation between Exhaustion and Self-Control. If an individual has high scores in one trait-EI factor, they tend to also have high scores on other trait-EI factors.

**Discussion**

Results supported all five of the researchers’ hypotheses, leading them to identify EI as being correlated with counselor burnout. These findings are consistent with the findings of other researchers.
investigating the relationship between the general constructs of EI and burnout (Moon & Hur, 2011; Testa & Sangganjanavanich, 2016). This study extends and specifies the nature of the correlation looking at perceived ability-based EI, perceived trait-based EI, and counselor burnout. The statistical analyses conducted between counselor burnout (CBI) and EI (TEIQue-SF) resulted in statistically significant negative correlations after controlling for family wise error with the Bonferroni approach, see Tables 1 and 2. Thus, these findings provide some support for cultivating EI as a strategy against counselor burnout. The trait EI factor of self-control, which is comprised of three subscales (Petrides, 2010): emotion regulation, stress management, and low levels of impulsiveness may be associated with the largest decreases in burnout. Therefore, counselor educators may design EI training programs focusing on the development of the trait EI factor of self-control and its subscales. Based on the correlational analyses conducted, TEIQue's self-control factor evidenced strong correlations with dimensions of the CBI. Using Petrides' (2009) description of individuals high on this factor to interpret these correlations, one sees that counselors-in-training who are capable of controlling their urges and desires are better able to function under stress. However, some dimensions of trait EI had lower correlations with total burnout scores such as sociability and emotionality. This information may be helpful for counselor educators and supervisors wishing to provide training and support to counselors in burnout prevention. If EI training is limited by time constraints there is some evidence to suggest allocating more time to the trait EI factors of self-control and well-being since they were most highly correlated with counselor burnout. EI training sessions may be tailored to the development of self-control with time dedicated to strategies for emotion regulation, stress management, and decreasing impulsivity. Sessions may also focus on activities that facilitate increases in well-being, specifically on strategies aimed at increasing self-esteem, enhancing trait happiness, and trait optimism (Petrides, 2010). For example, one intervention to enhance a dimension of self-control, stress management, could be experiential exercises aimed at identifying and reducing negative self-talk and enhancing positive self-talk (Seligman, 1991).

Implications

These findings have significant implications for current and future counseling professionals (including supervisors and counselor educators). Counseling programs and agencies can work towards developing and implementing emotional management or EI workshops to educate counselors-in-training and practicing counselors on the dangers of burnout and provide strategies to cultivate traits negatively correlated with burnout (Bogs, 2011). Interventions focused on EI enhancement (e.g., mindfulness) can be implemented in counseling programs and agencies. The perception of one's EI abilities was not as strongly related to one's level of burnout as the perception of one's traits and abilities. Counselor educators could perhaps implement psycho-educational programs for counselor trainees focusing on the development of one's perception of his or her traits and abilities (since perceptions of both are more highly inversely correlated with burnout).

Limitations and Future Research

The researchers acknowledge the following limitations to the study. First, the instruments used to obtain data were self-report measures. Second, the samples used to collect EI and burnout data were convenience samples; a student population was recruited. However, the researchers did not account for the impact of school stressors on burnout, which may be a contributing factor (IsHak et al., 2013). Third, it is possible that social desirability was at work during the data collection process, influencing the results; for example, some students might have wanted to appear “mentally healthy” when they were, in fact, burned out. Fourth, is the likelihood that individuals who were already burned out chose not to participate in this study. Given these limitations, the researchers caution readers seeking to interpret the findings reported.

Future research could focus on developing a comprehensive model of intervention for mental health counselors to prevent and/or buffer burnout taking a two-pronged approach emphasizing both EI abilities and traits; both are correlated with counselor burnout. Research should also test the efficacy of such models with pre and post measures, using longitudinal designs. The study should be replicated with counselors in practicum, internships,
residency, and full-time practice using non-self-report ability based EI measures (i.e., MSCEIT). Researchers should also examine whether EI training (such as Caruso’s ability based training) could be developed and implemented for Petrides’ trait based EI to see if counselors-in-training efforts to increase EI would be associated with subsequent decreases in burnout. Finally, future research should also focus on hypothesizing and testing mediating models of EI and burnout.

Conclusion

In spite of the limitations of this study, the results provide some information that may be useful to counselors-in-training, counselors, counselor educators, supervisors, and program administrators in understanding the nature of the relationship between EI and counselor burnout. Results suggest that increases in EI specifically self-control and wellbeing factors may be associated with decreases in counselor burnout. Future research should seek to replicate findings with a more heterogeneous sample. In addition, research should focus on the development of programs curriculums specifically for counselors, to enhance these EI factors. Subsequent research could also test the efficacy of such EI training programs aimed at enhancing EI and decreasing counselor burnout.

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References


Theoretical Preferences of Counselor Education and Social Work Students

Gregory T. Hatchett & Jennifer E. Sharp
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Abstract
The primary objective of this study was to compare the theoretical preferences of graduate students in counselor education and social work within an academic department in the Midwest United States. As expected, counseling students reported stronger preferences for humanistic theoretical orientations, whereas social work students reported stronger preferences for theoretical orientations that emphasize systemic change (family, feminist, multicultural). Across the entire sample, theoretical preferences were unrelated to the number of graduate credit hours completed; however, school counseling students who were currently enrolled in a practicum or internship course reported much lower preferences for both cognitive and feminist therapy.

Keywords: counseling students, theoretical preferences, social work students, practicum, internship

One of the most important development tasks facing a counseling student is the formation of a coherent theoretical orientation for understanding and working with clients. While several models and guidelines are available for helping students navigate this complex process (e.g., Finch, Mattson, & Moore, 1993; Spruill & Benshoff, 2000), very little is known about the actual theoretical orientations that students select or how these decisions may be associated with personal or programmatic variables. Much of the research in this area has been limited to the extent to which theoretical preferences are related to personality characteristics or other intrapersonal variables (e.g., Freeman, Hayes, Kuch, & Taub, 2007; Minton & Myers, 2008; Murdock, Banta, Stromseth, Viene, & Brown, 1998; Ogunfowora & Drapeau, 2008). Though several of these studies have reported statistically significant results, much of the variance in students’ theoretical preferences remains unexplained.

Another factor that might explain some additional variance in counseling students’ theoretical preferences is that of program track or specialization. The Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016) currently offers accreditation to master’s degree programs in seven specialty areas: addiction; career; clinical mental health counseling; clinical rehabilitation, college counseling and student affairs, marriage, couple, and family; and school counseling. Of these seven areas, school and clinical mental health counseling programs represent the two most common specializations within counselor education. While students in school and clinical mental health counseling programs complete a common core curriculum, which is denoted by Professional Counseling Identity, students in these two programs also receive divergent training and clinical experiences unique to their areas of specialization. Because of such experiences, it would not be surprising if school and clinical mental health counseling students developed different ideas about which theoretical frameworks will be most appropriate and effective for their particular areas of specialization. For instance, school counseling students might report stronger preferences for brief, task-oriented theoretical approaches such as solution-focused or reality therapy, whereas clinical mental health counseling students might have more favorable attitudes toward those theoretical orientations such as cognitive behavioral therapy that are frequently recommended for the treatment of specific mental disorders (e.g., Barlow, 2014).

While we could not locate any published studies on the extent to which theoretical preferences varied across school and clinical mental health students or practicing counselors, we did find comparable research that examined theoretical differences between clinical and counseling psychologists. In one such study, Watkins, Lopez, Campbell, and Himmel (1986) found that clinical psychologists identified more with psychodynamic and behavioral approaches, whereas counseling psychologists were more likely to identify with humanistic and cognitive orientations. In another similar study, Zook and Walton (1989) found that clinical psychologists were more likely to endorse psychodynamic approaches, whereas counseling psychologists were more likely to endorse humanistic approaches. In both of these studies, researchers used theoretical preferences as a proxy for professional identity; in other words, differences between clinical and counseling psychologists in their preferred theoretical orientations were used to make inferences...
about the extent to which the professional identifies of clinical and counseling psychologists converged and diverged with one another. Similar to the debates surrounding clinical and counseling psychology (e.g., Tyler, 1992), questions have been raised about the professional identities of school and clinical mental and the extent to which they should be recognized as integrated or distinct professions (Calley & Hawley, 2008). Because of this, a comparison of the theoretical preferences of school and clinical mental health counseling students might provide some indirect evidence on the extent to which they view themselves and their roles differently, i.e., their professional identities.

In addition to comparing school and clinical mental health counseling students to each other, it might also be valuable to compare their theoretical preferences with students from an alternative helping profession. Social work is a popular alternative to counselor education for those seeking graduate-level training in therapy. According to the Council on Social Work Education (2011), there were nearly 50,000 students enrolled in master degree programs in social work during the 2010-2011 academic year. Though social workers frequently work alongside counselors in clinical and school settings—and may even have similar job responsibilities—social work has traditionally distinguished itself by a strong social justice perspective that emphasizes societal and legislative change as the preferred means for helping individuals overcome psychological and social barriers (e.g., DuBois & Miley, 2011). While this framework has become increasingly more prominent in counselor education programs (e.g., Chang, Crethar, & Ratts, 2010), counseling has historically defined itself by a developmental and humanistic framework that emphasizes the importance of the client-counselor relationship as the vehicle for facilitating client change (e.g., Hansen, 2003). Because of these divergent philosophies of helping, counseling and social work students might report systematic differences in their views on the helping process, differences which might demarcate important differences in their emerging professional identities (e.g., Goodyear, 2000).

Toward this end, the primary objective of this study was to compare the theoretical preferences of graduate students across three graduate programs: school counseling, clinical mental health counseling, and social work. In the absence of any prior empirical research on programmatic differences, we identified two tentative hypotheses based on each profession’s historical and conceptual framework for working with clients. First, we predicted that counseling students, irrespective of specialty track, would report stronger preferences for a humanistic model compared to the social work students. Second, given social work’s strong emphasis on systemic change and social justice (e.g., DuBois & Miley, 2011), we predicted that social work students would endorse stronger preferences than counseling students for theoretical orientations that emphasized systemic change. We did not make any specific predictions as to how graduate students in these three programs would differ on other commonly endorsed theoretical orientations.

In addition to examining the role of program enrollment on students’ theoretical preferences, we also conducted some exploratory analyses on the relationship between theoretical preferences and two additional student variables: number of graduate hours completed in a program and current enrollment in a practicum or internship course. Because of the exploratory nature of these analyses, we did not make any specific predictions about these associations.

Method

Participants

Participants were recruited from the graduate programs in school counseling, clinical mental health counseling, and social work at a medium-sized (N = 15,000 students) public university located in the Midwest US. All three graduate programs are administratively housed in the same academic department. The counseling programs in school and clinical mental health counseling are both accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), and the graduate program in social work is accredited by the Council on Social Work Education (CSWE).

While the social work program is clearly distinct from the two counseling programs, the counseling faculty views the school and clinical mental health counseling programs as specialty tracks that diverge from an integrated counselor education core. For
example, students in the school and community mental health programs complete eight core courses together that are taught by a mixture of counselor educators with backgrounds in school and clinical mental health counseling. Additionally, the counseling theories course is taught by a counselor educator with a school counseling background, whereas the course in research and program evaluation is taught by a counselor educator with a background in clinical mental health counseling. School counseling students also take three specialty courses in school counseling. While these courses are not taught from a single theoretical perspective, the school counseling program is heavily influenced by the ASCA Comprehensive School Counseling Model (American School Counselor Association, 2012). Clinical mental health counseling students take seven additional specialty courses taught by faculty members with theoretical perspectives that include cognitive-behavioral, eclecticism, family systems, and ecological counseling models.

During the spring 2013 semester, a total of 137 out of the 206 (67%) graduate students across the three programs agreed to participate in the study. With regards to program enrollment, 53 (39%) of the students were enrolled in the social work program, 50 (37%) were enrolled in the clinical mental health counseling program, and 32 (23%) were enrolled in the school counseling program. (Two students did not report their program of study.) With regards to gender, 86% of the participants identified as female, and 14% identified as male. Participants’ ages ranged from 21 to 61 with a median of 27 (M = 30.5, SD = 8.7). With regards to racial/ethnic classifications, 86.9% of the students described themselves as white/Caucasian, 10.9% as black/African-American, and 1.5% as belonging to another racial/ethnic category. With regards to sexual orientation, 91% of the sample described themselves as heterosexual, 7% as homosexual/gay/lesbian, and 2% as bisexual.

Materials

**Information Sheet.** The participants completed an information sheet that inquired about the following characteristics or experiences: sex, age, race/ethnicity, sexual orientation, program enrollment, number of grade credit hours completed in program, completion of a theories course, enrollment in a practicum/internship course, and preferred theoretical orientation. With regards to this later item, participants were instructed to select a single, preferred theoretical orientation from the following list: psychoanalytic/psychodynamic, cognitive-behavioral, humanistic/existential, family/systems, multicultural, or other. (A space was also provided for a constructed response.)

**Theoretical Orientation Profile Scale-Revised (TOPS-R; Worthington & Dillon, 2003).** The TOPS-R is an 18-item, self-report inventory designed to measure the preferences of mental health professionals for six common theoretical orientations: psychoanalytic/psychodynamic, humanistic/existential, cognitive-behavioral, family systems, feminist, and multicultural. For each orientation, examinees respond to three items that inquire about the extent to which they (a) identify with that theoretical orientation, (b) conceptualize clients from that orientation, and (c) use techniques from that orientation. Examinees respond to the items that inquire about theoretical identification with a 10-point Likert-scale that ranges from 1 (not at all) to 10 (completely). Examinees respond to the items that inquire about case conceptualization and techniques with a slightly different 10-point Likert scale that ranges from 1 (never) to 10 (always).

Among the samples used in the development of the TOPS-R, Worthington and Dillon (2003) reported that all six scales exhibited internal consistency (α) estimates greater than .90. Excellent estimates of internal consistency have also been reported in subsequent studies that used the TOPS-R as an operational variable (Minton & Myers, 2008; Ogunfowora & Drapeau, 2008).

Procedure

After reading and signing an informed consent document, the participants completed the TOPS-R and the information sheet during a single administration period that lasted approximately 30 minutes.
Results

Prior to conducting the main analyses, we compared the student groups on three variables—number of graduate hour credits, completion of a theories course, and current enrollment in a practicum/internship course—that might moderate any between-group differences in theoretical preferences. Across all programs, participants had completed an average of 24.9 (SD = 16.8) graduate credit hours in their respective programs. Social work students had completed an average of 21.4 (SD = 15.7) hours, while the clinical mental health and school counseling students had completed an average of 25.2 (SD = 18.6) and 29.8 (SD = 15.3) hours, respectively. These group differences did not reach statistical significance [F(2, 131) = 2.35, p = .09]. In the total sample, 48% of the students were currently enrolled in a practicum or internship course; the corresponding percentages for social work, school counseling, and clinical mental health counseling students were 51%, 50%, and 44%, respectively. These differences also failed to reach statistical significance [\(\chi^2(2) = .554, p = .76\)]. We did find a programmatic difference in the percentage of students who had completed formal coursework in counseling theories [\(\chi^2(2) = 13.27, p = .001\)]. While 92% of the clinical mental health counseling and 84% of school counseling students had completed formal coursework in theories, only 63% percent of the social work students had done so. Because of this difference, we used coursework in theories (yes = 1, no = 0) as a covariate in the between-group analyses.

When asked to select a single, preferred theoretical orientation, the full sample reported the following choices: 73 (53.3%) cognitive-behavioral, 36 (26%) humanistic/existential, 18 (13%) family/systems, 2 (1.5%) solution-focused, 2 (1.5%) reality therapy, 1 (.7%) psychodynamic, 1 (.7%) Gestalt, 1 (.7%) narrative, and 1 (.7%) other. Table 1 contains a listing of the participants’ preferred theoretical orientations, organized by graduate program enrollment.

<table>
<thead>
<tr>
<th>Table 1. Frequency of Preferred Theoretical Orientations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Clinical Mental Counseling</td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Cognitive-Behavioral</td>
</tr>
<tr>
<td>Humanistic</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td>Solution-Focused</td>
</tr>
<tr>
<td>Psychoanalytic/Psychodynamic</td>
</tr>
<tr>
<td>Reality</td>
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<tr>
<td>Gestalt</td>
</tr>
<tr>
<td>Narrative</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>
These results are presented for descriptive purposes only; we did not report any inferential tests on the relationship between categorical theoretical preferences and graduate program enrollment because many of the cells were too small.

Table 2 presents the descriptive statistics for the TOPS-R scales, organized by graduate program enrollment.

<table>
<thead>
<tr>
<th>Scales</th>
<th>α</th>
<th>M</th>
<th>SD</th>
<th>M</th>
<th>SD</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td></td>
<td>CMHC Counseling</td>
<td></td>
<td>School Counseling</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>TOPS-R Psychodynamic</td>
<td>.93</td>
<td>3.24</td>
<td>1.84</td>
<td>3.13</td>
<td>1.76</td>
<td>2.21</td>
<td>1.09</td>
</tr>
<tr>
<td>TOPS-R Humanistic</td>
<td>.95</td>
<td>6.01</td>
<td>2.31</td>
<td>5.95</td>
<td>2.28</td>
<td>6.67</td>
<td>2.17</td>
</tr>
<tr>
<td>TOPS-R Cognitive</td>
<td>.94</td>
<td>7.06</td>
<td>1.97</td>
<td>7.44</td>
<td>1.81</td>
<td>6.53</td>
<td>2.05</td>
</tr>
<tr>
<td>TOPS-R Family</td>
<td>.94</td>
<td>4.63</td>
<td>2.35</td>
<td>3.91</td>
<td>2.30</td>
<td>3.79</td>
<td>2.10</td>
</tr>
<tr>
<td>TOPS-R Feminist</td>
<td>.95</td>
<td>3.61</td>
<td>.69</td>
<td>3.41</td>
<td>.68</td>
<td>3.51</td>
<td>.55</td>
</tr>
<tr>
<td>OPS-R Multicultural</td>
<td>.95</td>
<td>4.98</td>
<td>2.26</td>
<td>4.99</td>
<td>2.03</td>
<td>3.91</td>
<td>2.25</td>
</tr>
</tbody>
</table>

To test the first hypothesis, ANCOVA was used to evaluate whether counseling students (combined) reported stronger preferences than the social work students for a humanistic theoretical orientation, controlling for prior coursework in theories. The counseling students as a group ($M = 6.21, SD = 2.22$) scored significantly higher than the social work students ($M = 5.64, SD = 2.32$) on the TOPS-R Humanistic scale: $F(1, 130) = 42, p = .03, d = .25$. To test our second hypothesis, ANCOVA was again used to evaluate whether the social work students reported stronger preferences than the counseling students (combined) for systemic theoretical models, as indicated by scores on the TOPS-R Family, Feminist, and Multicultural scales. When tested as directional hypotheses, results indicated that the social work students scored significantly higher than the counseling students (combined) on the TOPS-R Family [$F(1,130) = 18.02, p < .001, d = .82$], Feminist [$F(1,130) = 8.16, p = .003, d = .54$], and Multicultural scales [$F(1,130) = 3.51, p = .03, d = .39$].

We also conducted exploratory analyses on the extent to which all three groups of graduate students differed across all of the six TOPS-R scales. A series of ANCOVAs, controlling for prior coursework in counseling theories, was used to evaluate whether graduate students in school counseling, clinical mental health counseling, and social work differed, on average, on the six scales that comprise the TOPS-R. [Because we did not expect scores on the six TOPS-R to group coherently into a linear composite, ANCOVA were used instead of MANCOVA.] The three groups of students scored differently on the TOPS-R Psychodynamic [$F(2,129) = 4.62, p = .01$], Family [$F(2,129) = 8.97, p < .001$], and Feminist [$F(2,129) = 4.54, p = .01$] scales; there were not any statistically significant group differences on the TOPS-R Humanistic [$F(2,129) = 1.23, p = .30$], Cognitive Behavioral [$F(2,129) = 1.27, p = .28$], or Multicultural [$F(2,130) = 2.83, p = .06$] scales.

Pairwise comparisons (Sidak adjusted) were then conducted to follow-up the significant univariate results obtained on the TOPS-R Psychodynamic, Family, and Feminist scales. On the TOPS-R Psychodynamic scale, the social work students scored higher than the school counseling students ($d = .68, p = .009$); the clinical mental health counseling students did not differ from either the social work ($d = -.34, p = .37$) or school counseling ($d = .34, p = .32$) students on this scale. On the
TOPS-R Family scale, social work students scored higher than both the school counseling ($d = .70, p = .004$) and clinical mental health counseling students ($d = .75, p < .001$); the school and clinical mental health counseling students did not differ on this scale ($d = .05, p = .99$). Finally, on the TOPS-R Feminist scale, the social work students scored higher than the clinical mental health counseling students ($d = .60, p = .01$); the school counseling students did not differ from the social work ($d = -.39, p = .24$) or clinical mental health counseling students ($d = .21, p = .71$) on this scale.

We conducted several additional exploratory analyses to examine whether participants’ theoretical preferences, as measured by the six TOPS-R scales, were associated with two additional variables: number of graduate credit hours completed and current enrollment in a practicum or internship course. We ran these analyses for all 137 participants combined and then separately by graduate program; there were no statistically significant associations between the number of graduate credit hours completed and scores on the six TOPS-R scales for the entire sample ($Mdn r = -.05$); furthermore, none of these relationship reached statistical significance for the school counseling students ($Mdn r = .08$), clinical mental health counseling students ($Mdn r = -.03$), or social work students ($Mdn r = .00$). Across the entire sample, there was a small statistically significant correlation between current practicum/internship enrollment (yes $=1$, no $=0$) and preferences for feminist therapy ($rpb = -.20, p = .02$). However, among the school counseling students, practicum/internship enrollment was fairly strongly and negatively correlated with preferences for both cognitive ($rpb = -.39, p = .03$) and feminist therapy ($rpb = -.50, p = .03$); none of the associations reached statistical significance for the clinical mental health ($Mdn rpb = -.06$) or social work ($Mdn rpb = -.05$) students. In other words, school counseling students who were currently enrolled in practicum/internship reported lower preferences for cognitive therapy than clinical mental health counseling students currently enrolled in practicum/internship ($d = -.78, p = .02$) as well as lower preferences for both cognitive ($d = -.78, p = .03$) and feminist therapy ($d = -.97, p = .004$) compared to those school counseling students who were not currently enrolled in practicum/internship. Thus, for the school counseling students, current enrollment in a practicum/internship was associated with a decline in preferences for both cognitive and feminist therapy.

Discussion

Since its inception, the counseling profession has struggled to create a coherent professional identity that clearly distinguishes itself from other helping professions (Hanna & Bemak, 1997). Though much has been written about the importance of professional identity and the need to strengthen it (e.g., Cashwell, Kleist, & Scofield, 2009), much less effort has been toward empirical research on the operationalization and empirical correlates of this broad construct. Professional identity is believed to be a multifaceted construct that subsumes a number of different facets, such as membership in professional associations, licenses or certifications held, the nature of one’s professional activities, and theoretical orientation (e.g., Calley & Hawley, 2008). The purpose of this study was to evaluate the extent to which one component of professional identity, theoretical preferences, varied as a function of graduate program enrollment: school counseling, clinical mental health counseling, and social work.

Because of the counseling profession’s historical emphasis on humanistic approaches to helping (Hansen, 2003), we predicted that counseling students, irrespective of specialty track, would report stronger preferences for a humanistic orientation than the social work students. This hypothesis was partially supported by our data. Counseling students reported stronger preferences than social work students for a humanistic theoretical orientation, but it should be noted that the difference between the counseling and social work students on the TOPS-R Humanistic scale was relatively small in magnitude ($d = .25$). In fact, we found that students across all three programs reported relatively strong preferences for a humanistic theoretical orientation. We also predicted that social work students would report stronger preferences than the counseling students for theoretical orientations that emphasized systemic change. This hypothesis was supported. Relative to the counseling students, social work students reported stronger preferences for family, feminist, and multicultural theoretical orientations. The differences between social work and counseling students were fairly large on the family scale ($d = .82$), while the group differences were in the moderate range on the feminist ($d = .54$).
and multicultural ($d = .39$) scales. Altogether, these results provide some support for the notion that school and clinical mental health counseling students share a similar framework for conceptualizing the counseling process (i.e., theoretical preferences), a framework that clearly diverged from that reported by the social work students. To the extent that one’s theoretical preferences signal professional identity, these results also provide some indirect evidence that the school and clinical mental health counseling share a similar professional identity.

We found some divergence between the theoretical preferences of school and clinical mental health counseling students who were enrolled in practicum and internship courses. Specifically, for the school counseling students, we found that participation in practicum/internship was associated with lower preferences for both cognitive and feminist therapy, a phenomenon that did not occur for the clinical mental health counseling students. Though speculative, it may be that school and clinical mental health counseling students maintain similar theoretical preferences while completing coursework in the eight content domains required in all CACREP-approved programs, denoted as Professional Counseling Identity (CACREP, 2016), but theoretical shifts may occur for school counseling students once they obtain experience in school counseling settings. For such students, cognitive and feminist counseling models may come to be viewed as less salient or effective in assisting students in the challenges typically encountered in Pre-K-12 educational systems.

Based on the results and limitations of the current study, we offer two general recommendations for future research in this area. First, the theoretical preferences of students in counselor education programs should be studied in a national sample of counseling students, representative of the variety of programs operating across the US. Such research might not only provide more accurate parameter estimates of counseling students’ theoretical preferences, but such research might also provide needed data on how students’ theoretical preferences vary as a function of additional programmatic and student variables, such as institutional profile, faculty characteristics, curriculum experiences, and accreditation status. A second line of research might investigate how students’ theoretical preferences evolve over time from program entry to post-graduate clinical practice. Though we conducted some exploratory analyses on the relationships between theoretical preferences and two programmatic variables (graduate hour completion & practicum/internship enrollment), our study was cross-sectional in nature. Longitudinal studies that are more qualitative in nature might provide richer data on how counseling students’ theoretical preferences are shaped by additional programmatic, supervisory, and clinical experiences.

**Limitations**

One of the major limitations of this study was the use of a convenience sample for testing our research hypotheses. All of the graduate students who participated in this study were enrolled in a regional, public university located in the Midwest United States. While a rather homogenous sample at a single university may have reduced some within-group variance, a sample of this nature puts a low upper limit on external validity. It would not be appropriate to generalize the theoretical preferences reported in this sample to graduate students in counselor education and social work programs across the US. The main objective of this study was to examine the relationships between program enrollment and theoretical preferences, not to estimate the theoretical preferences of graduate students at the population-level.

Questions can also be raised about our use of the TOPS-R (Worthington & Dillon, 2003) as the dimensional measure of theoretical preferences. In completing this inventory, examinees are asked to rate the extent to which they identify with, conceptualize clients from, and use techniques from six different theoretical orientations. Though the TOPS-R has been used in at least one study that included advanced counseling students as participants (Minton & Myers, 2008), the items on the TOPS-R may have less salience for graduate students who have minimal clinical experience with clients. We located only a single inventory, the Theoretical Evaluation Self-Test (TEST; Coleman, 2004), which was specifically designed to measure the theoretical preferences of students. However, research to date indicates that this inventory may not be a valid measure of distinct theoretical orientations (Coleman 2004, 2007). In making the decision to use the TOPS-R instead of the TEST, we decided to err on the side of using a well-validated
measure of theoretical preferences more appropriate for practicing clinicians over a less validated inventory designed specifically for use with students.

Finally, because of the exploratory nature of this study, we conducted a number of statistical analyses on the dataset, thereby compounding the risk of Type I errors (i.e., rejecting the null hypothesis when it should have been retained). In addition to testing our main hypotheses about expected differences between counseling and social work students, we conducted a number of additional group comparisons across programs and correlational analyses on the relationships between theoretical preferences and two additional student variables. Notably, some of these group comparisons were non-independent. Readers should keep in mind that there was a great deal of overlap between the hypothesis-driven and exploratory group comparisons. Nonetheless, these preliminary findings may have heuristic value in providing future researchers with more specific hypotheses on the relationship between graduate program enrollment and preferred theoretical orientations.

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References


Abstract
School-family collaboration is an element of professional school counseling supported by the American School Counselor Association (ASCA) as a means of impacting student success. Professional school counselors provide services in multiple ways, including through the establishment of productive partnerships with parents and families. Training for professional school counselors includes several relevant topics for serving children in diverse elementary and secondary schools; however, this training typically does not include coursework concerning family development and processes. To address this gap in the training of professional school counselors, this professional development module was created and offered to practicing school counselors in Virginia. This article provides an overview of the module, beginning with a review of the relevant literature that provided the rationale for the module. Additionally, the content and evaluation of the module are provided to allow for an examination of its effectiveness and applicability to the work performed by professional school counselors.

Keywords: school counselor, school-family collaboration, family bridges, counselor education

Acknowledgement
The professional development workshop described in this paper was funded by a grant awarded by the Virginia Counseling Association Foundation (VCA). The authors would like to thank the VCA foundation for this financial support, and the New Horizons Family Counseling Center at the College of William & Mary for the use of space for the workshop.

Counselors
School-family collaboration is an element of professional school counseling supported by the ASCA as a means of impacting student success (ASCA, 2012). Professional school counselors provide services in multiple ways, including through the establishment of productive partnerships with parents and families. Training for professional school counselors includes several relevant topics for serving children in diverse elementary and secondary schools (CACREP, 2009); however, this training typically does not include coursework concerning family development and processes. Additional professional development may be needed or desired by professional school counselors seeking to establish and strengthen collaborative relationships with parents and families. This article describes one such professional development approach and provides an evaluation of the module’s effectiveness in supporting school-family collaboration.

Review of the Literature
The benefits of family participation in schools have been extensively explored throughout the literature. Enhanced parental involvement positively influences student academic achievement, resulting in increased pass rates on standardized tests (Sheldon, Epstein, & Galindo, 2010), increased school completion rates (Ziomek-Daigle, 2010), and reduction of the achievement gap (Holcomb-Mccoy, 2010). Further, students’ socio-emotional outcomes are positively impacted by family involvement. The earlier parents connect with schools, the less likely adolescents will use illicit substances (Chen, Storr, & Anthony, 2005). Discipline issues within schools also decrease, as students are less likely to be excluded from school when parents become more active participants in the education process (McElderry & Cheng, 2014). Positive behavioral
changes may be due to the second-order change that occurs when interventions are applied in both school and home environments (Eppler & Weir, 2009). Clear communication and collaboration between schools and families may effectively promote long-term behavior changes for students.

School Counselor Preparation

Research has indicated that although strategies exist to prepare school counselors to understand family dynamics and eventually form collaborative relationship with families, school counseling students may not be receiving this preparation. For example, Holcomb-McCoy (2004) suggested the use of the family autobiography as a course requirement to facilitate comprehension of the family systems perspective. Paylo (2011) supported the use of the family autobiography, but also recommended a collaborative drawing activity to interactively assess family patterns and hierarchies as way to integrate a systems perspective within the master’s-level school counseling curriculum. Including a three-hour credit course specifically focused on family systems into school counseling training programs is generally preferred to prepare school counselors to collaborate with families (Mullis & Edwards, 2001; Paylo, 2011). Yet, Joe and Harris (2014) found that 60% of CACREP-accredited graduate school counseling programs in the southern region did not require family coursework for students. Moreover, of the 40% of programs that did require family-related coursework, only 12.5% and 10% focused on family systems and family development, respectively (Joe & Harris, 2014).

These findings mirror previous studies examining school counselor preparation in working with families. After surveying 126 school counselor preparation programs, Perusse, Poynton, Parzych, and Goodnough (2015) found that only 36.5% required school counseling students to complete coursework in couple and family counseling—an 11.6% decrease from when this same data was collected in the year 2000. Additionally, Akos and Scarborough (2004) completed a content analysis of internship syllabi, and found that only 17% of the syllabi emphasized systemic intervention. This lack of preparation in family coursework has not been due to unsupportive graduate programs. Epstein and Sanders (2006) found that 85% of colleges of education leaders believe that it is important for school counselors to know how to form collaborative relationships with families and community members, yet only 27% of these leaders reported that school counseling graduates were prepared to complete this task. This suggests that current school counselors may not have received sufficient training in family systems and development in their graduate programs.

To address the training gap, the authors facilitated a grant-supported professional development module specifically designed for professional school counselors interested in bolstering their collaboration with families. The module was designed to address stated needs related to school-family relationships. The authors conducted the module and evaluated its impact to determine its effectiveness in supporting the efforts of professiona

Method

Participants

Professional school counselors employed in elementary and middle schools in four Virginia school districts were invited via email and regular mail to register for the four-hour professional development session provided to them at no cost. The workshop was offered to counselors in these districts with high numbers of families who had been referred for counseling but who were waiting for services to become available at a university-based family counseling clinic. The demographics of these school districts varied in terms of the race/ethnicity and socio-economic status of the children and families within them. What was significant and common about these districts was a need for family services that exceeded the available supply.

A total of six school counselors attended the professional development session. Three school counselors worked in middle schools and three worked in elementary schools during the time of the professional development session. One of the six participants was a counselor-in-training in the internship phase of her training. All six of the participants were female; two participants were African-American and four were Caucasian. Four of the six participants worked in suburban school divisions and two worked in urban school divisions at the time of the session.
Building Family Bridges

The professional development module titled Building Family Bridges sought to expand the knowledge base and skills of the professional school counselors in attendance to support them in their service to students and families. Attendees were presented with knowledge concerning family development and processes, as well as family counseling tools for use in the school setting for the purposes of collaboration and support. Three doctoral level counselor education students facilitated the session, and drew upon their experiences as classroom teachers, professional school counselors, and family counselors to make the content relevant for the attendees. The workshop was held at a family counseling clinic associated with the graduate counseling program at a small liberal arts research university in Virginia. The family counseling clinic provides free counseling services to families in the surrounding school districts, and has provided workshops and other services to school personnel.

Session Content

The content for the Building Family Bridges module was drawn from the family counseling literature and emphasized theory and practice that is relevant to professional school counselors seeking to collaborate effectively with parents and families. Informed by the basic tenets of structural family therapy (Goldenberg & Goldenberg, 2013) and Walsh’s (2006) framework of family resilience, the curriculum of the module was designed to equip professional school counselors with a systemic lens through which to conceptualize their cases and interventions that can be easily incorporated into their counseling repertoire. At the conclusion of the module, the goal was for professional school counselors to be able to: a) explain normal family processes, including the impact of family life cycle transitions and stressors, b) use family counseling tools to gain a more dynamic understanding of the students and families they serve, c) identify and bolster family resilience factors, and d) apply their knowledge of family processes and development for effective school-family collaboration. Details of the curriculum follow this section.

Normal Family Processes. The module began with an exploration of socially constructed notions of normality with respect to families (Walsh, 2003). Family functioning was discussed in terms of interactional patterns shaped by both developmental and cultural contexts, rather than asymptomatic, typical, or ideal. The Circumplex Model of Marital and Family Systems provided a framework for assessment of internal norms, including rules, roles, and patterns of communication (Olson & Gorall, 2003).

Family Life Cycle. Building upon the discussion of normal family processes, this portion of the module examined the family as a system moving through time (Carter & McGoldrick, 2005). Individual development was discussed within the family context, and family development stages and tasks were identified. Life cycle transitions, such as the birth of a child or sending a child to college, were discussed in terms of their impact on both family and individual functioning. Additionally, dialogue about expected and unexpected stressors (e.g. illness, unemployment, natural disasters, racism, poverty etc.) demonstrated the importance of adaptability within the family system to support individual members who might be impacted by such stressors (Carter & McGoldrick, 2005).

Family Counseling Tools. To provide the professional school counselors with practical methods for using knowledge of family processes to collaborate with families, a portion of the module was devoted to teaching the attendees specific family counseling strategies. Family timelines, genograms and structural diagrams were presented as assessment tools to examine the family history and structure, and the impact that they may have on a student’s well-being (Goldenberg & Goldenberg, 2013). Other techniques included family floor plans and process diagrams that may deepen the school counselor’s understanding of students’ experiences within the home (Sherman & Fredman, 1986). Descriptions of these techniques can be found in Table 1.
Strengthening Family Resilience. To reiterate the importance of incorporating family considerations into school counseling, the last portion of the module focused on identifying and bolstering family resilience factors. According to Walsh (2006), resilience develops within interactional contexts rather than through the “heroic myth of rugged individualism” (p. 6). Hence, children demonstrate resilience within their families rather than in spite of their families. The attendees of the workshop were introduced to Walsh’s framework of family resilience and discussed resilience as a goal of counseling rather than an individual, internal trait. Walsh (2006) has identified three main factors that are key to family resilience: belief systems, organizational patterns, and communication processes. In terms of a family’s belief system, counselors explore the extent to which a family possesses meaning making structures when faced with adversity, maintains a positive outlook, and embraces transcendent or spiritual beliefs that provide inspiration and purpose. Organizational patterns that facilitate resilience include flexibility, connectedness, and social and economic resources, particularly in terms of larger systems that provide support. Finally, helpful communication processes include clear, consistent messages, open expression of emotions, and collaborative problem solving. Participants discussed these key family resilience processes and explore methods of identifying and bolstering these factors through their work with individual students and their families.

Table 1. Family Counseling Tools

<table>
<thead>
<tr>
<th>Counseling Technique</th>
<th>Description</th>
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<tbody>
<tr>
<td>Family Timeline</td>
<td>Counselor engages the individual and/or family in a discussion about the family’s experiences over time to create a timeline of significant family moments. Feelings associated with each moment are discussed and included on the timeline. Counselor identifies stressors and lifecycle transitions that have impacted the family and engages the client(s) in a discussion about them.</td>
</tr>
<tr>
<td>Family Genogram</td>
<td>Counselor assists the individual and/or family in construction a visual representation of the family members for three generations. Names, ages, and relational details are included. Counselor discusses patterns of communication and interaction with the client(s), and explores any significant events and or feelings associated with the genogram.</td>
</tr>
<tr>
<td>Structural Diagram</td>
<td>Counselor creates a diagram of the client’s family that illustrates the power structure, boundaries, and alliances within the family.</td>
</tr>
<tr>
<td>Family Floor Plan</td>
<td>Counselor assists the individual and/or family in diagraming the floor plan of the family’s home. The floor plan includes common areas, bedrooms, and outside spaces used by the family. Counselor uses questions that explore the activities and feelings associated with various areas (e.g. What are spaces where everyone in your family is together? How do you feel when you are in the kitchen?). For clients with parents in two separate homes, multiple floor plans can be created, discussed and compared.</td>
</tr>
<tr>
<td>Process Diagram</td>
<td>Counselor engages the individual and/or family in a discussion of a problem behavior or experience within the family. Questions are used to identify the causes and effects of these behaviors and to illuminated patterns that unintentionally maintain the behavior. Counselor helps the individual and/or family generate solutions that will interrupt problematic cycles faced within the family.</td>
</tr>
</tbody>
</table>
Evaluation

The program evaluation strategy used for *Building Family Bridges* was based upon Guskey's (2000) framework for professional development. This model, which focuses on professional development for educators, was adapted for school counselors. Guskey's model includes six elements of effective professional development that were considered throughout the evaluation process: demographics, reactions, learning, organization support and change, use of new information, and student outcomes (Guskey, 2000). The professional development session was assessed through the use of an evidence-based professional development observation protocol. This protocol, adapted from the Horizon Research Local Systemic Change through Teacher Enhancement Professional Development Observation Protocol (2005), focused on evaluating the design, implementation, content, instructional materials, presentation pedagogy, and culture of the professional development session.

Additional data were collected before, during, and after the professional development session. Before initiating the professional development planning, the third author who served as the program evaluator conducted an online, survey-based needs assessment with local school division administrators to determine the areas of focus that would be most beneficial to these stakeholders. Directly following the professional development session, participants completed a professional development session rating scale, adapted from a professional development observation scale used by the College of William and Mary’s School-University Research Network to assess participant responses to professional development offerings for educators. In addition, a follow-up survey was administered to session participants approximately four months after participating in the professional development session to determine the intermediate impact of participation on school counselor practices and student achievement and affective functioning.

Evaluation Results

Professional development session observation. The professional development session was observed using the protocol created for this purpose as described previously. The program evaluator attended the full professional development session and completed the checklist item throughout the session. Contextualizing comments and qualitative information related to program elements were also documented by the evaluator during the session to support summarizing the events, participant responses, and overall effectiveness of the professional development at the conclusion of the event. Professional development elements were rated on a five-point Likert scale, ranging from 'not at all' (1) to 'to a great extent' (5). All program elements were rated well above the median rating of 3.0. The program element with the highest rating was in the area of Content, with Exploring Pedagogy/Counseling Materials and Design also earning high ratings. The overall rating for the professional development session, which ranged from negative effect (1) to positive effect (5) on a five-point Likert scale, yielded a mean score of 5.0. The mean scores for each observation element are presented in Table 2.

**Table 2. Professional development observation mean ratings**

<table>
<thead>
<tr>
<th>Program Element</th>
<th>Mean Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design</td>
<td>4.50</td>
</tr>
<tr>
<td>Implementation</td>
<td>4.29</td>
</tr>
<tr>
<td>Content</td>
<td>5.0</td>
</tr>
<tr>
<td>Exploring Pedagogy/Counseling Materials</td>
<td>4.83</td>
</tr>
<tr>
<td>Culture</td>
<td>4.14</td>
</tr>
</tbody>
</table>

Professional development participant ratings. One hundred percent of all participants completed the post-session professional development evaluation survey, which was provided to participants in paper-pencil format directly following the professional development event. Participants were not asked to provide identifying information on this evaluation survey. Participants rated the overall program features on a four-point Likert scale ranging from poor (1) to outstanding (4); workshop facilitators were also rated on this scale. One hundred percent of participants rated the program features a 4.0. The participants also rated the workshop facilitators a 4.0. These evaluation responses indicated the professional development and facilitators effectively addressed participant needs and workshop session goals.
Qualitative responses from participants in the post-workshop survey indicated that the session materials, particularly the tools for working with students, were particularly valuable to participants. One participant identified that the “modeling of actual tools and having ideas to take back and implement” was useful; this feedback was echoed by all participants responding to this qualitative survey item. Participants identified several barriers to implementation, including time limitations and limited family engagement in school activities. One participant described that it is “difficult to find time in [the] school setting.” Another stated: “Some parents are more closed off and less willing to be receptive to sharing personal information.”

Despite these barriers, all participants reported that they intended to use what they learned in a variety of ways. Specifically, participants indicated they planned to use the tools provided when meeting with parents and students, increasing efforts to engage with families as part of school counseling responsibilities, and sharing information with peers. One respondent reported that she was considering “trying school wide activities like ‘unplugged night [a night where the family voluntarily turns off electronic devices and spends family time participating in activities that do not require electronic devices]’ or a conversation help for family dinner times.” Overall, participants identified a range of applications to their professional activities.

Professional development follow-up survey. A follow-up survey invitation was sent via email to participants approximately four months after the professional development session. These data were collected via a Qualtrics survey that did not collect any identifying data from participants. Three of the six professional development participants began the follow up survey, although only one of the six completed the full survey. Among the two participants who responded to the question, “How often have you applied what you learned in session in your school counseling setting?”, one participant responded ‘sometimes,’ and one responded ‘most of the time.’ Among the two participants who responded to the question, “How useful has the information you learned been in your school counseling practice?”, one participant responded ‘useful,’ and one participant responded ‘very useful.’ In response to the question, “How much information from the session have you shared with others in your school setting?”, one participant responded ‘none,’ and one responded ‘some.’

The one participant who provided responses to questions related to student outcomes indicated that the professional development experience had ‘some’ impact on her work with students. This participant also indicated that her collaboration with families has been impacted ‘some’ by her participation in the workshop. Finally, this participant reported that student psychosocial functioning has gotten ‘better’ as a result of integrating workshop learning into her counseling. No respondents provided qualitative data to contextualize the previous responses; as a result of the low response rate and lack of supporting qualitative data, these findings should be interpreted with caution.

Discussion

The Building Family Bridges professional development module described and evaluated in this article sought to support school-family collaboration through professional development for school counselors that focused on family development and processes. Informed by the stated needs as expressed by school administrators, the module included content focusing on interactional family patterns and processes, individual and family stressors over the lifetime, and family counseling techniques that can be applied in the school setting. The responses of the participants on the post-session professional development evaluation survey indicated that the program content and delivery were outstanding and addressed the needs of practicing professional school counselors. Of particular note is the value the participants placed on the techniques that were taught and modeled during the session. The participants appreciated the practical tools they carried with them out of the session, while also acknowledging that limitations placed on professional school counselors in the school environment may act as barriers to their use of these tools.

Along with leadership, advocacy, and systemic change, collaboration is a key theme of the ASCA National Model (ASCA, 2012). Through collaboration with parents and families, professional school counselors can support student success by capitalizing on the resources present within the
systems surrounding students. The Building Family Bridges professional development module discussed above provided information about family systems that broadened the knowledge base of the professional school counselors in attendance. Additionally, the techniques provided them with a method of approach when establishing and strengthening collaboration with the students and families that they serve.

Professional school counselors build collaborative teams with teachers, administrators, and other school personnel as well. In particular, teachers are likely to seek out school counselors for their expertise in various areas including family-related stressors (ASCA, 2012), especially given that school counselors are often the initial point of contact with parents and other stakeholders (Bryan & Holcomb-McCoy, 2010). The content of the Building Family Bridges professional development module included culturally sound tools that the participants can utilize in their work with students, parents, and families and share with their colleagues to promote collaboration that is responsive to both culture and context (Bryan & Holcomb-McCoy, 2010).

**Implications for Counselor Education**

Both the ASCA National Model and the 2009 CACREP standards of accreditation acknowledge the important role that professional school counselors play in establishing healthy and effective collaboration with parents, families, community members, and school personnel (ASCA, 2012; CACREP, 2009). Standards for school counseling students include knowledge of systems theories and processes, as well as strategies that facilitate partnerships with various stakeholders. The needs assessment and program feedback associated with the Building Family Bridges professional development module both indicated that despite the emphasis on collaboration in the ASCA model and the CACREP standards, a need for additional information, resources, and techniques focused on school-family collaboration exists. The 2016 CACREP standards for school counseling are less explicit regarding collaboration than the previous standards; however, the standards clearly state that school counseling students should develop “skills to critically examine the connections between social, familial, emotional, and behavior problems and academic achievement” (CACREP, 2015, emphasis added). Counselor educators seeking to address this area of knowledge and skill would be prudent to bolster the family-focused content of their curriculum to better prepare their school counseling students to establish effective collaboration with parents and families. Moreover, school counseling programs seeking or holding CACREP accreditation might consider requiring a course in family development and processes, particularly as they prepare to increase to the required 60 credits by 2020 (CACREP, 2015).

**Implications for Professional School Counseling**

The professional school counselors who attended the Building Family Bridges professional development module reported that the content was relevant to their work with students, parents, and families. Due to time constraints and consistent with their professional role, school counselors are not expected to conduct family therapy; however, incorporating family counseling theory and techniques into their repertoire of interventions can augment their service in schools, particularly in terms of school-family collaboration. Interventions may be used on an individual basis, such as exploring a family map or family floor plan with a student or parent, or may involve systemic interventions that facilitate communication among students and parents around issues such as family transitions and stressors. School counselors might also consider family-focused interventions that involve the entire school. Promoting family dinners and unplugged nights or weekends were examples of such whole-school efforts discussed during the Building Family Bridges workshop.

**Limitations**

The effectiveness of the Building Family Bridges professional development module should be considered in light of the small number of attendees. The module was delivered on a Saturday morning to professional school counselors who volunteered to attend without the expectation of receiving any compensation or incentive. Additionally, the workshop was not held in a school or other building associated with a school district. Rather, it was held at a university that may have been a significant distance from where the target population lives and works. Replicating this program with a larger number of professional school counselors would provide a broader, more in depth understanding of how a professional development activity focused on family development and processes can support professional
school counselors in their efforts to collaborate with parents and families.

**Conclusion**

Identified as an indirect service in the ASCA National Model (ASCA, 2012), collaboration is a key element of comprehensive, developmental school counseling programs. Effective collaborative relationships between schools and families provide support for students to positively impact their academic and behavioral performance in school. Despite having received adequate training, professional school counselors may lack knowledge and skills specific to family development and processes that would help facilitate partnerships with parents and families. A professional development opportunity such as *Building Family Bridges* is one method of augmenting school counselor training to better prepare professional school counselors to school-family collaboration.

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Multiculturally Competent Assessment: Guidelines for Multicultural Interviewing

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Abstract
With the increased need for multiculturally competent counseling, mental health professions have emphasized the importance of including a broad range of cultural variables into the assessment process. However, relatively little attention has been directed toward culturally focused assessment strategies. Specific multicultural assessment strategies that can be easily incorporated into clinical interviews have not been adopted by counselors and other mental health professionals. This article provides specific guidelines for applying multicultural clinical interviewing questions based on the existing multicultural counseling literature.

Keywords: multiculturally competent assessment, multicultural interviewing, multicultural competence, assessment, and clinical interview

As cultural diversity within U.S. population rapidly increases, counselors continue to face the challenge of providing multiculturally competent counseling service for individuals with varying cultural backgrounds (Lee, 2014). According to the 2014 U.S. Census Bureau national population projections, minority groups currently account for 37 percent of the population. By 2060, that number will exceed 57 percent (Colby & Ortman, 2014). This dramatic diversification supports the counseling field’s focus on multicultural competency.

For the last few decades, the counseling field has called for and placed greater emphasis in multicultural counseling and assessment (Lee, 2014; Pieterse, Evans, Rinser-Butner, Collins, & Mason, 2009). Multicultural counseling considerations are integrated and discussed in most counseling textbooks, hundreds of journal articles, and accreditation standards. Despite the emphasis on multicultural competence, research on multicultural counseling has almost exclusively focused on cultural awareness and knowledge (Hanna & Cardona, 2013). The limited research about specific multicultural counseling interventions support the need for developing appropriate multicultural counseling and assessment techniques and strategies (Hanna & Cardona, 2013).

A fundamental component of multicultural counseling is multicultural assessment (Dana, 2011; Pedersen, 1990; Sue, Ivey, & Pedersen, 1996). Assessment is the cornerstone of the counseling process by providing critical background information, including cultural factors necessary to develop an effective treatment plan (Dana, 2005; Jones, 2010). Researchers from related fields (e.g., psychology and psychiatry) have developed a few theoretical frameworks and models for assessing a client’s culture and context, but these models have had limited use or have not been adopted by most mental health professionals. The primary limitation is their inability to be easily incorporated into the clinical interview utilized by most clinicians (Aggarwal, 2012; Dana, 2005; Li, Jenkins, & Grewal, 2012). Thus, the purpose of this article is to provide (a) an overview of multicultural assessment, (b) a review of the existing models of multicultural assessment, and (c) specific guidelines, with example of multicultural clinical interviewing questions, for incorporating the multicultural assessment into the clinical interview.

Multicultural Assessment
Assessment in counseling refers to a systemic procedure, throughout the counseling relationship, of obtaining critical information about clients and integrating the information into the conceptualization of clients’ problems and development of appropriate treatment plans (Dana, 2005; Jones, 2010). With the increasing demand for multiculturally competent counseling, mental health professions have highlighted the importance of assessing a broad range of cultural variables into assessment. Cultural variables are defined broadly to include the following aspects: ethnicity, race, age, gender, language, sexual orientation, religious and spiritual orientation, socioeconomic status (SES), disability status, nationality, and other cultural contexts. Each of cultural variables has unique and mutually interactive issues. Today, the assessment of the cultural variables in counseling is viewed as a clinical, ethical, and social justice mandate (Pieterse & Miller, 2010).
Multicultural assessment refers to a systemic method of gathering information about various aspects of culture that a client brings to the therapeutic relationship and incorporating the cultural information into comprehensive understanding of clients’ problems and culturally-informed treatment plans (Dana, 2005; McKitrick, Edwards, & Sola, 2007). In particular, the initial cultural information gathering from clients is considered the most fundamental component of multicultural assessment; it is the beginning of every counseling relationship and the cornerstone of obtaining an accurate picture of clients and providing on-target treatment (Pederen, 1990; Pieterse & Miller, 2010; Sue et al., 1996). By implementing specific multicultural assessment strategies and techniques, counselors can obtain information about the effect of culture on key aspects of clients’ presenting problems. However, limited models of multicultural assessment exist that include specific, practical strategies for gleaning culturally relevant information directly from the clients that can be used to understand cultural influence on psychological well-being (Dana, 2011; Pieterse & Miller, 2010).

There have been attempts within the mental health professions to develop models of multicultural assessment that move from abstract discussion to specific guidelines for collecting and interpreting clients’ cultural information. However, these models have had limited use by mental health professionals due to the lack of practicability and applicability for everyday counseling practices (Aggarwal, 2012; Pieterse & Miller, 2010). Models of the multicultural assessment lack specific guidelines as to how to collect cultural data from clients, or are not easily incorporated into the clinical interview used by most mental health professionals (Aggarwal, 2012; Dana, 2005; Li et al., 2012). The following section aims to provide a review of the existing models of multicultural assessment, including the theoretical frameworks that underlie each models, and a discussion of their limitations.

Models of Multicultural Assessment

With the emphasis on multiculturally competent counseling, some theoretical frameworks and models relevant to multicultural assessment have been developed that are designed to be inclusive of cultural variables. Following is a review of five models of multicultural assessment: Person-In-Cultural Interview (PICI; Berg-Cross & Chinen, 1995), Multicultural Assessment Procedure (MAP; Ridley, Li, & Hill, 1998), Multicultural Assessment-Intervention Process Model (MAIP; Dana, 2005), Cultural Assessment Interview Protocol (CAIP; Grieger, 2008), and Cultural Formulation Interview (CFI; American Psychiatric Association [APA], 2013a).

**Person-in-Cultural Interview (PICI)**

The Person-in-Culture Interview (Berg-Cross & Chinen, 1995) is designed to train mental health professionals in multicultural understanding and to help establish a therapeutic relationship with clients from diverse cultures. This interview consists of 24 open-ended items that helps counselors explore the client’s cultural background without engaging in stereotyping. The framework for the interview builds upon the philosophy that the mechanism by which human basic needs are met is culturally derived (Berg-Cross & Chinen, 1995). As such, asking about basic needs spontaneously allows cultural relevant issues to emerge.

The PICI’s interview questions are rooted in four theories: psychodynamic, humanistic, family, and existential psychology. Psychodynamic questions are designed to provide counselors with an understanding of how an individual represents culturally appropriate expression of basic psychodynamic needs. Humanistic interview questions are based on the five motivational needs: physiological need, safety and security, love and belonging, self-esteem, and self-actualization (Maslow, 1968). Family questions are designed to assist counselors in understanding family cultures, including power dynamic and structure among family members. Lastly, existential psychology questions that focus on philosophical issues of human beings’ existence, such as religion, meaning of life, and social support (Berg-Cross & Chinen, 1995). Despite the comprehensiveness theoretical framework for interview questions, the PICI model has a primary limitation for counseling practice. This model was developed as a general tool for professionals across disciplines (e.g., social services, business, industry, and cooperation). Consequently, the PICI’s interview questions are not specifically tailored to counseling practice, neither does it provide specific guidelines...
for mental health professionals to rely on in counseling practice.

**Multicultural Assessment Procedure (MAP)**

The Multicultural Assessment Procedure (MAP; Ridley et al., 1998) is an assessment protocol comprised of four progressive phases driven by theory: (a) collecting cultural data using multiple methods, (b) interpreting data and hypothesis formulation, (c) hypothesis testing, and (d) relevant clinical formulation and assessment decision (Ridley et al., 1998, p. 869). Each of the four phases is described with guidelines and decision points that help counselors arrive at a culturally relevant decision-making. In particular, the MAP model considers the clinical interview as the central assessment method during the first phase of collecting cultural data. During the initial phase, this model suggests counselors to address such cultural variables as “level of acculturation, history of oppression, language, experience of racism and prejudice, sociopolitical issues, religious and spiritual practices, family composition, and cultural value affecting communication, and gender roles and sexuality” (Ridley et al., 1998, p. 871). Additionally, the authors recommend that mental health professionals formulate working hypotheses that address the client’s cultural values in relation to the presenting problem, the extremeness of the client’s behaviors within cultural contexts, and the client’s interpretation of the clinical presentation. Despite the initial attention on the role of the clinical interview as the primary method of collecting cultural data in multicultural assessment procedure (Dana, 2005), the MAP model does not include a specific guideline as to how to gather such cultural data (e.g., level of acculturation and history of oppression) within the context of a clinical interview, neither does it provide example of interview questions that can be integrated into the clinical interview format.

**Multicultural Assessment-Intervention Process (MAIP)**

The Multicultural Assessment-Intervention Process (MAIP; Dana, 2005) is designed to outline a process of assessment with ethnic and racial minorities. Within the MAIP model, counselors progress through a series of decision points as answering specific questions that lead to culturally relevant diagnostic formulation and intervention.

The questions assess the following areas: (a) client’s cultural orientation, (b) the availability of universal and cultural-specific instruments, (c) the suitability of using Anglo or standard norms, (d) cross-cultural intersections stress and the need for cultural-specific conceptualization, and (e) the necessity for a diagnosis (Dana 2005, p. 69). Furthermore, the MAIP emphasizes the importance of addressing cross-cultural intersection stress (e.g., acculturative distress) and the influence of oppression on minority populations in the diagnostic assessment process. Despite a major contribution to a specific outline of multicultural assessment process and the consideration of client’s cultural characteristics, the MAIP does not focus on a specific guideline as to how to assess such client’s cultural characteristics within a clinical interview format.

**Cultural Assessment Interview Protocol (CAIP)**

The Cultural Assessment Interview Protocol (CAIP; Grieger, 2008) is a pragmatic approach to multicultural assessment and emphasizes the clinical interview as the most critical tool in gathering cultural data from clients. The CAIP outlined 11 categories of cultural contexts to address, including the following: “(a) problem conceptualization and attitudes toward helping, (b) cultural identity, (c) level of acculturation, (d) family structure and expectation, (e) level of racial and cultural identity, (f) experience with bias, (g) immigration issues, (h) existential/spiritual issues, (i) counselor characteristics and behaviors, (j) implications of cultural factors between the counselor and the client, and (k) summary of cultural factors and implications for diagnosis, case conceptualization, and treatment” (Grieger, 2008, p. 140). The CAIP embraces the first nine categories for gathering cultural data, and each category includes a set of example interview questions that counselors may use with clients. Despite the pragmatic approach to collecting clients’ cultural data with the specific interview protocol and questions, the CAIP does not provide a specific implication as to how to integrate the interview protocol and questions throughout the clinical interview. As a separate interview protocol, the CAIP requires counselors’ extra commitment to complete the interview protocol within its own format, which takes up too much time.
The Cultural Formulation Interview (CFI), published in the fifth edition of Diagnostic and Statistical Manual of Mental Disorder (DSM-5), is a semi-structured multicultural interview that consists of 16 questions used to obtain information about the impact of cultural factors in the clinical encounter (APA, 2013a, p. 751). The CFI was developed as a potentially useful assessment tool to further enhance clinical understanding and decision-making. The CFI underscores the four main domains to assess cultural factors in a clinical encounter, including cultural definition of problem; cultural perceptions of cause, context, and support; cultural factors affecting self-coping and past help seeking; and cultural factors affecting current help seeking (APA, 2013a, p. 751). The CFI is considered a culturally-focused interview that can be used in its entirety or part at the initial assessment (e.g., clinical interview). However, as a separate interview protocol, the CFI is developed within its own format that does not have a natural flow with the clinical interview template. Despite the suggestion of using only some of the CFI questions, there is no description of how the CFI questions can be tailored throughout the clinical interview (Aggarwal, 2012). Additionally, examples of multicultural interview questions that the CFI proposes do not differ significantly from most standard clinical interview questions (Aggarwal, 2012).

Guidelines for Incorporating the Multicultural Assessment into Clinical Interview

Although the various models presented significantly inform the development of multicultural assessment, they have not been widely adopted by counselors because they lack specific guidelines for how to collect cultural data from clients, or are not easily incorporated into the clinical interview used by most mental health professionals (Aggarwal, 2012; Dana, 2005; Li et al., 2012). However, these models inform us of several overlapping cultural themes that are critical for counselor to address in multiculturally competent assessment, including (a) cultural identity, (b) cultural conceptualization of the problem, (c) cultural factors affecting psychosocial stressors, (d) cultural issues related social system and family, and (e) cultural issues affecting the therapeutic relationship. To make the information provided in these models more applicable for counselors, this section will provide specific guidelines for incorporating multiculturally competent assessment questions into clinical interview, based on these overlapping cultural themes. The cultural themes will be presented in accordance with relevant sections of clinical interview (e.g., identifying information, presenting problem, and developmental history) that allow counselors an opportunity to practically address each theme during clinical interview. Each cultural theme are arranged in the usual sequence of clinical interview sections, so we recommend counselors to address each cultural theme in the order of guidelines listed in this article. Additionally, this article will offer examples of culturally-relevant illustrative interview questions tailored to each cultural theme, so counselors can be guided to incorporate multicultural interview questions into their clinical interview.

Despite the recommended order of the cultural themes to address, we acknowledge that the circumstance of any interview procedure can vary due to client's level of functioning, available time, and focus of counseling. Therefore, we emphasize that this guideline should be used flexibly to maintain a natural flow of the interview and foster therapeutic relationship with clients.

Guideline 1: Cultural Identity

The assessment of cultural identity can be integrated throughout the clinical interview. Cultural identity refers to one's self-perception that is formed by the relationships with various cultural factors, such as sexual orientation, gender, age, race and ethnicity, language, religious belief, socio-economic status, nationality, and education (McCall & Simmons, 1978; Sue, Arredondo, & McDavis, 1992; Alarcón, 2009). Cultural identity is involved in constructing one's view of the world and identity. Therefore, counselors are encouraged to consider various aspects of the client's cultural identity to accurately assess the client's perception on presenting problems and treatment (APA, 2013a, p. 750; Dana, 2005; Grieger, 2008; Ridley et al., 1998). In particular, counselors need to be attentive to aspects of the client's cultural identity that are personally salient and determine the importance and meaning of the cultural identity in interaction with their presenting problems.
While exploring the clients’ identifying information during the clinical interview, counselors can tailor the subsequent questions relevant to the aspects of the client’s cultural identity that are salient for their life and the significance of their cultural identity in interaction with their presenting problems. The following include the example of questions (APA, 2013a, p. 754; Grieger, 2008, p. 151):

- Based on background information you just gave me, what aspect of your background is the most culturally salient to you?
- What aspects of your background do you feel culturally closest to?
- Are there any aspects of how you culturally identify that may impact on your problem? If so, in what way?
- Is there anything about your cultural identity that you perceive makes your problems (or concerns) worse or better?
- What does it mean to you to be a member of your cultural group(s)?

Additionally, it is essential to gather information about the client’s experience of multiple cultural identities due to migration history and how the experience influenced the client’s presenting problems. For example, it is reported that immigrants suffer distinctive psychological distress related to acculturative stressors, such as adjusting to new cultures that may contradict their traditional cultural values (Schwartz, Unger, Zamboanga, & Szapocznik, 2011; Suárez-Orozco, Suárez-Orozco, & Todorava, 2008) and cultural conflicts between generations (Aggarwal, 2010). While exploring the clients’ identifying information or developmental history during the clinical interview, the following questions can be useful for counselors to develop an empathic understanding of the client’s multiple identities and more accurately assess their influence on presenting problems (APA, 2013a, p. 754; Dana, 2005; Grieger, 2008, p. 152):

- I noticed that you come from a different country. How comfortable are you feeling with X culture?
- What are some aspects of your cultural identity that do not fit well in the new culture?
- Is there anything about your experience of adapting to a new culture that makes a difference to your problem?
- Are there any aspects of your cultural identity that do not fit in your cultural groups? If so, how does it influence the problem at this time?

**Illustration.** In the clinical interview session with a 21 years old, second generation immigrant, Asian American male with depression (referred to as Steven) who are reticent, counselors ask him further as collecting identifying information about him, “What does it mean to you to be an Asian American?” “Based on background information you just gave me, such as your ethnic, second-generation immigrant, age, etc., what aspect of your backgrounds are you feeling culturally closest to?” and “I noticed that you are a second-generation immigrant. Is there anything about your experience of adapting to an American culture that makes a difference to your problem?” These questions will allow counselors to understand the intersecting aspects of Steven’s cultural identity and his withdraw from school friends because of struggle with acculturation.

**Guideline 2: Cultural Conceptualization of the Presenting Problem**

With a better understanding of the client’s cultural identity, counselors need to be attentive to how clients conceptualize their presenting problems within their cultural contexts, which is called cultural conceptualization. Cultural conceptualization refers to the roles of cultural contexts that influence how the individual perceives, experiences, and explain their concerns or problems (APA, 2013a, p. 750). In many cultural contexts, clients may conceptualize and explain their presenting problems in an unfamiliar way to counselors (APA, 2013a, p. 750; Berg-Cross & Chinen, 1995; Dana, 2005; Grieger, 2008; Ridley, 1998). Also, the cultural variations in the conceptualization of the problem affect client’s expression or communication style. Clients may identify their problems as a specific term or cultural idiom, symptom, situation, or a relationship. For example, it is reported that Asians often perceive and express their psychological symptoms in the form of somatic symptoms (Grover & Ghosh, 2014). Therefore, it is critical for counselors to assess clients’ cultural understanding of their presenting problems that influence the counseling process in various ways, including building rapport, diagnosis, and treat-
The assessment of the cultural conceptualization of the problem can be integrated throughout the clinical interview. While probing the client’s presenting problem during the clinical interview, the following questions can be utilized to elicit information regarding the client’s cultural conceptualization and expression of the presenting problems (APA, 2013a, p.752; APA, 2013b; Berg-Cross & Chinen, 1995, p. 340; Grieger, 2008, p. 151):

- Each culture has its own ways in understanding problems and their causes. If you described your problem to somebody you feel close to in your culture, how would you do so? Or how do you describe your problem to your family or friends?
- How do you describe the cause of the problem to someone in your community or culture?
- How do you think your problem or concern cause pain in your body, mind, or spiritual wellbeing?
- Are there any specific expressions or terms for you or your culture that describes the problem?

Illustration. In the clinical interview session with Steven, counselors can ask him further as addressing the presenting problem, “How do you describe the problem you share with me to your family or friends?” and “How do you explain to your family or friends what causes your problem?” These questions provide counselors information on how Steven communicates his problem (e.g., “I told my family that my body hurt whenever I feel blue) and understand the cause of problem (e.g., I told my parents that my classmates do not like my accents and the way I interact with people. I think I am too shy and reticent).

Guideline 3: Aware of Cultural Factors Affecting Psychosocial Stressors

Cultural factors affecting psychosocial stressors refer to the interplay of various cultural contexts and factors in which a client lives. Many social groups face distinctive psychological distress associated with systemically traumatic events, such as discrimination (e.g. racism, sexism, xenophobia, or homophobia) that they experience due to their culturally minority status. For example, culturally marginalized social groups, such as racial and sexual minorities, immigrants, and women, often experience psychological oppression and posttraumatic symptoms that are attributed to institutional and interpersonal discriminations, which impacts or exacerbates their presenting mental health problems (Bostwick, Boyd, Hughes, West, & McCabe, 2014; McLaughlin, Hatzenbuehler, & Keyes, 2010). In fact, experience of discrimination or oppression has been found to be associated with the high rate of negative psychosocial well-being, such as depression, anxiety, dysfunctional lifestyle, internalized racism, and low self-esteem (APA, 2013a, p. 750; Bostwick et al., 2014; Paradies, 2006). Therefore, it is necessary for counselor to explore key psychosocial stressors (e.g., experience of discrimination or oppressive life circumstances) associated with cultural factors and contexts (e.g., cultural identity and backgrounds) in which clients live and its psychological consequences.

During exploration about history of presenting problem, developmental history, or social history during the clinical interview, counselors have an opportunity to further probe early systemically traumatic events or oppressed life circumstances associated to his or her cultural background and its psychological influence on the presenting problem. Examples of questions include the following (APA, 2013a, p. 754; Dana, 2005; Grieger, 2008, p. 152):

- Have you experienced unpleasant circumstances, such as racism, sexism, and any biases, because of your cultural background? If so, how do you think the experience impacts the presenting problems?
- Have you experienced oppression or discrimination? If so, how has the experience contributed to the current problem?
- Have you experienced personal challenges or stressors related to different aspects of your cultural background?
- If so, how have these experiences impacted your presenting problem?

Illustration. In the clinical interview session with Steven, counselors can ask him further, “Have you experienced unpleasant circumstance in your college, such discrimination or racism by your classmates or faculty, because of your Asian American background?” and “Do you think your problem is exacerbated by personal challenges related to your cultural background?” These questions may allow counselors to understand the impact of possible discrimination (e.g., struggle with microaggression
in the college) on his feeling of depression and isolation.

**Guideline 4: Cultural Issues Related to Family and Social System**

Cultural issues related to the social system and family, not only influence clients’ presenting problems, but also play a role in their vulnerability and resilience. These cultural issues include societal and family experiences that influence one’s cultural identity and presenting problem, such as social convention, family structure and dynamics, and gender roles (APA, 2013a, p.750; Berg-Cross & Chinen, 1995; Grieger, 2008; Ridley et al., 1998). In other words, the client’s presenting problems can be associated with cultural differences within the family or between the family and society. For example, the client may have a belief system about cultural identity (e.g., role of religion and gender) that deviates from the family’s cultural norms, which may impact or exacerbate the client’s presenting problem (APA 2013a, p. 750; Berg-Cross & Chinen, 1995; Grieger, 2008; Ridley et al., 1998). Additionally, exploring such cultural issues can uncover potential conflicts or incongruence in the perception among the clients and their society and family in terms of their presenting problem and expectation of counseling service. For example, the client may have a perception of their presenting problems or treatment expectation that is discrepant from that of their family members. Or the client's family culture may be inconsistent with social norms in relation to the understanding of mental health problems, cause of the mental health problems, and most useful treatments (APA, 2013a, p. 750; Berg-Cross & Chinen, 1995; Grieger, 2008; Ridley et al., 1998). Therefore, attempts to understand family or societal cultures related to clients’ presenting problems can provide an opportunity to elicit information about social system and family as a potential barrier or resource to the client’s treatment (APA, 2013a, p. 750; Hinton & Lewis-Ferández, 2010).

While exploring family or social history during the clinical interview, counselors can tailor the subsequent questions relevant to cultural issues related to social system and family. Example of questions includes the following (APA, 2013a, p. 754; APA, 2013b; Berg-Cross & Chinen, 1995, p. 340; Grieger, 2008, p. 152):

- What aspects of your cultural identity do you think that is the most salient to your family?
- Are there aspects of your cultural identity that does not fit in social convention or family culture? If so, how does it cause problems for you?
- How do you think that your family describes your problem? How do they understand what is going on your life?
- Does your family think about the problem differently from what you think? If so, how does this impact your problem?
- When you were in childhood or adolescence, did you think that your family was different from other families? If so, in what way?
- Has your family helped you cope with the presenting problem? If not, what kind of help do you expect from them?
- Do your family members or society share your spiritual or religious tradition? If not, how does it cause problems for you?

**Illustration.** In the clinical interview session with Steven, counselors can further ask him as addressing social system and family, “Is there aspects of your family culture that does not fit in the main American culture?” “How do you think that your family understands the cause of your feeling of depression and isolation?” and “How do you want your family to help you with this problem?” In response, Steven may point out incongruence in understanding of mental health problem and solution of it between his family culture and social norm.

**Guideline 5: Cultural Issues Affecting the Therapeutic Relationship**

Cultural issues related to the therapeutic relationship should be explored to alert counselors to cultural elements that may affect the therapeutic relationship between counselors and clients. Clients may face some difficulties in working with counselors due to cultural differences in gender, language, race, social status, and history between counselors and clients (APA, 2013a, p. 750; Grieger, 2008; Smith, Rodríguez, & Bernal, 2011). For example, historical differences in power and position among various cultural groups may impact the counseling relationship, producing tensions in the counseling encounter (APA, 2013a, p. 750; Grieger 2008). Additionally, clients may have had negative experiences from previous counseling,
including miscommunication or culturally insensitive interventions. In fact, it is reported that individuals from cultural minority groups often experience discriminatory practice by the lack of culturally-focused counseling services, including counselors’ insensitivity of cultural differences (Smith et al., 2011), contributing to the clients’ negative attitude toward counseling services (APA, 2013a, p. 750; Cabral & Smith, 2011).

Therefore, it is critical for counselors to pay attention to the client’s perception of the client-counselor relationship in regard with cultural backgrounds, and to address any past negative counseling experiences and its influence on the client’s view of therapeutic relationship and process. In doing so, it provides counselors the opportunity to address cultural differences in the current counseling relationship. While exploring the history of the previous counseling during the clinical interview, counselors can tailor the subsequent questions relevant to the cultural issues affecting therapeutic relationship. The following are examples of questions (APA, 2013a, p. 754; Grieger 2008. p. 155):

• I notice that you have an experience of seeking counseling in the past. Have you experienced any culturally insensitive counseling service before? If yes, would you tell what made you feel unpleasant about previous counseling?
• If you had negative experience with counseling in past, how does the experience affect your comfort-level and perception of current relationship with me as a counselor?
• Like you, I also have my own cultural background and identity. Are there aspects of my cultural identity or backgrounds that concern you? If so, in what way?

Illustration. A counselor conducting the clinical interview with Steven is of a different ethnic background. The counselor can ask him further, “I noticed that I have different ethnic background than yours. How does it feel for you to work with me whose different ethnic background?” “Do you have any concerns toward working with me whose different cultural backgrounds” Counselors will have opportunity to develop a trust and safe relationship with Steven by initiating this meaningful dialogue about cultural differences.

Conclusion

As the multicultural competence of counselors in mental health counseling settings become more essential, so does the need for more training on accurate, specific multicultural assessment during the assessment process. However, the counseling field faces challenges in preparing counselors to be competent in using multicultural assessment because the existing theories and models of multicultural assessment have the inability to be easily incorporated into clinical interview and lack of guidelines for competent practice. Therefore, this article aims to provide specific guidelines for incorporating the multicultural assessment into the clinical interview. Because most counselors must engage in clinical interview, they can benefit from using this specific guideline and questions to elicit comprehensive information on the client’s cultural background and experience.

Counselors should know what cultural factors they need to address during the clinical interview and how the cultural factors are associated with the client’s presenting problem. Counselors ask specific questions related to the client’s cultural backgrounds and experience to obtain comprehensive information required for developing effective interventions. Throughout the interview, counselors look for cultural factors that are salient to the client’s presenting problem and follow up those factors with multicultural interview questions to help establish culturally-informed interventions.

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References


Creating Safer Schools for LGBQT+ Students

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**Abstract**

Despite increased acceptance in society towards lesbian, gay, bisexual, queer, transgender, + (LGBQT+) youth, data from the Gay, Lesbian and Straight Education Network continues to show ongoing hostility towards LGBQT+ students in public schools in the United States. Moreover, this antagonistic environment has a substantial negative impact on LGBQT+ students' emotional health, grades, and plans for the future. School counselors have an ethical responsibility to improve school climates for all students, including LGBQT+ youth, and are uniquely qualified to do so. In this article, we offer a blueprint for school counselors to use to improve their school climates for LGBQT+ students. This plan includes establishing anti-discriminatory school policies, creating a network of visible LGBQT+ allies among staff, establishing Gay Straight Alliance clubs, and offering individual and group counseling to LGBQT+ students.

**Keywords:** LGBQT+ youth, safe schools, school counselors

In the United States, openness to individuals who identify as lesbian, gay, bisexual, queer, transgender, + (LGBQT+) appears to have never been greater. From a legal perspective, in 2015, the United States Supreme Court ruled in *Obergefell v. Hodges* that same-sex marriage is a constitutional right. In addition, there are signs of political changes in many states. Presently, 24 states prohibit discrimination based on sexual orientation, compared to only 12 states a decade prior. Twenty-one states forbid discrimination based on gender identity, compared to only one state in 2000 (Hatzenbuehler, Brickett, Van Wagenen, & Meyer, 2014). These estimates suggest that more than 7% of adolescent students (grades 6-12) in U.S. schools are part of the LGBQT+ population. Such a percentage indicates that millions of students attending public schools in the U.S. every day identify as lesbian, gay, bisexual, queer, and/or transgender.

**LGBQT+ Identity Prevalence**

General population surveys indicate that 3.5% of adults identify as lesbian, gay, or bisexual, and approximately 0.3% of adults identify as transgender (Gates, 2011). Although estimations of LGBQT+ youth are less common, researchers in one study combined surveys of adolescents in eight U.S. jurisdictions and estimated that 1.3% of youth identify as lesbian or gay, 3.5% identify as bisexual, and 2.4% of youth are unsure of their sexual orientation (Hatzenbuehler, Brickett, Van Wagenen, & Meyer, 2014). These estimates suggest that more than 7% of adolescent students (grades 6-12) in U.S. schools are part of the LGBQT+ population. Such a percentage indicates that millions of students attending public schools in the U.S. every day identify as lesbian, gay, bisexual, queer, and/or transgender.

**LGBQT+ Students’ Reported School Experiences**

Every two years, the Gay, Lesbian and Straight Educational Network (GLSEN) publishes results from a national school climate survey. In the 2014 report, researchers surveyed 7,898 LGBQT+ middle and high school students from all 50 states and the
District of Columbia (Kosciw et al., 2014). They found that 55.5% of LGBTQ+ students felt unsafe at school because of their sexual orientation. Anti-LGBTQ+ remarks were reportedly heard frequently or often by 71.4% of students surveyed, and 51.4% of students reported hearing “homophobic remarks from teachers or other staff” (Kosciw et al., pp. xvi-xvii). Nearly three quarters of the LGBTQ+ students surveyed said they were verbally harassed, and 16.5% of them reported having been physically assaulted. Among the LGBTQ+ participants who reported harassment or assault, most did not report the experiences to school staff, and of those who reported experiencing offending behavior, 61.6% said that school staff did nothing to respond to their reports (Kosciw et al.).

Furthermore, it is clear that this victimization of LGBTQ+ youth has a powerful impact on emotional health as well academic outcomes. In a 2011 study, researchers found that lesbian, gay and bisexual youth were four times as likely to attempt suicide as heterosexual youth, and questioning youth were three times as likely to make a suicide attempt (Centers for Disease Control and Prevention [CDC], 2011). The suicide attempts by lesbian, gay and bisexual youth were approximately five times as likely to lead to injury, poisoning or overdose requiring treatment by a medical professional, as compared to their straight peers (CDC). When considering the impact of victimization on school performance, Kosciw and colleagues (2014) found that LGBTQ+ students who experienced higher levels of victimization had lower grade point averages than those harassed less often. These students are also less likely to make plans for post-high school education, and are considered high risk for dropping out of school (DePaul et al., 2009).

Furthermore, evidence indicates serious long-term consequences for youth who are bullied in school. School bully victims are at a markedly increased risk for suffering psychiatric disorders in adulthood and to be slow to recover from illnesses (Wolke, Copeland, Angold & Costello, 2013). They are also more likely to engage in risky and illegal behaviors in adulthood (Wolke et al.). In addition, youth victims are at an increased risk for living in poverty as young adults compared to non-victims. The severity of their financial problems tends to increase as the frequency of their victimization increases (Wolke et al.).

The second theme suggested by Kosciw and colleagues (2014) study is more hopeful. LGBTQ+ students who attended schools with explicit LGBTQ+ supports reported fairing better than those who did not attend such schools. For example, students surveyed who attended schools with LGBTQ+ curricula (e.g. learning about lesbian, gay, bisexual and transgender historical events and positive role models) reported hearing derogatory remarks less frequently than students attending schools without LGBTQ+ curricula. Students in schools with Gay Straight Alliance (GSA) clubs also reported hearing the term “gay” used in negative ways less frequently than students attending schools without GSAs. Furthermore, students surveyed who were able to identify many supportive staff members at their schools reported higher levels of safety, fewer missed days of school, and higher grade point averages. Unfortunately, only 38.7% of students surveyed could identify multiple supportive staff members in their schools (Kosciw et al., 2014).

School Counselors and LGBTQ+ Students

Professional school counselors possess a minimum of a Master’s degree and provide services to elementary, middle, and high school students. They assist students in academic, social/emotional, and career development and utilize classroom guidance lessons, individual counseling, and small group counseling to do so. They also provide students with individual student planning for course selection and college/career planning (Gysbers & Henderson, 2012). In addition, school counselors are called to be advocates for students’ needs, and to help create a safe learning environment that promotes the rights of all students across cultural backgrounds (Sandhu, 2000). Lastly, school counselors’ responsibilities include social advocacy for students and working with teachers and administrators to collaborate in helping the whole child (Gysbers & Henderson).

A safe learning environment for students is one in which all student populations, including LGBTQ+ students, feel comfortable and supported. In such an environment, students, faculty, and staff respect diverse sexual orientations and create a sense of belonging for all students (Michigan State University, 2004). In their role as advocates, school counselors have a responsibility to make a positive
impact on the school climate for LGBTQ+ students. This responsibility is apparent in the American School Counseling Association’s (ASCA) ethical standards for school counselors, which state that “each person has the right to be respected, be treated with dignity and have access to a comprehensive school counseling program that advocates for and affirms all students, including: … sexual orientation, gender, gender identity/expression … ” (ASCA, 2010, Preamble). Moreover, ASCA’s 2014 position statement on LGBTQ+ youth demonstrates their unequivocal encouragements of school counselors supporting LGBTQ+ students. ASCA states “school counselors are committed to the affirmation of all youth regardless of sexual orientation, gender identity and gender expression and work to create safe and affirming schools” (ASCA, 2014, pp. 38-39).

Given the results of the 2014 GLSEN Climate Survey, it is clear that more needs to be done for LGBTQ+ students. Students spend substantial time in school during the week, so educators have a great opportunity and responsibility to create a positive learning environment. Students who report being in a positive school climate have fewer disciplinary problems (Nelson, Martella, Marchand-Martella, 2002), report a stronger feeling of safety (Syvertsen, Flanagan & Stout, 2009) and report increased satisfaction with life (Suldo, McMahan, Chappel & Loker, 2012). Moreover, students in a positive school climate have self-reported higher grade point averages, regardless of their family structures (O’Malley, Voight, Renshaw & Eklund, 2015). School counselors can be effective in improving climate generally, and more specifically in reducing homophobia in schools and providing helpful counseling and advocacy services to LGBTQ+ students (Byrd & Hays, 2013). However, some school counselors may lack a plan for doing so. In the remainder of this article, a comprehensive plan to improve school climate for LGBTQ+ students is outlined (Depaul et al., 2009; Roe, 2014). All of the interventions presented in this plan appear especially relevant for school counselors to implement, allowing them to take a more proactive approach toward establishing best practices for helping LGBTQ+ students feel safe in schools.

A Plan to Improve School Climate for LGBTQ+ Students

It is unlikely that a single intervention in any school will be sufficient to create meaningful and broad change for LGBTQ+ students. Rather, the problem of LGBTQ+ victimization is most effectively addressed with a multi-faceted approach (Depaul et al., 2009; Goodrich, Harper, Luke, & Singh, 2013). The following comprehensive plan includes four strategies: anti-discriminatory policies, a network of allies, Gay-Straight Alliances, and individual and group counseling.

Anti-Discriminatory Policies

The first step in creating an improved school climate for LGBTQ+ students is establishing clear anti-discriminatory school policies that include protections for sexual identity and sexual orientation, as well as incorporate LGBTQ+ inclusive language in school communications (Depaul et al., 2009). Many schools have anti-bullying policies, but not all include statements about LGBTQ+ issues. For example, Kosciw et al. (2014) found that the majority of the students surveyed reported awareness of anti-bullying policies at their schools, but only 10.1% indicated that these policies included sexual orientation issues. Yet, such policies can have a powerfully supportive impact for LGBTQ+ students. For sexual minority youth at schools whose anti-bullying policies included an LGBTQ+ component, there were a significantly reduced number of suicide attempts for lesbians and gays (Hatzenbuehler & Keyes, 2013). In contrast, schools that had anti-bullying policies but no gender or sexual orientation language, were not associated with reduced suicide attempts among lesbian and gay youth (Hatzenbuehler & Keyes). As advocates for systemic change, school counselors can work with school administrators to establish clear policy statements against verbal and physical harassment of LGBTQ+s and promote LGBTQ+ inclusive language in curricula. If school administrators are initially resistant to change, it may be effective to cite statistics from the National Climate Survey, focus on concerns for safety since this is a responsibility of all administrators, and emphasize the positive benefits from change (GLSEN, 2013). To ensure that any such policies are understood by students and staff, school counselors can conduct classroom guidance lessons and offer teacher workshops to allow everyone an opportunity to explore the
meaning of the school’s policies and the possible ways all school community members can foster a supportive climate.

Creating a Network of Allies

A second step in improving school climate for LGBQT+ students involves collaborating with other school staff and faculty members to build a visible support network for LGBQT+ students. Kosciw and colleagues (2014) found that more than one-third of 7,898 surveyed students reported feeling that school administration was unsupportive toward LGBQT+ students. Students reported more comfort talking with teachers about LGBQT+ issues than with any other type of staff member (Kosciw et al., 2014). Surveyed LGBQT+ students also stated that when more allies are present, they feel safer. These statistics suggest that creating a large network of staff who openly demonstrate LGBQT+ support within a school could assist in creating an improved school climate for LGBQT+ students. To create such a network, school counselors can enlist diverse allies that include everyone from school administrators to teachers to bus drivers (Cooper, Dollarhide, Radliff, & Gibbs, 2014). Such displays may include displaying Safe Space stickers in classrooms or offices, correcting individuals who use derogatory LGBQT+ terms, and incorporating notable LGBQT+ figures into curricula. Hillard, Love, Franks, Laris, and Coyle (2013) found that LGBQT+ students wished they observed such support more frequently. Furthermore, having just one understanding adult in a school can be a protective factor for LGBQT+ youth (Byrd & Hays, 2013; Goodenow, Szalacha & Westheimer, 2006; Kosciw et al.), therefore creating a network of allies can increase the opportunity for LGBQT+ students to connect with supportive adults and may help them avoid victimization in the future. The use of Safe Space stickers and public correction of homophobic slurs will also serve to let those who are not yet ready to publicly identify their sexual orientation and identity that confidential conversations with at least certain adults will be protected.

Allies are important not only because of their support for LGBQT+ students, but also because they can provide school counselors with networks of mutual support when resistance to change is encountered (Cooper et al., 2014). If a school lacks an initial number of existing allies, school counselors may benefit from educating faculty and staff members about the impact that verbal hostility and microaggressions have on LGBQT+ youth, as well as the best techniques for responding to LGBQT+ negative language when it occurs. One common training is known as Safe Space Training, which is available through many local GLSEN chapters and remotely through GLSEN webinars (http://www.glsen.org/educate/professional-development). In a 2013 study, Byrd and Hays found that Safe Space Training was associated with significantly higher levels of knowledge about LGBQT+ issues among training participants compared to individuals who did not participate in such training. This program provides information about how to verbally support LGBQT+ students, and the Safe Space kit from GLSEN supplies stickers, signs and posters that staff can use to openly identify themselves as a safe space. By creating an understanding of LGBQT+ discrimination, school counselors may also create allies among faculty and staff members who can in turn demonstrate their support for LGBQT+ students.

Gay Straight Alliance

GSAs are extracurricular clubs for middle and high school students where LGBQT+ and straight students can meet, explore different aspects of themselves, and promote school tolerance of LGBQT+ issues (Valenti & Campbell, 2009). GSAs are associated with long-term positive well-being scores in young adults who identified as LGBQT+ in high school and were interviewed years later (Twoomey Ryan, Diaz & Russell, 2011). Twoomey and colleagues interviewed 245 individuals between the ages of 21 and 25 who identified themselves as lesbian, gay, bisexual, or transsexual. The researchers also administered surveys on four indicators of psychosocial adjustment. Those subjects who reported having a GSA club in high school had higher scores for psycho-social well-being, higher self esteem levels, reduced dropout risk and demonstrated higher college-level education attainment. Those that participated in GSA clubs also had fewer substance abuse problems and lower suicide risk as adults (Twoomey et al.). GSAs can also lead to positive peer social relationships and increase students’ sense of connection to their schools (Lee, 2002). Moreover, these clubs can be helpful in promoting acceptance of sexual minority youth among all students (Varjas et al., 2007). Despite the demonstrated value of GSAs, Kosciw et al. (2014)
found that they were prevalent in only 50.3% of the schools of their surveyed participants.

The absence in other schools may be due to faculty disinterest, rather than student disinterest. While interviewing 12 GSA club advisors, Valenti and Campbell (2009) found that all admitted to weighing the benefits and risks of becoming advisors, which included fear arising from openly supporting LGBTQ+ students at school. These fears included lack of credibility with LGBTQ+ youth (most study participants were heterosexual), loss of employment, and being accused of recruiting “to the ‘gay lifestyle’” (Valenti & Campbell, p. 238). Despite these notions, none of the study participants expressed regret at having become a GSA advisor (Valenti & Campbell). It may be helpful for school counselors to consider these concerns when recruiting GSA club advisors. In addition, school counselors might want to facilitate discussions among GSA club advisors so that anxieties and experiences can be shared.

**Individual and Group Counseling**

Regardless of a school’s systemic support for LGBTQ+ students, educators may be wise to include individual counseling for sexual minority youth and group counseling for LGBTQ+ bullying victims (Varjas et al., 2007). Counseling allows school counselors to assist students who have already endured negative experiences due to their sexual orientation or gender identity (DePaul et al., 2009). Such direct, responsive services are an area in which school counselors can make a uniquely positive impact. LGBTQ+ students suffer substantial emotional and academic consequences when in a hostile school environment (Kosciw et al., 2014), and some LGBTQ+ students may benefit most through the personal connections established in individual and group counseling. Researchers have found that social support and collective self-esteem contribute significantly to the psychological well-being of sexual minority youth (Detrie & Lease, 2007). Although LGBTQ+ experience some challenges similar to those of other minorities, they also have the unique stress of deciding when and how to come out to parents and the public. Craig, Austin and McInroy (2013) offered group counseling to sexual minority youth that provided affirmative, supportive, safe, and empowering talk, specifically focused on such sexual minority issues as coming out, social isolation, homophobia, and stigmatization. The sessions lasted 45 minutes and covered 8-10 weeks. The results of pre and post surveys showed a significant improvement in participants’ proactive coping skills and self-esteem. In schools, often no faculty or staff members other than school counselors have the training and experience to offer such valuable social and emotional support.

**Future Implications**

In this article, the authors reviewed four distinct ways in which school counselors can work to improve school climates for LGBTQ+ students. First, ethical standards obligate advocacy on behalf of the marginalized (ASCA, 2010) and inclusive school policies appear to be valuable to all. Second, a national survey indicates that a network of allies is beneficial to LGBTQ+ students (Kosciw et al. 2014). Third, research demonstrates that GSA clubs provide long term benefits psycho-social, educational and employment benefits (Twoomey et al., 2011). Finally, individual and group counseling can be effective in creating positive change on a wide range of relevant student topics (Gysbers & Henderson, 2012). Although some data exist regarding an array of specific tools that have been effective in schools, no best practices for a definitive combination of interventions have yet been established through research. School counselors who wait for research that convincingly endorses an optimal comprehensive LGBTQ+ safe climate program will miss immediate opportunities to help students using existing methods that are recognized as effective when used individually. The ASCA National Model states that “to achieve the best results for students, school counselors regularly evaluate their program...” and the most effective way of doing so is to “implement data-driven comprehensive school counseling programs” (ASCA, 2012, p. 99). The more that school counselors press forward with implementation of multi-modal interventions and assemble data within their schools, the better off students will be and the sooner we will have helpful data to support comprehensive intervention effectiveness.

**Conclusion**

School climates for LGBTQ+ students are often unsupportive and even hostile (Kosciw et al., 2014). It is imperative that educators work to change unsafe school climates so that all students, including those who identify as LGBTQ+, feel accepted.
and supported. Given their role as change agents in schools, school counselors are well-qualified to do so (ASCA, 2014). Ensuring that school policy and curricula are LGBTQ+ inclusive, educating staff and students about LGBTQ+ student issues, promoting the creation and identification of LGBTQ+ allies, and offering confidential counseling sessions would address the major intervention ideas found in literature, as well as climate needs raised by GLSEN survey participants. School counselors that intervene using these methods have the opportunity to make meaningful improvements in the emotional health and academic success of LGBTQ+ students. Data collection and program evaluation of such interventions will add critical understanding to the current knowledge regarding the support of LGBTQ+ students.

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Incorporating Therapeutic Movement Techniques into School Counseling
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Abstract
Movement is the outward expression of one’s internal world. In schools, students are expected to maintain attention and behavior throughout the school day. School counselors are responsible for building students personal/social, academic, and career foundations, as well as helping them focus in school. Incorporating new strategies to enhance this foundation building can be useful to the professional school counselor. One innovative strategy is the use of movement in therapy, which has become its own specialty area known as Dance Movement Therapy (DMT). While school counselors do not have the credentials to practice as a DMT, the foundation and ideals that DMT embodies can be used to incorporate movement into schools. Specific ideas of how to incorporate movement techniques into a school counseling program, ethical issues, and potential barriers of using movement in schools are discussed.

Keywords: Dance movement therapy, school counseling, lessons, emotional expression

When a baby is born, movement is one of the signs that denote the baby is alive and healthy. Humans come into life moving, and many of their daily functions from breathing to walking are comprised of movement. It is a natural assumption to say that movement is at the core of functionality (Sheets-Johnstone, 2010, p. 2). As children grow and learn, movement is the first form of learning followed by word of mouth (Sheets-Johnstone, 2010, p. 2). Movement always meets some kind of need, either functional or emotional. It can even be seen as a form of language in itself. As children, movement is a natural and innate tendency; however in society today there are not as many opportunities to move and stay active (Furmanek, 2014, p. 81). Given the increase in technology, more than fifty percent of children own and utilize media devices. It is estimated that children aged 8-18 average over seven and a half hours per day using entertainment media, watching television, or playing video and computer games (US Department of Health, 2013).

Benefits of Movement in Schools
School counselors are not only concerned about the personal and social needs of students. They are also tasked with helping ensure students’ academic success. One of the problems that inhibit academic success is length of attention span and the ability to pay attention in a classroom environment. The areas of the brain responsible for movement, cognitive thought, and attention span are the same (Furmanek, 2014, p. 81). Research states that linking movement to learning can enhance the children’s learning by creating a mind-body connection (Furmanek, 2014, p. 81-83). It has also been shown that allowing students to move throughout the day helps them to recharge and refocus when returning to the classroom. “Play, recess, and physical education enhance social skills, emotional intelligence, and conflict resolution ability (Jensen, 2005, p. 64).” Learning through movement and manipulation is one of the most recognized learning styles (Block, Parris, Whiteley, 2008; Dunn, 2009). Given the numerous benefits of movement, it is logical to incorporate movement and expression of movement in other areas of the school day besides recess and physical education alone.

Dance/Movement Therapy
Movement Therapy has a broad history with many different modalities being used to invoke emotion or expression. Some of these include Eastern disciplines such as yoga or tai chi, five rhythms movement, sensory awareness, the continuum movement, and dance/movement therapy. The American Dance Therapy Association defines dance movement therapy (DMT) as the use of movement as a process that furthers physical and emotional integration of an individual (American Dance Therapy Association, 2014). Dance is seen as being therapeutic outside of the context of therapy and creates a sense of community in groups (Chaiklin & Wengrower, 2009, p. 5). In a metaanalysis on the effects of DMT, Ritter and Graff (1996) reported DMT as a potentially effective mode of intervention for children. They also reported movement therapy as an effective tool for increasing body awareness and decreasing anxiety. DMT is a goal directed approach that seeks to create change and expand coping abilities while helping clients stay in control (American Dance Therapy Association,
Like many other modalities, the DMT therapist should remain non-judgmental. DMT is not only for work with the individual, but it is also encouraged for group work, as it can increase group cohesion, participation, and self-confidence (American Dance Therapy Association, 2014). Overall, the focus is on the process of the movement experience and not the skill at which clients perform.

**Dance Movement Therapy Sessions**

Attention is placed on free movement and expression; however, there are movement therapy techniques used to inspire movement or to create change. Some of these movement techniques include mirroring techniques, inventing routines, role-playing, enactments, or attempting to understand a story told by someone else’s movement. These techniques are used in various ways through the course of a session and every practitioner has his/her own approach to the way a session is carried out. Overall, a typical DMT session will have three main sections. The first section of the session is the warm-up and would allow the therapist to set up the environment as well as assess the client’s growth. It is understood in movement therapy that creative expression often reflects dimensions of the child’s life. As such, growth within the art medium is a signal of growth in other areas of functioning (Bruscia, 1988). As movement therapy is a non-verbal expression of the human experience, assessment within movement requires a counselor to be in tune to the child’s symbolism (similar to play therapy). The second section of the session is known as the main event and is based on areas of growth or struggle for the client(s). Therapists often use games or activities to work on themes the client is presenting with such as anxiety, anger, and increasing self-awareness (Veach & Gladding, 2010; Mills & Daniluk, 2002; Ritter & Graff, 1996) The last section of the session is a grounding activity. The grounding activity allows the client to gain closure from the session and work to transition back into other activities (Levy, 1988, p. 41-43).

**Client Benefits of Dance Movement Therapy**

Multiple studies have been conducted on the impact of Dance Movement therapy, and the research shows that there are improvements made when using DMT with children, both who have and do not have mental health disorders. These gains include an increase of cognitive skills, academic achievement, test scores, attitude, and positive behaviors (Camilleri, 2007). DMT can help to facilitate socialization and integration within the group system especially when used at a group or classroom level (Camilleri, 2007). The children participating in DMT can build their self-esteem and body awareness while gaining an outlet for emotional expression (Camilleri, 2007). Physically, students can build muscular coordination, a larger movement vocabulary, and release tension while also gaining enjoyment (Camilleri, 2007). While the benefits listed are overarching, there are many benefits that are geared towards specific populations. With children who have been abused, research has shown that movement can help them regain control of their bodies and regulate their emotions (Camilleri, 2007; Mills & Daniluk, 2002). DMT may also help abused children reconnect with their bodies (Mills & Daniluk, 2002). Bullying prevention is another concern that can be addressed in conjunction with DMT. Dance Movement Therapy can aid children in building the skills needed to become resilient and in developing skills such as emotional awareness, self-assertion, empathy, managing anger, and spatial awareness that help protect them from bullying (NoBullying.com, 2014). The use of movement could allow the non-English-speaking student to release the pressure that he/she experiences when trying to communicate in English. Grief is another area that has been explored in working with DMT. Use of DMT allows students to express their emotions and work towards healing (Philpott, 2013, p. 150). Although more research needs to be done regarding interventions for specific populations, there are many clients that can potentially benefit from the use of DMT.

**Combining School Counseling and DMT**

**Incorporating Movement Interventions in Counseling Practice**

The school counselor needs to create an environment that both inspires movement and allows clients to feel safe. Children express more feelings of success when the environment is supportive and does not have a competitive nature (Furmanek, 2014, p. 81-82). The movements used in counseling should be simple and geared towards their ability and developmental level to allow the activities to be fun and not frustrating. The goal should not be for the students to perform the movements correctly, but more focus should be placed on acknowledging
effort and participation (Furmanek, 2014, p. 82-83). The school counselor can also model the movement for them as well as adapt the intervention to meet different needs of students (Parnell, 2013, p. 26). Below are examples of interventions school counselors can implement when working with students in groups, individual, or classroom guidance settings.

Circles and Line Dancing. When doing groups or classroom guidance, choose a rhythmic upbeat music and allow children to dance in a line or circles. The focus is on gaining confidence, not on dance skill. One child can be a leader and start a dance move that the other children in the line or circle can copy. This allows the leader to feel a sense of self-efficacy and the act of mirroring allows children to learn how to attend to others (ADTA, 2015).

Mirroring Activity. The use of mirroring as a technique is universal to counseling and education. Students partner with each other and stand across from each other as if they were looking at themselves in a mirror. The first student would make some form of movement while still looking at the other. The second person would then need to mirror that movement. The roles would be reversed after a few minutes (Martinovich, 2006, p. 221). Having the students guess what the movement is expressing after mirroring it could expand this activity. Students can also close their eyes to enhance their experience (Veach & Gladding, 2006). This intervention is designed to assist people in feeling connected to another person. The students would be also able to see how emotions are expressed differently in different people.

Emotional Expression Activity. Younger children and those who are diagnosed with a sensory disorder may have difficulty interpreting social cues or learning the way others express emotions. Because movement and emotion are intertwined, movement can be used as a teaching tool with students to learn to both express their own emotions and to interpret others’ emotions. One example of an emotional expression activity would be for the school counselor to play two different types of music focusing on two different emotions. One choice could be a positive, upbeat song and the other could be slow and sad. Students can be asked to move their bodies and faces according to the emotional experience the music is creating. After playing each song and allowing students to express the emotions they identify, the school counselor would then facilitate a discussion about what emotion was being experienced and ways a person can show that emotion (Martinovich, 2006, p. 234-235). The activity could be used with individuals, small groups, or classroom guidance. It could be expanded by using many different songs and a larger range of emotions depending on developmental level.

Free Expression Dance. If students are older or are comfortable with dance, there are many less structured activities that can be used to allow children to express their emotions. The school counselor could assign the student the task of creating a dance that expresses what they have been feeling for the past day or week, particularly if there is a struggle the student is facing. The counselor would be supportive and nonjudgmental. After the student performs his/her dance, the counselor could introduce ideas to change the dance, such as what would it look like if the struggle went away. The dance could become a way for the student to express feelings and communicate better with the counselor. However, the student and the feelings should guide free expression.

Bubble Space. The kinesphere is a movement therapy term referring to each person’s bubble of space (Goodill, 1987). It is the space formed when one foot is on the ground and the person reaches his/her arms and legs out in each direction. The school counselor can work with students on respecting their own kinespheres and others’ kinespheres as well. With smaller children, the counselor can ask questions, such as “What does it feel like when other people come into our bubble of space?” or “How do you let other people know you don’t want them in your bubble of space?” School counselors can also model for students how important it is to respect each other’s kinespheres.

Grounding Intervention: Modified Tree Pose. The goal of grounding interventions is to help the child ground in his or her body and be physically present in his/her environment (de Tord & Bräuninger 2015). Instruct students to stand with both legs together and arms straight down at the sides of the body. Ask students to envision growing roots into the ground from the soles of their feet, literally grounding them. Slowly have the students lift arms out to either side and stretch them overhead, fingers towards the ceiling, palms together. While making soft wind sounds, let the arms sway back and forth like a tree, continuing to focus on rooting the soles of the feet.
Legal and Ethical Implications

With any counseling practice, it is important to remember that work must be in the realm of the counselors' competency and knowledge. To become a Board Certified Dance/Movement Therapist there are required graduate level courses and a certification process (American Dance Therapy Association, 2014). School counselors must work within their professional scope and never represent themselves as certified Dance Movement Therapists unless the appropriate credentials have been obtained. However, the school counselor can still incorporate movement components and the ideas behind DMT into practice without representing as a dance movement therapist. When using DMT techniques, the school counselor should understand the ethical standards of DMT and the American School Counselor Association to ensure that no harm is done to students. Children should never be forced to move, nor should children be asked to move in ways that are uncomfortable or unsafe (ASCA, 2004). The focus for the school counselor is on increasing rapport with students and expanding their repertoire of interventions while never representing themselves as a dance or movement therapist. The focus for the student is on engaging with the school counselor and other students and gaining skills, rather than learning dance skills.

Identifying and Overcoming Barriers of DMT

Congruent with the barriers of many forms of therapeutic practice in the schools, there are barriers that exist that could hinder implementation of movement techniques. Allotment of time and space are the two biggest obstacles that school counselors face.

Time

Dance/Movement therapy techniques may require longer sessions to allow for free expression. School counselors may only see students for 15-30 minutes. To address this constraint, school counselors may need to use targeted interventions that incorporate movement, but limit full expression of the intervention. Similar to other interventions, the school counselor may need to use the brief and more directed version of a technique. The other constraint related to time is that students opening up emotionally might contribute to a more difficult transition back to class. Therefore, grounding activities may be essential to the school counselor using movement techniques. The school counselor could use the grounding technique (previously described), deep breathing techniques, or read a story to calm the children before returning to the learning environment.

Space

Space and resources also have proven to be barriers when it comes to incorporating DMT movement. Some school counselors have their own classroom (mostly at the elementary level). However, many school counselors' offices cannot accommodate free movement for students. The counselor would have to coordinate use of bigger spaces that allow students to move more freely, but also maintain client confidentiality. One solution may be to use an empty classroom or multipurpose room, and hang window coverings on any windows. With recent technological advances, having portable music is more convenient. Lastly, should a school counselor be strapped for space and not have access to larger space, the counselor could limit the activity to the available space.

Conclusion

Incorporating movement may allow students to express feelings that may not have surfaced verbally. Humans move in ways that are consistent with their emotions because many movements are motivated by emotion (Sheets-Johnstone, 2010, p. 3). Expressing movement could allow clients to become aware of what they are experiencing in a safe, trusting environment that has no pressure for them to be anything but themselves. It can also instill a sense of capability (Sheets-Johnstone, 2010, p. 5). The ultimate goal of incorporating movement for a client would be to allow the client to explore ways to express personal feelings or beliefs while demonstrating that feelings are supposed to be expressed.
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ABOUT THE VIRGINIA COUNSELORS ASSOCIATION (VCA)

VCA is the Virginia Counselors Association. VCA was founded in Richmond in 1930 as the Virginia Personnel and Guidance Association (VPGA). VCA is dedicated to the goal of meeting the needs of Virginia counselors in a variety of work settings. It is a dynamic and active organization that has been effective in responding to state-wide issues and in providing opportunities for professional interaction at the state and local levels.

GUIDING PRINCIPLES

The vision and mission of VCA will be the driving force as the Association strives to meet the organizational goals with careful consideration of fiscal responsibility in carrying out the work of the Association. The organizational goals set forth shall be reviewed annually to evaluate areas in need as the board engages in work to improve and strengthen the organization.

VCA VISION

Equity, unity and public support for professional counseling in a variety of settings for all people in Virginia.

VCA MISSION

VCA members in all settings will provide best counseling practices that enhance human development and functioning throughout the life span and promote public confidence in the counseling profession.
“Success is not final, failure is not fatal: it is the courage to continue that counts.”

– Winston S. Churchill