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The refereed, online, open-source journal promoting scholarship and academic inquiry within the profession of counseling

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Population-Based Mental Health Facilitation (MHF): A Grassroots Strategy That Works

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The World Health Organization (WHO) estimates that at least 450 million people worldwide live with unmet mental health problems. Additionally, one in four people will experience psychological distress and meet criteria for a diagnosable mental health disorder at some point in their lives. This data speaks to the need for accessible, effective and equitable global mental health care. Available mental health resources are inequitably distributed, with low- to middle-income countries showing significantly fewer mental health human resources than high-income countries. The need to proactively address this care-need gap has been identified by WHO and various national organizations, including NBCC International (NBCC-I). NBCC-I's Mental Health Facilitator (MHF) program addresses the global need for community-based mental health training that can be adapted to reflect the social, cultural, economic and political climate of any population, nation or region.

Keywords: **global, mental health, international, mental health facilitator, MHF, population, community, WHO**

Developing and promoting mental health services at the grassroots level while also maintaining a global perspective is, to say the least, an overwhelming task. The National Board for Certified Counselors' International division (NBCC-I) has responded to this task in two deliberate steps. Initially, NBCC-I collaborated with the World Health Organization's (WHO) Department of Mental Health and Substance Abuse to establish the global Mental Health Facilitator (MHF) training program. The MHF program addresses the international need for population-based mental health training that can be adapted to reflect the social, cultural, economic and political realities of any country or region. Once the program was effectively addressed by WHO and NBCC-I as a viable strategy to reduce mental health issues on a global basis, NBCC-I independently developed a curriculum and implementation method that has begun to make a promising global impact (Hinkle, 2006, 2007, 2009, 2010a, 2010b, 2012a, 2012b, 2012c, 2013; Hinkle & Henderson, 2007; Hinkle & Schweiger, 2012; Schweiger & Hinkle, 2013).

For years the global burden of mental disorders on individuals, families, communities and health services has been considerably underestimated (Chisholm et al., 2000; Murray & López, 1996a, 1996b; Ustün & Sartorius, 1995). Resources for mental, neurological, and substance use disorders have been slow in development, insufficient, constrained, fragmented, inequitably distributed, and ineffectively implemented (Becker & Kleinman, 2013; Chen et al., 2004; Gulbenkian Global Mental Health Platform [GGMHP], 2013a; Hinkle & Saxena, 2006). While mental and neurological disorders comprise only 1% of deaths worldwide, they account for 8–28% of the disease burden (GGMHP, 2013a; Murray et al., 2012; Prince et al., 2007; WHO, 2004a), with the majority of these disorders occurring in low- to middle-income countries.

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Mental Health: An International Problem

Most mental disorders are highly prevalent in all societies, remain largely undetected and untreated, and result in a substantial burden to families and communities. Although many mental disorders can be mitigated or are avoidable, they continue to be overlooked by the international community and produce significant economic and social hardship. Moreover, in all countries there is an enormous gap between the prevalence of mental disorders and the number of people receiving care (Becker & Kleinman, 2013; Saraceno et al., 2007; Weissman et al., 1994; Weissman et al., 1996; Weissman et al., 1997; WHO, 2010a, 2010b). In less-developed countries, more than 75% of persons with serious mental disorders do not receive treatment (Demyttenaere et al., 2004). Unfortunately, psychiatry's best efforts at training physicians to provide mental health care within the global context are simply too small for such a large, global problem (Furtos, 2013; Hinkle, 2009, 2010b, 2012b, 2012c; Patel, 2013). The focus has been too long on medicine and not on local communities (Patel, 2013). In fact, every person's health care is local (Unützer, 2013). The major issue with the current provision of care is, therefore, the limited size and training of the community health care workforce (Becker & Kleinman, 2013).

Globally, one in four people will experience psychological distress and meet criteria for a diagnosable mental disorder at some point in their lives (WHO, 2005). This ominous data speaks to the need for accessible, effective and socially equitable mental health care (Hinkle & Saxena, 2006). WHO estimates that more than 450 million people worldwide live with mental health problems; these numbers are no doubt bleak. More specifically, WHO estimates that globally more than 154 million people suffer from depression, 100 million are affected by alcohol use disorders, 25 million have schizophrenia, 15 million experience drug abuse, and nearly one million people die each year by suicide (Saraceno et al., 2007). Depending on the source, unipolar depression has been estimated to be in the top four causes of loss of disability-adjusted life years across the six socially diverse continents (Murray & López, 1996a, 1996b; Vos et al., 2012).

Furthermore, it has been estimated that as many as 25% of all primary care consultations have a mental health component (Goldberg & Huxley, 1992; Warner & Ford, 1998; WHO, 2006a). Mental disorders are related to a range of problems, from poverty, marginalization, and social disadvantage, to relationship issues such as divorce, physical conditions such as heart disease, reductions in economic productivity, and interruption of child and adolescent educational processes (Alonso, Chatterji, He, & Kessler, 2013; Breslau et al., 2013). At the developmental level, at least 10% of children are considered to have mental health problems, but pediatricians and general medical practitioners are not typically equipped to provide effective treatment (Craft, 2005). With mental disorders contributing to an average of 20% of disabilities at the societal level, the evidence is clear that these disorders pose a major challenge to global health (Alonso, Chatterji, et al., 2013; Alonso, Petukhova, et al., 2013). Moreover, the associated economic burden exceeds that of the top four non-communicable diseases (i.e., diabetes, cardiovascular, respiratory and cancer; Bloom et al., 2011).

Unfortunately, most international mental health systems are dominated by custodial psychiatric hospitals that deplete resources for treatments with little efficacy (WHO, 2005). In contrast, governments and nongovernmental organizations (NGOs) should scale up services for community mental health with programs that reflect credible evidence of effectiveness (Patel, 2013; Patel, Araya, et al., 2007). Murthy (2006) has indicated that there is no global community mental health blueprint to achieve universal mental health access, and that effective community workforce strategies need to be matched to each country's unique situation. It is an ecological fallacy to try to understand people and mental health issues outside the environments in which they exist (Galea, 2013). Thus, a radical shift is urgently needed in the way mental disorders are managed, and this clearly includes community-based care that can be effectively implemented via non-health as well as health sectors (GGMHP, 2013a, 2013b; Hinkle, 2012b).

Global Community Mental Health

Serious mental disorders are generally associated with substantial role disability within the community. About 35–50% of mental health cases in developed countries and approximately 75–85% in less-developed countries have received no treatment in the 12 months preceding a clinical interview. Due to the high prevalence of mild and sub-threshold cases, the number of untreated cases is estimated to be even larger. These milder cases, which can be found in communities all over the world, require careful consideration because they are prone to progress to serious mental disorders (WHO, 2010a, 2010b; WHO World Mental Health Survey Consortium, 2004).

It is important to note that in most low- to middle-income countries, community workers are often the people's first line of contact with the health care system (Anand & Bärnighausen, 2004; Hongoro & McPake, 2004). However, there is a long history of issues with the sustainability of community programs (Walt, 1988), and the lack of community service providers with the necessary competencies to address needs remains the most significant barrier to the provision of mental health services. Although human resources are the crucial core of health systems, they have been a neglected developmental component (Hongoro & McPake, 2004), particularly in the field of mental health. WHO's "Mental Health Atlas" (2005) specifies a critical global shortage of mental health professionals (e.g., psychiatrists, psychiatric nurses, psychologists, social workers, neurologists). Similarly, an informal international survey of clinical mental health, school, and career and work counselors by NBCC-I indicated that the professional counselor workforce has yet to be adequately identified on a global scale (Hinkle, 2010b). Moreover, extant mental health services are inequitably distributed; lower-income countries, where behavioral risk factors tend to cluster among people of lower socioeconomic status, have significantly fewer mental health human resources than higher-income countries (Coups, Gaba, & Orleans, 2004; WHO, 2005; WHO World Mental Health Survey Consortium, 2004).

In low- to middle-income countries, human resources are clearly limited, and the quality and productivity of the existing workforce is often challenged. Investment in human resources for community mental health care is insufficient in absolute terms as well as in distribution (Hongoro & McPake, 2004). For instance, the global average for physicians is 170 per 100,000 people, but in Nepal and Papua New Guinea there have been as few as five doctors for this ratio (WHO, 2004a). In 2003, approximately 36% of doctors' posts and 18% of nurses' posts were unfilled around the world (Bach, 2004). Moreover, general practitioners are not typically adept at providing mental health care, including detection, referral and management of mental disorders (Chisholm et al., 2000). Therefore, partnerships between formal primary and informal community health care systems need to be more prevalent, effective and integrated.

Two facets for integrating mental health into primary care are (a) financial and human resources and (b) collaboration with non-health sectors. NGOs, community workers and volunteers can play a significant role in supporting formal primary care systems for mental health. For example, village health workers in Argentina, India and the Islamic Republic of Iran have been trained to identify and refer people for medical assistance. Even countries that have adequate services, like Australia, use local informal services to support mental health patients (see WHO, 2006b). Because psychiatric hospital beds are extremely limited, the demand for mental health services within communities becomes even more critical (Forchuk, Martin, Chan, & Jensen, 2005). Furthermore, early detection and treatment of mental disorders and co-occurring emotional and behavioral problems not only decreases the chance of lower physical health later in life, but also associated costly hospitalizations (Alonso, Chatterji, et al., 2013; Alonso, Petukhova, et al., 2013; Scott et al., 2013).

An urgent, radical change in the way mental disorders are managed and monitored—one that moves away from lengthy institutional hospitalizations and toward population-based mental health care in the community—is needed (GGMHP, 2013a, 2013b; Hinkle, 2009). The need to proactively address this care-need gap from a praxis, or practical, rather than a theoretical approach has been repeatedly identified by WHO and various national and international organizations, including NBCC-I (Hinkle & Schweiger, 2012). Communities in developing countries have historically lacked opportunities for mental health training, skill development, and capacity building (Abarquez & Murshed, 2004); however, long years of training are not necessary for learning how to provide fundamental help for people who are emotionally distressed.

Volunteer community workers are a large untapped community resource of potential service providers for people suffering from problems associated with mental health (Hoff, Hallisey, & Hoff, 2009). Chan (2010) has reported that "there is a widely shared but mistaken idea that improvements in mental health require sophisticated and expensive technologies and highly specialized staff. The reality is that most of the mental, neurological and substance use conditions that result in high morbidity and mortality can be managed by non-specialist health-care providers" (p. iii). The research has substantiated that it is feasible to deliver psychosocial-type interventions in non-specialized health care settings (WHO, 2010a, 2010b). Enhancing basic community mental health services, both informally and formally, is a viable way to assist the *never-served*. The MHF program is part of a grassroots implementation trend that has already begun in communities around the globe (e.g., Canada, Europe, Africa, Asia, United States; Hinkle, 2007, 2013; Hoff, 1993; Hoff et al., 2009; Marks & Scott, 1990; McKee, Ferlie, & Hyde, 2008; Mosher & Burti, 1994; Patel, 2013; Rachlis & Kushner, 1994).

A Brief Review of Grassroots Community Mental Health Approaches

Unfortunately, governmental psychiatric hospitals have a long history of human rights violations and poor clinical outcomes (Hinkle, 2010b). They also are costly and consume a disproportionate amount of mental health care monies. In contrast, informal community caregivers are not generally part of the formal health care system; examples include traditional healers, professionals such as teachers, police and various community workers, NGOs, consumer and family associations, as well as laypeople. Informal care is typically accessible because it is an integral part of the community. However informal, this care should not replace the core of formal mental health service provision (Saraceno et al., 2007; WHO, 2010a, 2010b), but serve as a grassroots, adjunctive care system.

For example, beginning as early as 1963, the work of Rioch et al. portrayed community paraprofessionals serving as in- and out-patient "therapists." Similarly, as far back as 50 years, Albee (1967) reported that the dearth of manpower in mental health services could be lessened by the use of paraprofessionals who could arrange for neighborhood outreach and basic psychiatric evaluations (Hines, 1970).

Likewise, in 1969 Vidaver suggested the development of mental health technicians with generalist skills for lateral and vertical mental health employment mobility. Vidaver (1969) further commented that community colleges were able to train local community helpers for a variety of informal roles in mental health services without years of higher education. Interviewing (i.e., communication), consultation, and community liaison techniques (i.e., referral) were depicted by Vidaver as important general skills for community helpers. One year later, Lynch and Gardner (1970) developed a training program with the goal of training laypeople to be "helpers in a psychiatric setting" (p. 1476), emphasizing communication skills training with a focus on the "front line of operation" (p. 1475) provided by paraprofessionals and professionals providing backup services.

Also in 1970, the U.S. military addressed mental health manpower shortages by increasing the use of paraprofessional specialists who learned entry-level skills to help soldiers in need (Nolan & Cooke, 1970). Training included conducting interviews; collecting historical, situational and observational data; and developing referral skills to connect the soldier with professional mental health resources. Identifying common mental health problems and relating to problems in a realistic way were included in the training. Program evaluations indicated that trainees "quickly and confidently transpose their course-acquired skills to the job situation" (Nolan & Cooke, 1970, p. 79).

More recently, basic psychological first aid programs have been effective in Bangladesh, where psychosocial support is used in emergency situations (Kabir, 2011). As well, nurses and health care staff have been trained as *mental health facilitators* in the United Kingdom to recognize depression, anxiety, stress, drug and alcohol problems, grief reactions, and domestic violence; make referrals; and provide support and aftercare. These nurses also assist people with co-occurring disorders and provid mental health promotion in the schools. Furthermore, the nursing profession in the United Kingdom has noted that community mental health care is a particular problem area, resulting in the development of the *mental health assistant practitioner* as a creative practice strategy to reduce the costs of services as well as improve multi-professional communication based on local needs (Warner & Ford, 1998; Warne & McAndrew, 2004).

Although implementing such grassroots community mental health programs is not easy, global health care organizations have demonstrated greater need to develop innovative uses of informal mental health assistants and facilitators to establish community mental health services (Warne & McAndrew, 2004). In the long run, if the gap in mental health services is sufficiently closed, it must include the use of non-specialists to deliver care (Eaton, 2013; Eaton et al., 2011; Hinkle, 2006, 2009). Such non-specialized workers will have received novel training in identifying mental stress, distress and disorders; providing fundamental care; monitoring strategies; and making appropriate referrals (see Becker & Kleinman, 2013; Hinkle & Schweiger, 2012; Hinkle, Kutcher, & Chehil, 2006; Jorm, 2012; Saraceno et al., 2007).

The Mental Health Facilitator Training Program

Existing data speaks loudly to the need for accessible, effective and equitable global mental health care. However, a common barrier to mental health care is a lack of providers who have the necessary competencies to address basic community psychosocial needs. This barrier has been clearly identified by WHO and various national and international organizations, including NBCC-I (Eaton, 2013; Hinkle, 2006, 2009, 2012c; Hinkle & Saxena, 2006; Patel, 2013; WHO World Mental Health Survey Consortium, 2004; WHO, 2005, 2010a, 2010b).

General MHF Background Information and Rationale

In 2005, officers from NBCC-I met with the director of the WHO Department of Mental Health and Substance Abuse to discuss the challenges of international mental health care. As a result of these meetings, WHO selected 32 international mental health professionals to evaluate NBCC-I's proposed MHF program, with almost 100% supporting its development. Subsequently, the curriculum and master training guide were completed by NBCC-I in 2007. Drafts of the curriculum and proposed teaching methods were piloted on two occasions in Mexico City with mental health professionals from Europe, the Caribbean, Africa and the United States. Additional subject matter experts facilitating pilot development included mental health professionals from Malaysia, Canada, Trinidad, St. Lucia, Turkey, India, Mexico, Botswana, Romania and Venezuela.

The resulting MHF training program draws on a variety of competencies derived from related disciplines, including but not limited to psychiatry, psychology, social work, psychiatric nursing, and counseling. Its eclectic programming and international composition allowed for a flexible training model with expertise drawn from global practices. Because MHF training is transdisciplinary, traditional professional helping silos are not reinforced; skills and competencies are linked instead to population-based mental health needs rather than professional ideologies. Thus, individuals with MHF training (MHFs) can effectively identify and meet community mental health needs in a standardized manner, regardless of where these needs are manifested and how they are interpreted. Mental health and the process of facilitating it is based on developing community relationships that promote a state of well-being, enabling individuals to realize their abilities, cope with the normal and less-than-normal stresses of life, work productively, and make a contribution to their communities.

The MHF training program was first taught in Lilongwe, Malawi in 2008 and has since been taught approximately 108 times by 435 trainers, including 181 master trainers in 20 countries. The MHF program recently expanded to provide mental health assistance in more established countries, as manifested in the program's current popularity in the United States (Schweiger & Hinkle, 2013). This expansion also marks the completion of an educators' edition of the MHF curriculum for use in schools with a focus on students, teachers and schooling.

To date, the MHF training program has been implemented globally to enhance mental health care at various levels. At the formal, primary health care level, general medical practitioners provide acute and long-term treatment to individuals with a variety of mental disorders, supplemented by the efforts of individuals with MHF training. MHFs also augment specialized services by functioning within a mental health care team to provide support, targeted assistance, referral and follow-up monitoring (Paredes, Schweiger, Hinkle, Kutcher, & Chehil, 2008). Likewise, informal community care is characterized by community members without formal mental health education or training providing much-needed services. At this level, nonclinical forms of mental health care such as psychological support or strategic problem solving by community leaders, family groups, and local elders (including indigenous healers) are emphasized. MHF training has been used to bridge the gap between formal and informal mental health care where MHFs work within both systems and do so simultaneously (Hinkle, Kutcher, & Chehil, 2006). With due respect to horizontal and vertical considerations, MHFs have augmented traditional, formal inpatient services by working with mental health teams to provide family support and education, monitor follow-ups, and provide practical "in the trenches" assistance (see Figure 1). This is where informal care, including self-care, becomes critical (Murthy, 2006).

Contextualizing the MHF Program

Most importantly, it is ill-advised to attempt to understand people outside their environments; people must be considered within the characteristics of their respective populations (Galea, 2013). The MHF program is designed to be flexible so local experts can modify components of the training to reflect the realities of their situation. Local stakeholders then identify and include specific competencies in their MHF trainings. As a consequence, consumers and policymakers ensure that MHF trainings provide culturally relevant services to the local population. Furthermore, the MHF training curriculum was conceived as a dynamic document and is revised once each year based on input from local institutions and individuals who provide MHF training. This contextual, organic approach grounds the MHF program in the principle that mental health care is a combination of both universally applicable and context-specific knowledge and skills (Furtos, 2013; Hinkle, 2012a; Paredes et al., 2008). The program consists of integrated knowledge ranging from basic mental health information and promotion to specific, local, culturally relevant helping strategies. The global MHF program

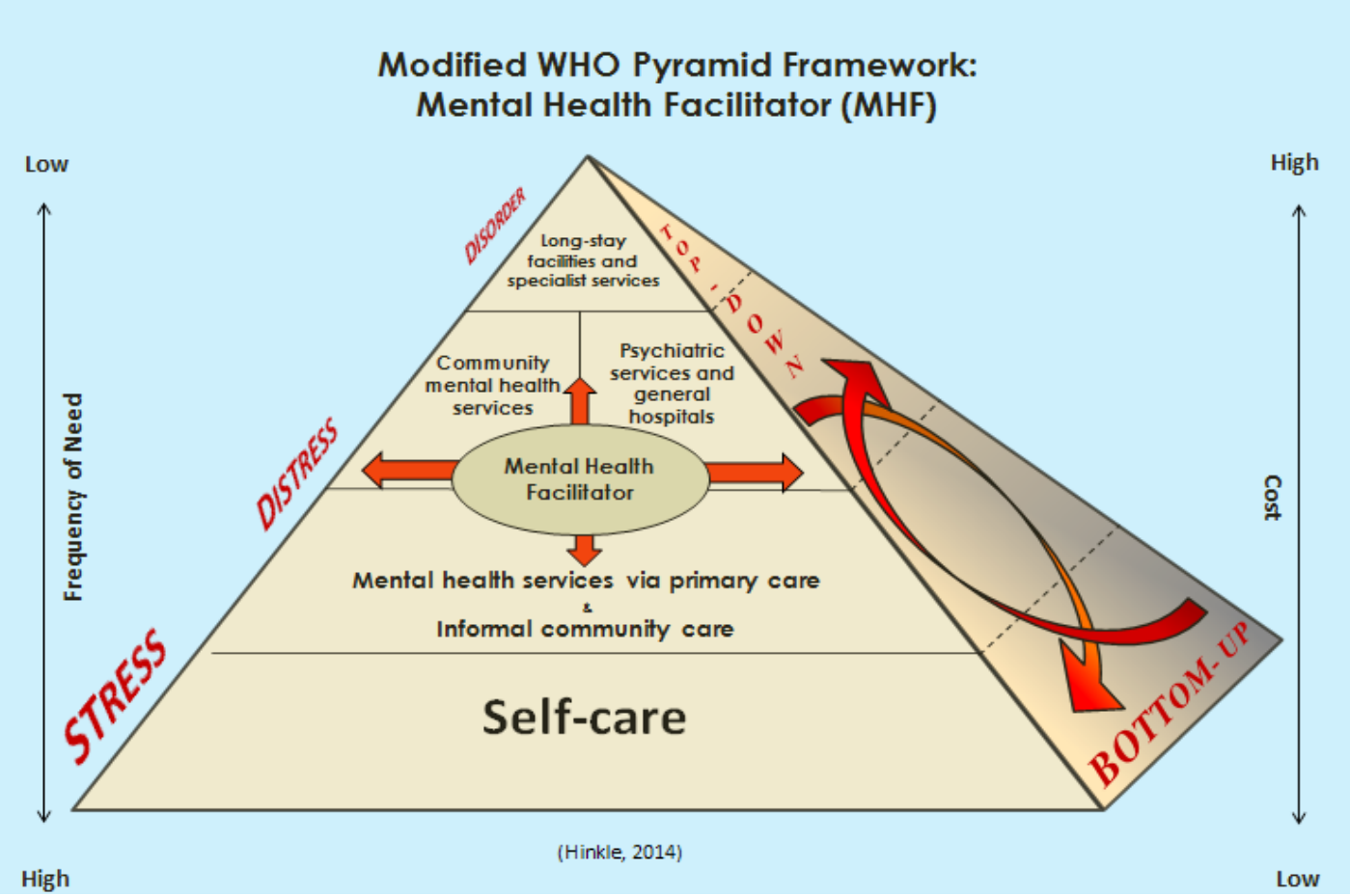

Figure 1. Modified WHO Pyramid Framework: MHF (Hinkle, 2013b)

provides equitable access to quality first-contact interventions, including but not limited to mental health advocacy, helping skills, and monitoring and referral, all of which respect human dignity and rights, and meet local population needs.

Individuals receiving MHF training represent a broad cross-section of the community. Diverse trainee backgrounds increase the possibility of addressing the various gaps in local mental health care, which helps local policy makers, service providers, NGOs and communities meet mental health needs without costly infrastructural investments. Moreover, contextualized MHF training facilitates further development and delivery of community-based care consistent with WHO recommendations for addressing the gap in global mental health services.

Bottom-Up vs. Top-Down Community Strategies

It is commonly known that top-down approaches across public services generally have limited success. Conversely, long-term strategies that enhance the successful implementation of public mental health services are best when they are centrally facilitated from a locally directed, bottom-up approach (Rock, Combrinck, & Groves, 2001). From both a service delivery and administrative perspective, a bottom-up strategy has its advantages. One obvious benefit is that it requires local stakeholders to articulate objective and verifiable goals that use a "common currency" (p. 44) or terminology (Rock et al., 2001).

Similarly, MHFs have the advantage of serving as community leaders developing "upstream" versus "downstream" care, as well as providing important links to professional mental health care (Hinkle, Kutcher, & Chehil, 2006; Hoff et al., 2009; McKinlay, 1990). MHFs working in communities apply primary prevention principles by anticipating mental health services for people who may be vulnerable. For instance, MHFs in Bhutan provide drop-in peer assistance for young people challenged by rapid changes in their society. When MHF services are available at the secondary prevention level, people with mental health issues can often avoid disruptive and costly hospitalization. MHFs can assist with reducing long-term disabling effects among people recovering from a mental disorder by applying tertiary prevention measures from the bottom up (Hinkle & Saxena, 2006; Hoff et al., 2009). Furthermore, governmental direction from the top needs to intersect with community efforts from the bottom (Isaac, 2013; see Figure 1); and once programs are vetted from the top, they need to be diverted to bottom-up management (Eaton, 2013).

Although community mental health programs may achieve local success, few have been systematically scaled up to serve the needs of national populations. Despite the array of treatments for mental health, little evidence exists regarding their feasibility and effectiveness when integrated into routine care settings among low- and middle-income countries. Even though bottom-up approaches offer advantages, they also require outcome measurements, something that mental health workers have found traditionally burdensome (Rock et al., 2001). For example, evidence-based mental health interventions for people exposed to conflict and other disasters are weak, especially for strategies implemented in the midst of emergencies (Patel, Araya, et al., 2007). Only a small fraction of the clinical research trials regarding mental health treatment have been administered in low-income countries, resulting in a dearth of knowledge about treatment effectiveness in poor, culturally diverse settings (Becker & Kleinmen, 2013). Consequently, the MHF process is currently undergoing an evaluation in two diverse countries on two separate continents to seek evidence for the effectiveness of this training program. This is a critical step in the program's continued development, because empirical evaluation of lay health workers' implementation of community mental health services in low- and middle-income countries has been historically insufficient (Lewin et al., 2005). However, if the global strategy is only to collect more information and add to data resources, there will continue to be a gap in human resources.

As planned, individuals seeking MHF training have represented a broad cross-section of local society, ranging from school teachers and principals to business owners, clergy and neighborhood workers. MHF volunteers are also police officers, neighborhood workers, community leaders, NGO employees, elders and indigenous healers. In fact, such healers in Malawi, Africa have learned to apply their first-contact mental health skills to identify, assess, support and refer people in need of acute mental health care through the MHF program. This diversity of trainee backgrounds at the grassroots level increases possibilities for addressing as many gaps as possible in community mental health care. Indeed, grassroots efforts emanate from the ground level (Eaton, 2013; Hinkle, 2010b, 2012a; Hinkle & Schweiger, 2012; Schweiger & Hinkle, 2013).

The Global MHF Partnership

Partnerships among NGOs, governments, agencies and academia can make a difference in the mental health workforce capacity by integrating global expertise with local knowledge (Fricchione, Borba, Alem, Shibre, Carney, & Henderson, 2012; WHO, 2009). As countries recognize the dearth of community health services and attempt to develop fundamental services with a mental health focus, the MHF training program is appealing because of its emphasis at the "street" or "trenches" level (Hinkle, 2012a). This is a critical component of the MHF training program since local stakeholders always have more at stake in risk reduction and capacity building than agencies outside the local neighborhood, village or barrio (Abarquez & Murshed, 2004). For

example, MHF training has benefited the people of Mexico City, who have had historically limited access to mental health services (Suck, Kleinberg, & Hinkle, 2013a).

The initial stage of the MHF training process identifies local partners who have the willingness and ability to increase local mental health care capacity. NBCC-I negotiates MHF training with partners such as educational institutions, government agencies, NGOs, private companies or other entities capable of managing a training. An ideal global partner has the capacity and ability to maintain the MHF program and promote continuing mental health education. NBCC-I and respective training partners identify master trainers who can train more trainers, ensuring a multiplier effect (NBCC-I, 2013). In countries where English is not a primary or spoken language, it is necessary to translate and adapt the MHF curriculum and materials. Thus far, MHF partnerships have resulted in the curriculum being translated into 10 languages:Arabic, Bahasa Malaysian, Bhutanese [Dzongka], Chinese, German, Greek, Japanese, Portuguese, Spanish and Swahili.

The MHF Curriculum: General Features

NBCC-I has responded to the care-need gap challenge, and developed and standardized the MHF curriculum drawing on a variety of competencies derived from related mental health disciplines within a cultural context. General, nonclinical, first-responder forms of community mental health care such as basic assessment, social support and referral are included in the MHF curriculum. Similar models that include assessment, advising, agreement on goals, interventions, support and follow-up have been used successfully in mental health care (Fiore et al., 2000; Hinkle, 2012b, 2012c; Whitlock, Orleans, Pender, & Allan, 2002). Currently there are MHFs on five continents, with new trainings being coordinated almost weekly. In developing the curriculum, an eclectic group of professional contributors allowed for a flexible training model with expertise drawn from various international practices. The training consists of 30 hours that can be taught on consecutive days, or divided into its 20 modules and taught over several weeks, depending on the needs of the local community (Hinkle & Henderson, 2007). As local stakeholders are identified and trained using the MHF curriculum, they become the foundation on which to build community mental health care.

The MHF training includes a certificate of completion for anyone successfully completing the program, and additional certificates of completion for *trainers* and *master trainers*. Trainers are required to hold a bachelor's degree or its equivalent, and master trainers must have a master's degree or its equivalent in a mental health–related discipline. One affirming by-product of the training is the identification of individuals who desire more training and education in mental health services. For example, the MHF program in Bhutan has led to specified substance abuse training in several communities, as well as two students seeking graduate studies in counseling in the United States.

Specific Features of the MHF Curriculum

The MHF curriculum is based on the universality of mental stress, distress and disorders (Desjarlais, Eisenberg, Good, & Kleinman, 1995; Hinkle & Henderson, 2007). MHF training includes numerous topics such as basic helping skills, coping with stress, and community mental health services. The program consists of fundamental, integrated mental health knowledge and skills ranging from community advocacy and commitment, to specified interventions such as suicide mitigation. Also included in the curriculum are segments on working with integrity and not providing services outside the limits of training and experience (Hinkle, 2010a; Reyes & Elhai, 2004). In general, MHFs are taught that negative and unhealthy assumptions about life and living contribute to additional mental and emotional stress (Browne & Winkelman, 2007; Feiring, Taska, & Chen, 2002; Sonne, 2012).

More specifically, the curriculum begins with a section on the benefits of investing in mental health, cost-effective interventions, impacts of mental disorders on families, barriers to mental health care, confidentiality and privacy, and the goals of the MHF program. Understanding perspectives regarding human feelings, effective nonverbal and verbal communication, and using questions effectively in the helping process also are covered in the curriculum, as well as how to assess problems, identify mental health issues, and provide support (Hinkle & Henderson, 2007). Making effective referrals is a crucial segment of the curriculum because this skill also serves the purpose of steering people to physicians for co-occurring physical disorders such as diabetes, heart disease and chronic pain (Gureje, 2013).

MHF trainees also learn how to effectively end a helping relationship—an essential skill taught to mental health workers for the past 40 years (Hines, 1970; Hinkle & Henderson, 2007). MHFs learn that the helping process involves joining with the person seeking assistance, identifying specific concerns, assessing the level of difficulty, surveying the possibilities, solving problems and making choices, and referring to more formal care where appropriate. This is accomplished within a simple framework emphasizing personal strengths and mitigation of significant stress.

Following the basic helping skills section of the curriculum, which emphasizes the age-old but important phenomena of human development and diversity, trainees concentrate on the abilities, needs and preferences that all people possess and how these are integrated in various cultures (Elder & Shanahan, 2007; Huston & Bentley, 2010; Lerner, 2007). A section on understanding various types of encountered problems introduces trainees to the concept of a *balanced, less balanced, little balanced, or off balance* mental health continuum, alongside how to solve problems and set goals with people experiencing difficulty coping with life (Hinkle & Henderson, 2007). Similarly, trainees learn about stress, distress and basic mental disorders including anxiety and post-traumatic stress disorder (PTSD), depression and mania, psychosis and schizophrenia, substance abuse and dependence, delirium and dementia, mental retardation (intellectual disability), chronic pain, and epilepsy. Child reactions to trauma (van Wesel, Boeije, Alisic, & Drost, 2012) and child maltreatment (Wekerle, 2011) also are covered in the MHF curriculum, which emphasizes helping children and adolescents in the least restrictive environment and as close to their communities as possible (Hinkle & Henderson, 2007).

Preventing suicide and effectively dealing with an actual suicide are two topics of relevance covered in MHF training. Suicide is a leading cause of death in low- and middle-income countries, especially among young people (WHO, 2006a). Self-poisoning using pesticides is common, with estimates of 300,000 of these deaths a year in the Asia-Pacific region alone (Patel, Araya, et al., 2007), validating the need for suicide's inclusion in the curriculum.

In the 1990s, humanitarian organizations began to recognize the increased need for psychosocial support after various types of disasters (Barron, 2004; Wells, 2006). Disasters result in tremendous loss of property, resources and life. In addition, political, economic and social disruptions are common consequences that have mental health–related implications. Therefore, information about assisting individuals and families in the aftermath of disasters is included in the MHF curriculum (Hinkle & Henderson, 2007; Wells, 2006). The MHF training also emphasizes ways to assist with situations involving domestic violence, refugees, migrants and victims of human trafficking and war, as well as other unfortunate forms of crisis.

Stress-related disorders, as depicted in the MHF curriculum, go largely untreated in many areas of the world, especially when crises and disasters strike. It is all too often the scenario that an earthquake, typhoon, hurricane or human-made crisis has occurred, and limited or no mental health care services are available following the event. Attempts to provide assistance in the aftermath of these disasters have come from governmental responses, NGOs, and community and religious organizations, but it is important to note that even professional

mental health workers receive cursory instruction in disaster interventions (Hinkle, 2010a). The need for greater mental health response services is apparent; MHFs from Lebanon to Liberia have assisted communities following civil war and refugee crises, and MHFs in China have assisted in the aftermath of a major earthquake using the basic mental health training they received from the MHF curriculum.

Regardless of their genesis, many mental health–related concerns are largely dependent on problem-solving abilities, a focus on cultural values regarding mental health functioning, and social and economic support (Hinkle et al., 2006; Hoff et al., 2009), all of which are addressed in the MHF curriculum. Studies from stress-related literature suggest that a fundamental problem-solving coping approach is generally associated with positive outcomes (Benight, 2012; Taylor & Stanton, 2007), whereas avoidant-related coping is associated with negative outcomes (Littleton, Horsley, John, & Nelson, 2007); thus the emphasis on problem-solving skills in the MHF curriculum.

Lastly, consulting with helping professionals during mental health emergencies and recognizing the importance of self-care when working in crisis situations also are part of the MHF curriculum. The curriculum culminates with the all-important local contextualizing of what trainees have learned during their MHF training (Hinkle & Henderson, 2007; Sonne, 2012).

Potential Limitations

Unfortunately, organizational, cultural, and professional concerns coinciding with the often ambiguous role and purpose of mental health care can beset the expanding use of community helpers and may have an unintended impact on role identities among the general health workforce (see Warne & McAndrew, 2004). Possibly complicating matters further, the MHF program is a set of concepts and skills, not a professional designation. One concern associated with the MHF program is therefore its potential for propagating invisibly and resulting in new worker roles that cause confusion within standardized health care. Although "the potential of the fully visible and verbal paraprofessional to effect changes in the delivery of psychiatric care is vast" (Lynch & Gardner, 1970, p. 1478), it could become problematic in some locations if MHFs are not strategically blended into community health services. It has long been known that without a viable, transparent strategy, the utilization of MHFs could make for strained relationships in places where the program is not fully vetted. Furthermore, organizational structures that are not flexible or willing to pursue institutional change and innovation may have more difficulty accepting the MHF program (Hinkle, 2012b). Therefore, local and global political and networking skills are critical to the MHF program's sustainability.

Working conditions and available remuneration for community programs and workers raises several questions that will need to be addressed at some point (Hongoro & McPake, 2004). For instance, could municipalities and governments make MHF a job classification with an upwardly mobile career ladder within existing mental health services? Where financial incentives are not possible, could ad hoc benefits such as access to more training be feasible? How will MHF trainings be sustained in communities over time? Will volunteers be able to conduct the MHF program with limited resources? Additionally, for the program to be sustainable, trainers must have incentives to train more MHFs as community service providers. Without trainers teaching more programs, it is likely that a multiplier strategy will have limited success.

Another potential criticism of the MHF program is that the quality and safety of care could be compromised using community workers. However, the more critical point remains that providing basic assistance is much safer and salubrious than providing no care at all (see Hongoro & McPake, 2004). As in mental health nursing, supervision and mentoring of MHFs will at some point become an issue (Eaton, 2013; Warne & McAndrew,

2004). Furthermore, supportive supervisory relationships are important because supervisors are perceived as role models (Thigpen, 1979) in addition to providing needed guidance for informal community mental health workers.

Future MHF training strategies will need to incorporate continuing community educational development in mental health. Twinning or pairing universities in developing countries with those in less-developed countries is one method for increasing continuing education efforts. Distance learning can be an effective delivery method as well. However, twinning and distance education are all too often not core interests in developing nations, which tend to lack expertise in managing such partnerships (see Fricchione et al., 2012; Hongoro & McPake, 2004).

Conclusion

For the MHF program to proliferate, it will take not only training, education and implementation in often less than optimal working conditions, but also savvy negotiation of often poorly managed political systems that experience some level of corruption and inability to impact the universal stigma that plagues mental illness. To manage the program effectively, the global MHF strategy will need to continue to be accessible from the bottom up and maintain an uncomplicated implementation process. Patel (2013) has advocated that community mental health must be simplified, available where people live, locally contextualized, affordable and sustainable. The MHF program has met all of these criteria with the exception of sustainability, and only more time will tell the level of program longevity.

Advances in alleviating the costs of mental disorders have been limited and slow in coming (Becker & Kleinman, 2013). It is abundantly obvious that the challenges of unmet mental health needs negatively impact societies and economies around the globe. Becker and Kleinman (2013) have recently reported that "according to virtually any metric, grave concern is warranted with regard to the high global burden of mental disorders, the associated intransigent, unmet needs, and the unacceptable toll of human suffering" (p. 71). The burden of mental disorders at the social and individual level is comparable to that of physical disorders and substantially impacts the capital of all countries. Social factors are critical to the promotion and prevention of mental health (GGMHP, 2013b). Furthermore, children exposed to adult mental health disorders among their caregivers, as well as emotional psychological trauma, are predicted to have higher risks of mental disorders in adulthood, further compounding the problem (Chatterji, He, & Alonso, 2013; Patel, Araya, et al., 2007; Patel, Flisher, Hetrick, & McGorry, 2007). WHO (2010a, 2010b) has recommended bridging the care-need gap; however, this will not occur while services are embedded in professional silos rather than being population-centered (Chatterji & Alonso, 2013; Hinkle, 2012c).

The need to address workforce issues affects the quality and quantity of international mental health services (Warne & McAndrew, 2004); there is a clear link between human resources and population health. Community and family caregiving for mental disorders, often uncompensated, has a "tremendous value from a public health perspective by way of offsetting the costs and services of expensive and critically shorthanded healthcare professionals" (Viana et al., 2013, p. 134). At the American Psychiatric Association's annual convention in 2013, Galea reported that the social aspects of mental health are not a sideshow, but at the very core and not being paid attention to. Unfortunately, not even the laudable efforts of the WHO or United Nations have been able to bring countries that are in desperate need of basic mental health care together effectively. Sadly, psychiatry alone cannot do enough in the global context; world mental health is a social issue (Galea, 2013) and much larger than any one profession (Furtos, 2013). This reality underscores the need for urgent development of grassroots community mental health programs.

For over 40 years, community mental health workers have known that a key component of any program's design is its ability to be flexible (see Lynch & Gardner, 1970). Flexibility allows for the modification and contextualization of programs by local leaders to reflect realities of current social contexts and circumstances (Furtos, 2013; Rock et al., 2001). As aforementioned, this approach grounds the MHF program on the principle that mental health care is a combination of basic, universally applicable and context-specific knowledge and skills. Supportive social networks in the community result in less need for expensive professional treatments and hospitalizations (Forchuk et al., 2005). Moreover, grassroots approaches will aid global attempts at deinstitutionalization.

Governments of low-income countries are constrained by a lack of resources. In fact, in 85% of low-income countries, essential psychotropic medications are not available (Becker & Kleinman, 2013); monies for mental health care are disproportionately lacking even though their associated burden is tremendous (WHO, 2004a). Wider horizontal approaches to global community health care have been successful in the management of childhood illness (Gwatkin, 2004) and can likewise be successful in general mental health care. Furthermore, the benefits of essential psychotropic medications can be greatly enhanced by adjunctive psychosocial treatments including population-based models of mental health care (Patel, Araya, et al., 2007; Patel, Flisher, et al., 2007).

In summary, the MHF program is making an impact from Bhutan to Berlin and from Botswana to Bulgaria. Its training process provides equitable access to first-responder interventions including mental health promotion, advocacy, monitoring and referral, and the implementation of community MHF training furthers the development and delivery of community-based care consistent with WHO's recommendations for addressing global mental health needs. The population-based, transdisciplinary MHF training model provides countries with a workable human resource development strategy to effectively and equitably bridge the mental health need-care service gap, one country at a time.

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References

Abarquez, I., & Murshed, Z. (2004). *Field practitioner's handbook*. Bangkok, Thailand: Asian Disaster Preparedness Center.

Albee, G. W. (1967). The relationship of conceptual models to manpower needs. In E. L. Cowen, E. Gardner, & M. Zax (Eds.), *Emergent approaches to mental health problems* (pp. 63–73). New York, NY: Appleton-Century-Crofts.

Alonso, J., Chatterji, S., He, Y., & Kessler, R. C. (2013). Burdens of mental disorders: The approach of the World Mental Health (WMH) surveys. In J. Alonso, S. Chatterji, & Y. He (Eds.), *The burdens of mental disorders: Global perspectives from the WHO World Mental Health surveys* (pp. 1–6). Cambridge, United Kingdom: Cambridge University Press.

Alonso, J., Petukhova, M. V., Vilagut, G., Bromet, E. J., Hinkov, H., Karam, E. G.,…Stein, D. J. (2013). Days totally out of role associated with common mental and physical disorders. In J. Alonso, S. Chatterji, & Y. He (Eds.), *The burdens of mental disorders: Global perspectives from the WHO World Mental Health surveys* (pp. 137–148). Cambridge, United Kingdom: Cambridge University Press.

Anand, S., & Bärnighausen, T. (2004). Human resources and health outcomes: Cross-country econometric study. *The Lancet*, *364*, 1603–1609.

Bach, S. (2004). Migration patterns of physicians and nurses: Still the same story? *Bulletin of the World Health Organization*, *82*, 624–625.

Barron, R. A. (2004). International disaster mental health. *Psychiatric Clinics of North America*, *27*, 505–519.

Becker, A. E., & Kleinman, A. (2013). Mental health and the global agenda. *New England Journal of Medicine*, *369*, 66–73.

Benight, C. C. (2012). Understanding human adaptation to traumatic stress exposure: Beyond the medical model. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*, 1–8.

Bloom, D. E., Cafiero, E. T., Jané-Llopis, E., Abrahams-Gesse, S., Bloom, L. R., Fathima, S., … Weiss, A. (2011). *The global economic burden of non-communicable diseases.* Geneva, Switzerland: World Economic Forum.

Breslau, J., Lee, S., Tsang, A., Lane, M. C., Aguilar-Gaxiola, S., Alonso., J.,…Williams, D. R. (2013). Associations between mental disorders and early termination of education. In J. Alonso, S. Chatterji, & Y. He (Eds.), *The burdens of mental disorders: Global perspectives from the WHO World Mental Health surveys* (pp. 56–65). Cambridge, United Kingdom: Cambridge University Press.

Browne, C., & Winkleman, C. (2007). The effect of childhood trauma on later psychological adjustment. *Journal of Interpersonal Violence*, *22*, 684–697.

Chan, M. (2010). Foreword. In *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings* (p. iii). Geneva, Switzerland: World Health Organization.

Chatterji, S., He, Y., & Alonso, J. (2013). Conclusions and future directions. In J. Alonso, S. Chatterji, & Y. He (Eds.), *The burdens of mental disorders: Global perspectives from the WHO World Mental Health surveys* (pp. 244–247). Cambridge, United Kingdom: Cambridge University Press.

Chen, L., Evans, T., Anand, S., Boufford, J. I., Brown, H., Chowdhury, M.,…Wibulpolprasert, S. (2004). Human resources for health: Overcoming the crisis. *The Lancet*, *364*, 1984–1990.

Chisholm, D., James, S., Sekar, K., Kumar, K. K., Murthy, S., Saeed, K., & Mubbashar, M. (2000). Integration of mental health care into primary care. *The British Journal of Psychiatry*, *176*, 581–588.

Coups, E. J., Gaba, A., & Orleans, T. (2004). Physician screening for multiple behavioral health risk factors. *American Journal of Preventive Medicine*, *27*, 34–41.

Craft, A. (2005). What are the priorities for child health in 2004? *Child: Care, Health and Development*, *31*, 1–2.

Demyttenaere, K., Brufferts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J. P.,… Chatterji, S. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization Mental Health Surveys. *Journal of the American Medical Association*, *291*, 2581–2590.

Desjarlais, R., Eisenberg, L., Good, B., & Kleinman, A. (1995). *World mental health*. Oxford, United Kingdom: Oxford University Press.

Eaton, J. (2013, October). Document two. In J. de Almeida (Chair), *Innovation in deinstitutionalization: A WHO expert survey*. Symposium conducted at the International Forum on Innovation in Mental Health, Gulbenkian Global Mental Health Platform, Lisbon, Portugal.

Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R.,… & Saxena, S. (2011). Scale up of services for mental health in low-income and middle-income countries, *The Lancet*, *378*, 1592–1603.

Elder, G. H., & Shanahan, M. J. (2007). The life course and human development. In R. M. Lerner & W. Damon (Eds.), *Handbook of child psychology*. (Vol. 1, pp. 665–715). Hoboken, NJ: John Wiley & Sons.

Feiring, C., Taska, L., & Chen, K. (2002). Trying to understand why horrible things happen: Attribution, shame, and symptom development following sexual abuse. *Child Maltreatment*, *7*, 25–39.

Fiore, M. C., Bailey, W. C., Cohen, S. J., Dorfman, S. F., Goldstein, M. G., Gritz, E. R., …Wewers, M. E. (2000). *Treating tobacco dependence and use: Clinical practice guideline.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.

Forchuk, C., Martin, M. L., Chan, Y. L., & Jensen, E. (2005). Therapeutic relationships: From psychiatric hospital to community. *Journal of Psychiatric and Mental Health Nursing*, *12*, 556–564.

Fricchione, G. L., Borba, C. P. C., Alem, A., Shibre, T., Carney, J. R., & Henderson, D. C. (2012). Capacity building in global mental health: Professional training. *Harvard Review of Psychiatry*, *20*, 47–57.

Furtos, J. (2013, May). *Globalization and mental health: The weight of the world, the size of the sky*. Presidential symposium conducted at the American Psychiatric Association Annual Meeting, San Francisco, CA.

Galea, S. (2013, May). *Re-emerging research around the social and economic production of mental health: Toward a comprehensive model of mental health*. Presidential symposium conducted at the American Psychiatric Association Annual Meeting, San Francisco, CA.

Goldberg, D., & Huxley, P. (1992). *Common mental disorders: A bio-social model*. London, England: Routledge.

Gulbenkian Global Mental Health Platform. (2013a). Integrating mental and physical health, promoting social inclusion, humanizing mental health care. Retrieved from http://www.gulbenkianmhplatform.com/

Gulbenkian Global Mental Health Platform. (2013b). International forum on innovation in mental health. Lisbon, Portugal: Author.

Gureje, O. (2013, October). Document one. In B. Saraceno (Chair), *Integrating the response to mental disorders and other chronic diseases in health care systems*. Symposium conducted at the International Forum on Innovation in Mental Health, Gulbenkian Global Mental Health Platform, Lisbon, Portugal.

Gwatkin, D. R. (2004). Integrating the management of childhood illness. *The Lancet*, *364*, 1557–1558.

Hines, L. (1970). A nonprofessional discusses her role in mental health. *American Journal of Psychiatry*, *126*, 1467–1472.

Hinkle, J. S. (2006, October). *MHF town meeting: Ideas/questions.* Presentation at the NBCC Global Mental Health Conference: Focus on the Never Served, New Delhi, India.

Hinkle, J. S. (2007, June). *The mental health facilitator training: Ongoing developments*. Presentation at the 12th International Counseling Conference, Shanghai, China.

Hinkle, J. S. (2009, July). *Mental health facilitation: The challenge and a strategy*. Keynote address at the Association for Multicultural Counseling and Development/Association for Counselor Education and Supervision 2nd Annual Conference on Culturally Competent Disaster Response, Gabarone, Botswana.

Hinkle, J. S. (2010a). International disaster counseling: Today's reflections, tomorrow's needs. In J. Webber & J. B. Mascari (Eds.), *Terrorism, trauma, and tragedies: A counselor's guide to preparing and responding* (3rd ed., pp. 179–184). Alexandria, VA: American Counseling Association.

Hinkle, J. S. (2010b, August). *Mental health facilitation: A global challenge and workable strategy*. Manuscript presented at the 18th Asian Pacific Education Counseling Association Biennial Conference-Workshop, Penang, Malaysia.

Hinkle, J. S. (2012a, September). *The Mental Health Facilitator program: Optimizing global emotional health one country at a time*. Retrieved from http://www.revistaenfoquehumanistico.com/#!Scott Hinkle/c1lbz

Hinkle, J. S. (2012b, May). *Mental health facilitation: A global strategy*. Manuscript presented at the Asian Pacific Educational Counseling Association Conference, Tokyo, Japan.

Hinkle, J. S. (2012c, October). *Population-based mental health facilitation (MHF): A strategy that works*. Manuscript presented at the Seventh World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders, Perth, Australia.

Hinkle, J. S. (2013a, February). *Population-based mental health facilitation (MHF): Community empowerment and a vision that works*. Manuscript presented at the North Carolina Counseling Association 2013 Conference, Greensboro, NC.

Hinkle, J. S. (2013b, November). *La salud mental en e mundo*. Presentation at the Old Dominion University Counseling Institute, Buenos Aires, Argentina.

Hinkle, J. S., & Henderson, D. (2007). *Mental health facilitation*. Greensboro, NC: NBCC-I.

Hinkle, J. S., Kutcher, S. P., & Chehil, S. (2006, October). *Mental health facilitator: Curriculum development*. Presentation at the NBCC International Global Mental Health Congress, New Delhi, India.

Hinkle, J. S., & Saxena, S. (2006, October). *ATLAS: Mapping international mental health care*. Presentation at the NBCC International Global Mental Health Congress, New Delhi, India.

Hinkle, J. S., & Schweiger, W. (2012, September). *Mental health facilitation around the world*. Manuscript presented at HOLAS Second Counseling Conference of the Americas, Buenos Aires, Argentina.

Hoff, L. A. (1993). Review essay: Health policy and the plight of the mentally ill. *Psychiatry*, *56*, 400–419.

Hoff, L. A., Hallisey B. J., & Hoff, M. (2009). *People in crisis: Clinical and diversity perspectives* (6th ed.). New York, NY: Routledge.

Hongoro, C., & McPake, B. (2004). How to bridge the gap in human resources for health. *The Lancet*, *364*, 1451–1456.

Huston, A. C., & Bentley, A. C. (2010). Human development in societal context. *Annual Review of Psychology*, *61*, 411–437.

Isaac, M. (2013, October). Document two. In J. de Almeida (Chair), *Innovation in deinstitutionalization: A WHO expert survey*. Symposium conducted at the International Forum on Innovation in Mental Health, Gulbenkian Global

Mental Health Platform, Lisbon, Portugal.
Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist*, *67*, 231–243.
Kabir, B. (2011, January–May). Compassionate and dignified emergency health service delivery in Bangladesh. *Asian Disaster Management News*, *17*(1), 4–6.
Lerner, R. M. (2007). Developmental science, developmental systems, and contemporary theories of human development. In R. M. Lerner & W. Damon (Eds.), *Handbook of child psychology* (Vol. 1, pp. 1–17). Hoboken, NJ: John Wiley & Sons.
Lewin, S. A., Dick, J., Pond, P., Zwarenstein, M., Aja, G., Van Wyk, B.,…Patrick, M. (2005). *Lay health workers in primary and community health care.* The Cochrane Database of Systematic Reviews, *2005*(1), CD004015.
Littleton, H. L., Horsley, S., John, S., & Nelson, D. V. (2007). Trauma coping strategies and psychological distress: A meta-analysis. *Journal of Traumatic Stress*, *20*, 977–988.
Lynch, M., & Gardner, E. A. (1970). Some issues raised in the training of paraprofessional personnel as clinic therapists. *American Journal of Psychiatry*, *126*, 1473–1479.
Marks, I., & Scott, R. (Eds.). (1990). *Mental health care delivery, impediments and implementation*. Cambridge, United Kingdom: Cambridge University Press.
McKee, L., Ferlie, E., & Hyde, P. (2008). *Organizing and reorganizing: Power and change in health care organizations*. Houndmills, Bastingstoke, Hampshire, United Kingdom: Palgrave MacMillan.
McKinlay, J. B. (1990). A case for refocusing upstream: The political economy of illness. In P. Conrad & R. Kern (Eds.), *The sociology of health and illness: Critical perspectives* (3rd ed., pp. 502–516). New York, NY: St. Martin's Press.
Mosher, L. R., & Burti, L. (1994). *Community mental health: A practical guide*. New York, NY: W. W. Norton.
Murray, C. J. L., & López, A. D. (1996a). Evidence-based health policy: Lessons from the Global Burden of Disease study, *Science*, *274*, 740–743.
Murray, C. J. L., & López, A. D. (1996b). *The global burden of diseases: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. Boston, MA: Harvard School of Public Health, WHO and World Bank.
Murray, C. J. L., Vos, T., Lozano, R., Naghavi, M., Flaxman, A. D., Michaud, M.,…Andrews, K. G. (2012). Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: A systematic analysis for the Global Burden of Disease Study 2010. *The Lancet, 380*, 2197–2223.
Murthy, R. S. (Ed.). (2006). *Mental health by the "people."* Peoples Action for Mental Health, Bangalore, India.
National Board for Certified Counselors-International. (2013). *Mental health facilitator (MHF)*. Retrieved from http://www.nbccinternational.org/What_we_do/MHF
Nolan, K. J., & Cooke, E. T. (1970). The training and utilization of the mental health paraprofessional within the military: The social work/psychology specialist. *American Journal of Psychiatry*, *127*, 74–79.
Paredes, D., Schweiger, W., Hinkle, S., Kutcher, S., & Chehil, S. (2008). The mental health facilitator program: An approach to meet global mental health care needs, *Temas Selectos en Orientación Psicológica*, *3*, 73–80.
Patel, V. (2013, October). *Integrating mental health care in priority health programs: Addressing a grand challenge in global mental health*. Manuscript presented at the International Forum on Innovation in Mental Health, Gulbenkian Global Mental Health Platform, Lisbon, Portugal.
Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., DeSilva, M.,…Van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet*, *370*, 991–1005.
Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *The Lancet*, *369*, 1302–1313.
Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). No health without mental health. *The Lancet*, *370*, 859–877.
Rachlis, M., & Kushner, C. (1994). *Strong medicine: How to save Canada's health care system*. New York, NY: HarperCollins.
Reyes, G., & Elhai, J. D. (2004). Psychosocial interventions in the early phases of disasters. *Psychotherapy: Theory, Research, Practice, Training*, *41*, 399–411.
Rioch, M. J., Elkes, C., Flint, A. A., Usdansky, B. S., Newman, R. G., & Silber, E. (1963). National institute of mental health pilot study in training mental health counselors. *American Journal of Orthopsychiatry*, *33*, 678–689.

Rock, D., Combrinck, J., & Groves, A. (2001). Issues associated with the implementation of routine outcome measures in public mental health services. *Australasian Psychiatry*, *9*, 43–46.

Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J.,…Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *The Lancet*, *370*, 1164–1174.

Schweiger, W. K., & Hinkle, J. S. (2013, October). *The Mental Health Facilitator (MHF): A program to meet diverse international and domestic needs*. Presentation at the 2013 Association for Counselor Educators and Supervisors Conference, Denver, CO.

Scott, K. M., Wu, B., Saunders, K., Benjet, C., He, Y., Lépine, J.-P.,…Von Korff, M. (2013). Early-onset mental disorders and their links to chronic physical conditions in adulthood. In J. Alonso, S. Chatterji, & Y. He (Eds.), *The burdens of mental disorders: Global perspectives from the WHO World Mental Health surveys* (pp. 87–96). Cambridge, United Kingdom: Cambridge University Press.

Sonne, J. L. (2012). *PsychEssentials: A pocket resource for mental health practitioners.* Washington, DC: American Psychological Association.

Suck, A. T., Kleinberg, E., & Hinkle, J. S. (2013). Counseling in Mexico. In T. H. Hohenshil, N. E. Amundson, & S. G. Niles (Eds.), *Counseling around the world: An international handbook* (pp. 315–322). Alexandria, VA: American Counseling Association.

Taylor, S., & Stanton, A. L. (2007). Coping resource, coping processes, and mental health. *Annual Review of Clinical Psychology*, *3*, 377–401. doi:10.1146/annurev.clinpsy.3.022806.091520

Thigpen, J. D. (1979). Perceptional differences in the supervision of paraprofessional mental health workers. *Community Mental Health Journal*, *15*, 139–148.

Unützer, J. (2013, October). Document one. In B. Saraceno (Chair), *Integrating the response to mental disorders and other chronic diseases in health care systems*. Symposium conducted at the International Forum on Innovation in Mental Health, Gulbenkian Global Mental Health Platform, Lisbon, Portugal.

Ustün, T. B., & Sartorius, N. (Eds.). (1995). *Mental illness in general health care: An international study*. Chichester, England: John Wiley and Sons.

van Wesel, F., Boeije, H., Alisic, E., & Drost, S. (2012). I'll be working my way back: A qualitative synthesis on the trauma experience of children. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*, 516–526.

Viana, M. C., Gruber, M. J., Shahly, V., de Jonge, P., He, Y., Hinkov, H., & Kessler, R. C. (2013). Family burden associated with mental and physical disorders. In J. Alonso, S. Chatterji, & Y. He (Eds.), *The burdens of mental disorders: Global perspectives from the WHO World Mental Health surveys* (pp. 122–135). Cambridge, United Kingdom: Cambridge University Press.

Vidaver, R. M. (1969). The mental health technician: Maryland's design for a new health career. *American Journal of Psychiatry*, *125*, 1013–1023.

Vos, T., Flaxman, A. D., Naghavi, M., Lozano, R., Michaud, C., Ezzati, M.,…Murray, C. J. L. (2012). Years lied with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990–2010: A systemic analysis for the Global Burden of Disease Study 2010. *The Lancet*, *380*, 2163–2196.

Walt, G. (1988). *Community health workers: Policy and practice in national programmes*. London, England: London School of Hygiene and Tropical Medicine, EPC publication number 16.

Warne, T., & McAndrew, S. (2004). The mental health assistant practitioner: An oxymoron. *Journal of Psychiatric and Mental Health Nursing*, *11*, 179–184.

Warner, L., & Ford, R. (1998, October). Mental health facilitators in primary care. *Nursing Standard*, *13*, 36–40.

Weissman, M. M., Bland, R. C., Canino, G. J., Faravelli, C., Greenwald, S., Hwu, H. G.,…Yeh, E. K. (1994). The cross national epidemiology of obsessive compulsive disorder. *Journal of Clinical Psychiatry*, *55*, 5–10.

Weissman, M. M., Bland, R. C., Canino, G. J., Faravelli, C., Greenwald, S., Hwu, H. G.,…Yeh, E. K. (1997). The cross-national epidemiology of panic disorder. *Archives of General Psychiatry*, *54*, 305.

Weissman, M. M., Bland, R., Canino, G., Greenwald, S., Lee, C., Newman, S.,…Wickramaratne, P. J. (1996). The cross-national epidemiology of social phobia: A preliminary report. *International Clinical Psychopharmacology*, *11*, Suppl: 3, 9–14.

Wekerle, C. (2011). Emotionally maltreated: The under-current of impairment? *Child Abuse & Neglect*, *35*, 899–903. doi:10.1016/j.chiabu.2011.09.002

Wells, M. E. (2006). Psychotherapy for families in the aftermath of a disaster. *Journal of Clinical Psychology: In Session*, *62*, 1017–1027.

Whitlock, E. P., Orleans, C. T., Pender, N., & Allan, J. (2002). Evaluating primary care behavioral counseling interventions: An evidenced-based approach. *American Journal of Preventive Medicine*, *22*, 267–284.

WHO World Mental Health Survey Consortium. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization world mental health surveys. *Journal of the American Medical Association*, *291*, 2581–2590.

World Health Organization (2004a). Atlas: Country resources for neurological disorders. Geneva, Switzerland: Author.

World Health Organization. (2005). *Mental health atlas*. Geneva, Switzerland: Author.

World Health Organization. (2006a). *Integrating mental health into primary care: A global perspective.* Geneva, Switzerland: Author.

World Health Organization. (2006b). *Preventing suicide: A resource for counsellors*. Geneva, Switzerland: Author.

World Health Organization. (2009). *Scaling up nursing & medical education: Report on the WHO/PEPFAR planning meeting on scaling up nursing and medical education*. Geneva, Switzerland: Author.

World Health Organization. (2010a). *Mental health and development: Targeting people with mental health conditions as a vulnerable group*. Geneva, Switzerland: Author.

World Health Organization. (2010b). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings*. Geneva, Switzerland: Author.

Integrating Left-Brain and Right-Brain: The Neuroscience of Effective Counseling

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Based on emerging findings from neuroscience, the counseling professional can consider a different approach to research-informed practice, by integrating left- and right-brain processing in client care. This new model is commensurate with counseling's historical lineage of valuing the counseling relationship as the core ingredient of effective counseling.

Keywords: **counseling, neuroscience, evidence-based, effectiveness, right-hemisphere, intuition**

During the past decade, the field of counseling has considered the notion of identifying effective counseling practices. In 2005, the American Counseling Association's (ACA) Code of Ethics included a recommendation to use therapies that "have an empirical or scientific foundation" (C.6.e). The *Journal of Counseling & Development* introduced a new journal feature in 2007, entitled "Best Practices." In 2009, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) modified their Standards for addiction counseling (I.3., p. 22), clinical mental health counseling (I.3., p. 34), and marriage, couple, and family counseling (I.3., p. 39) to require that the student "knows evidence-based treatments" (EBTs; p. 5). In the September 2012 edition of *Counseling Today*, Dr. Bradley Erford, the current ACA President, asserted the following in his monthly column:

> If professional counselors use the best available research-based approaches to help clients and students, then counselor effectiveness, client satisfaction and third-party insurer satisfaction all improve. When professional counselors provide effective services, it also helps our professional advocacy and lobbying efforts with federal, state, and local politicians and bureaucrats, and leads to more counseling jobs and higher pay scales. (p. 5)

Erford argues that counselors must use research to inform practice—the public, insurance companies, and clients demand it. Yet until recently, only one approach to research-informed practice has been available to the counseling profession—namely the EBT movement that originated in the field of psychology. Many techniques and theories exist outside of the EBT movement, in addition to other models for best practices such as the common factors movement (Duncan, Miller, Wampold, & Hubble, 2010). Counselors may feel confused about which model to follow. An approach to research-informed practice that is more commensurate with the counseling profession's values and identity is the application of research evidence from neuroscience to inform counseling interventions.

Current Direction: The Left-Brain Pathway

The left side of the brain is responsible for rational, logical, and abstract cognition and conscious knowledge. Neuroscientists such as Allan Schore (2012) have suggested that activities associated with the left

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hemisphere (LH) currently dominate mental health services. This is evidenced by the current reliance upon psychopharmacology over counseling services, the manualization of counseling, a reductionist and idealistic view of "evidence-based practice," and a lack of respect for the counseling relationship in client outcomes despite a large body of evidence. McGilchrist (2009) takes this argument further: if left unchecked, the modern world will increase its reliance upon the LH compared to the than right hemisphere (RH), with disastrous consequences. A "left-brain world" would lead to increased bureaucracy, a focus on quantity and efficiency over quality, and a valuing of technology over human interaction, and uniformity over individualization. While this dystopia has not been fully realized yet, one could argue that the field's current reductionist and cookie-cutter approach to mental health services and reliance on quantitative over qualitative research all point in one direction.

To understand the importance of the association between the LH and the current mental health system, the author reviews the history of the counseling effectiveness movement, along with the counseling profession's gradual adherence to this left-brain movement.

The History of "Effectiveness"

It is hard to know when the term *effectiveness* was first used in counseling circles. A long history of competition exists between different theoretical schools that sought to find evidence for the efficacy of their theory and discredit (or at least, disprove) all pretenders. Eventually, in 1995, the American Psychological Association (APA) defined *effectiveness* by identifying counseling interventions that were considered to have adequate research support (Task Force for Promotion and Dissemination of Psychological Procedures, 1995). The criteria for delineation were narrow: at least two randomized controlled studies or multiple pre-and post-individual studies, and the existence of a treatment manual. This model of efficacy was based on the Federal Drug Administration's (FDA) criteria for what constituted acceptable research evidence for a new medication's efficacy. The field of psychology was concerned at the time about medications being considered the "first line of treatment" for mental disorders instead of counseling and psychotherapy, thus wanting to provide empirical evidence for counseling efficacy that could be used for political and financial leverage in the marketplace (LaRoche & Christopher, 2009). Various terms were used for this movement: *psychological treatments*, *empirically validated treatments*, *empirically supported treatments*, and *EBT*. This movement soon became synonymous with the definition of *effectiveness* in counseling and psychotherapy.

Criticisms abounded throughout the mental health services community. It became apparent that these interventions were difficult to implement, or else that practitioners were resistant (Becker, Stice, Shaw, & Woda, 2009). Criticisms focused on the inadequate representation of certain demographic and minority groups, the disregard for the predominance of co-occurring disorders within client populations, the exclusionary definition of "research evidence," and the lack of consideration for clinical expertise and judgment (Bernal & Scharró-del-Rio, 2001; LaRoche & Christopher, 2009).

Training programs in the mental health services field have also been resistant to training students in EBTs. Weissman et al. (2006) found that only 28.1% of psychiatry preparation programs and 9.8% of social work preparation programs required both didactic instruction and clinical supervision in EBT use. In clinical psychology preparation programs, 16.5% (PhD) and 11.5% (PsyD) required didactic instruction and clinical supervision in EBTs. This is a low rate, considering that the inclusion of training in psychological treatments is required for APA doctoral program accreditation (Chambless, 1999). No data are currently available on the percentage of counselor education programs that require both didactic instruction and clinical supervision in EBT use. However, one could argue that the 2009 CACREP Standards mandate instruction and supervision in the use of EBTs. If counselors do not find another path, counselor education may adhere to the training model

of psychology, requiring a greater emphasis on teaching techniques rather than relational skills, and inflexibly following standards of practice rather than individualized instruction. Counselor education may become a left-brain discipline.

Counseling Approaches and the Left-Brain

Counselors are already using EBTs in practice settings. Field, Farnsworth, and Nielsen (2011) conducted a small unpublished national pilot study in the use of EBTs by National Certified Counselors (NCCs; n = 76). Demographics were consistent with the most recent demographical survey of NCCs (National Board of Certified Counselors, 2000). The majority of participants reported utilizing EBTs within the past year (69.4%), and the number of EBTs utilized was surprisingly high (M = 9.17, SD = 6.94, SEM = 0.97) for those who utilized EBTs. Furthermore, of those who used EBTs, only 6% (n = 3) did not report using a form of cognitive-behavioral therapy (CBT). Although this was a small pilot study, and thus results cannot be wholly generalized to the counselor population, initial findings seem to indicate that EBT utilization may be practically synonymous with CBT utilization. This is alarming, since research has shown that when psychotherapies are directly compared to one another, studies in which CBT is claimed to be more beneficial than other treatments subsequently achieved comparative outcomes (e.g., Wampold, Minami, Baskin, & Tierney, 2002). The apparent "fit" between CBT and the EBT movement can be elucidated when considering that following a manualized protocol and using conscious verbal analysis (CBT) are both LH functions, and studies have found a link between CBT and activation in the dorsolateral prefrontal cortex of the LH (Siegle, Steinhauer, Friedman, Thompson, & Thase, 2011). Put simply, CBT activates the LH, and the EBT movement values LH over RH processing.

It could be argued that the emergence of the EBT movement has propelled CBT into first place among interventions used in practice settings. Structured interventions that can be easily manualized and measured such as CBT seem to correspond with strict and rigid guidelines for empiricism compared to therapies that are more abstract and unstructured (e.g., humanistic-existential and relational forms of counseling). The dominance of CBT may only solidify following the initiation of EBT training within graduate programs. Yet even Aaron T. Beck, the founder of cognitive therapy, asserted that "you can't do cognitive therapy from a manual any more than you can do surgery from a manual" (Carey, 2004, p. F06). In other words, the purely LH approach of rigidly following a treatment manual is not sufficient for effective counseling practice.

The Right-Brain Pathway

The right side of the brain is associated with unconscious social and emotional learning, and includes intuition, empathy, creativity, and flexibility. Some may argue that counseling has always been associated with RH processes (J. Presbury, personal communication, November 25, 2012). There are signs that the field of counseling is moving toward the valuing of RH processes during interventions, evidenced by the empirical respect attributed to the therapeutic relationship (e.g., Magnavita, 2006; Norcross & Wampold, 2011; Orlinsky, Ronnestad, & Willutzki, 2004), and the admission that EBTs are unsuccessful if applied rigidly. The APA Task Force on Evidence-Based Practice (2006) intoned that "sensitivity and flexibility in the administration of therapeutic interventions produces better outcomes than rigid application of…principles" (p. 278). A purely LH counseling approach may be overly rigid, problematic since counselor rigidity has been found to impair the counselor-client relationship (Ackerman & Hilsenroth, 2001).

Clinical Judgment vs. Intuition

In 2006, the APA issued a new definition of evidence-based practice, derived largely from the definition provided in 2001 by the Institute of Medicine (APA, 2006). Evidence-based practice was redefined as

consisting of three elements: research evidence, clinical judgment, and client contextual variables (APA, 2006; Institute of Medicine, 2001). Yet the APA's revised definition of evidence-based practice still privileged LH processing. Whereas *clinical judgment* can be defined as the application of rational and analytical reasoning when working with clients (LH function), *clinical intuition* can be described as the attunement to unconscious and implicit knowledge when working with clients, and has been associated with activation in areas of the RH (Bolte & Goschke, 2005). Often difficult to articulate, intuition has been commonly described as "the unthought known," a "gut feeling," and "a working hypothesis" (Bollas, 1987). Lieberman (2000) defined clinical intuition as "the subjective experience associated with the use of knowledge gained through implicit learning" (p. 109). It is now known that effective counseling requires *both* conscious reasoning and unconscious intuition—in other words, the integration of the LH and RH of the brain. As the famous attachment theorist John Bowlby (1991) once wrote, "clearly the best therapy is done by the therapist who is naturally intuitive and also guided by the appropriate theory" (p. 16).

Studies on counselor development have found that experienced counselors tend to rely more on intuition than manualized protocols (Rønnestad & Skovolt, 2003; Stoltenberg, McNeill, & Delworth, 1998). As any experienced practitioner can attest, counselors tend to learn intuitive skills such as timing and word choice with experience. Welling (2005) wrote, "no therapist can reasonably deny following hunches, experiencing sudden insights, choosing directions without really knowing why, or having uncanny feelings that turn out to be of great importance for therapy" (p. 19). Volz and von Cramon (2008) concluded that the counselor's intuition is often reliable and accurate during the counseling process. The difference between novice and experienced counselors can be understood as a difference in amount of accumulated experiences from prior client encounters within the unconscious, which informs intuitive clinical judgments (Schore, 2012). Less-experienced counselors are prone to make more inaccurate intuitive clinical decisions given their lesser clinical experience and, therefore, their less sculpted unconscious intuition.

Creativity vs. Replication

Creativity in the counseling process allows clinicians to individualize treatment, and consider the client's contextual values during decision making (APA, 2006). This is the third part of the APA's definition of evidence-based practice. Creativity has also been associated with the RH (Grabner, Fink, & Neubauer, 2007), and occurs when counselors are attuned to implicit memories. Creativity occurs when counselors trust their unconscious, where novel ideas are generated, based on environmental cues. Creativity is typically an emergent and unconscious process, unfolding in the immediacy of the counseling room. Counselors often cannot fully prepare for what the client brings to the session. Every session therefore requires some degree of creativity by the counselor, whose flexible response to the interpersonal contact with the client is crucial to establishing a deep and sustained therapeutic bond. For this reason, there is no existing evidence-based protocol for nonverbal body language or affective response by the counselor; these behaviors and responses are highly individualized and contextual, and thus cannot be manualized. Without creativity, the counselor is reduced to the role of technician, administering treatments in a consistent yet rote and rigid manner. The manualization of counseling naturally limits the creative process and RH processing for both counselor and client. While studies are needed, it is possible that a rigid LH approach to the counseling process would restrict rather than enhance the creative capacities of counselor and client, and neglect the client's natural problem-solving ability (Bohart & Tallman, 2010).

To take a purely LH approach to counseling is to negate the importance of unconscious intuition and clinical experience in counselor effectiveness. Shrinking clinical expertise to merely conscious decision making is reductionist and misses a large body of evidence suggesting that unconscious information also guides clinical decisions. It is entirely possible that many clinical decisions are based more on RH than LH processes. For

example, some counselors have experienced moments with clients when they instinctively know the diagnosis or what problem a client is experiencing, without formally checking off symptoms from diagnostic criteria. Counselor educators and supervisors can help trainees to hone unconscious intuition by asking questions such as the following: What is your gut feeling about this client? What prior clinical experiences may have led you to that conclusion? What unconscious decisions have you made that you were satisfied with? What unconscious information are you ignoring or suppressing?

The Centrality of the Counseling Relationship

The importance of RH processing extends to the counseling relationship, which is considered to have a central role in client outcomes. In 2001, the APA formed a Task Force on Evidence-Based Therapy Relationships, concluding in 2011 that the counseling relationship was central to client outcomes to an equivalent or greater extent as the treatment method, and "efforts to promulgate best practices or evidence-based practices (EBPs) without including the relationship are seriously incomplete and potentially misleading" (Norcross & Wampold, 2011, p. 98). Fifty years of research support the centrality of the counseling relationship in client outcomes (Orlinsky et al., 2004). Magnavita (2006) concluded, "the quality of the therapeutic relationship is probably the most robust aspect of therapeutic outcome" (p. 888). By the end of the 1990s, counseling was beginning to move toward a two-person interpersonal model in place of a one-person intrapersonal model for conceptualizing client problems and planning treatment (Cozolino, 2010). Some have argued that identifying and utilizing specialized treatments for certain disorders is therefore misleading, since research studies have consistently found that the "confounding variable" of the therapeutic relationship is the primary factor for counseling efficacy (Norcross & Wampold, 2011).

During counselor-client interactions, the level of intersubjective attunement and engagement strongly influences the quality of this interpersonal contact. As Bromberg (2006) wrote, when counselors try to "know" their clients instead of "understand" their clients through their engagement in the shared intersubjective field of the here and now, "an act of recognition (not understanding) takes place in which words and thoughts come to symbolize experience instead of substitute for it" (p. 11). When this moment of meeting occurs, the client can safely contact, describe, and regulate inner experience. During the client's heightened emotional states, the counselor can model healthy emotional regulation for the client. This secure holding environment enables clients to experience and cope with their own dysregulated emotions and thus serves as a corrective emotional experience. Because the LH is specialized to manage "ordinary and familiar circumstances" while the RH is specialized to manage emotional arousal and interpersonal interactions (MacNeilage, Rogers, & Vallortigara, 2009), many if not most counseling interventions enhance RH processing for both counselor and client.

Neuroscience supports the integration of both the LH and RH in interactions between counselor and client. The counseling relationship is informed by linguistic content and auditory input (LH function), in addition to visual-facial input, tactile input, proprioceptive input (the body's movement in space), nonverbal gestures, and body language (RH function). Whereas the LH is involved in conscious processing of language, the RH is responsible for a large amount of social and emotional behavior that occurs during the counseling relationship, such as the moment of contact between counselor and client (Stern, 2004), attention to the external environment (Raz, 2004), empathic resonance of both linguistic content and nonverbal behavior (Keenan, Rubio, Racipoppi, Johnson, & Barnacz, 2005), mental creativity (Asari, Konishi, Jimura, Chikazoe, Nakamura, & Miyashita, 2008), social learning (Cozolino, 2010), emotional words (Kuchinke, Jacobs, Võ, Conrad, Grubich, & Herrmann, 2006), and emotional arousal (MacNeilage et al., 2009). Clearly, all of these RH functions are crucial to the development of a strong counseling relationship. One cannot establish an effective counseling relationship by merely attending to verbal content (LH); a strong counseling relationship requires the integration of both LH and RH processes. Approximately 60% of communication is nonverbal (Burgoon,

1985), which is a RH function (Benowitz, Bear, Rosenthal, Mesulam, Zaidel, & Sperry, 1983). Since so much of counseling is nonverbal and unspoken, yet "known" to the counselor, the practice can be better understood as a communication cure rather than a talking cure (Schore, 2012).

Proposed Direction: Integration of Left- and Right-Brain Pathways

A balance needs to be struck between the extreme polarities of creative vs. structured and repetitive approaches, individualization vs. fidelity to manuals, flexibility vs. rigidity, unconscious vs. conscious, emotions vs. cognitions, and RH vs. LH. Radical adherence to either polarity is less effective. At one polarity, fidelity to a structured, rigid, conscious, LH-activating manualized treatment would lack the flexibility and individualization necessary to establish a strong counseling relationship. At the other extreme, fidelity to a purely spontaneous, flexible, unconscious and RH-activating individualized approach would result in the impossibility of research evidence and thus be unproven. This has been a criticism of some theoretical approaches, such as psychoanalysis (Modell, 2012). Counselors can avoid rigidly following treatment manuals, *and* avoid completely spontaneous approaches that lack research evidence. According to emerging evidence from neuroscience, an integrated approach to client care seems necessary for effective counseling practice (Schore, 2012). The RH and LH seem equally important to human functioning and survival. These often function in tandem with one another. For example, both hemispheres are integral to problem solving; the RH generates solutions, while the LH decides on a single solution to best fit a problem (Cozolino, 2010).

Conclusion

Counseling effectiveness requires the integration of both right- and left-brain processing. Effective counseling is determined not only by what the counselor does or says; it is determined also by the quality of the counselor's interaction with the client (Bromberg, 2006). In a two-person relational system, the interaction between counselor and client is at the core of effective counseling. The neuroscience literature suggests that hemispheric processing for both counselor and client is bidirectional. The counselor's RH-to-RH attunement to the client's subjective experience in the here-and-now encounter of the counseling room informs unconscious intuition and creativity for both counselor and client.

The counselor develops an implicit understanding of the client's inner world and generates clinical intuitions that guide the counselor's decision making. The client is provided with a RH-to-RH holding environment from which deep emotions and sectioned-off past experiences can be explored, and creativity is sparked by the need to respond to the uniqueness of the counseling environment. In cases when clients seem to benefit from interventions that target LH processing, the counselor's often intuitive and unconscious adjustment is a result of the RH-to-RH interaction between counselor and client. Integrating LH interventions may provide a helpful structure to address client problems and facilitate RH processing when the counselor and client both expect change to occur and demonstrate belief in the chosen intervention, which further strengthens the therapeutic bond (Frank & Frank, 1991).

Prior to incorporating a manualized protocol, counselors can therefore establish rapport and attend to the therapeutic alliance and counseling relationship. This attention to RH processing provides a foundation from which the structure of a LH-activating, manualized treatment can be provided, thus mitigating potential ruptures to the therapeutic relationship that occur when counselors abruptly or rigidly apply treatment manuals in a rote fashion. In this manner, both LH and RH processing is enhanced, which is crucial to successful counseling outcomes.

Taking such an approach would integrate the left and right brain in counselor practice. By incorporating research evidence from neuroscience, counselors have a new model for research-informed counseling practice that fits the historical lineage of prizing the counseling relationship as the core ingredient in therapeutic change. While it is not easy to value both structure and spontaneity, or uniformity and individuality, achieving this balance will result in practice behaviors that are more commensurate with the counseling profession's values and identity.

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References

Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy*, *38*, 171–185. doi:10.1037/0033-3204.38.2.171

American Counseling Association. (2005). *ACA code of ethics*. Alexandria, VA: Author.

American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *The American Psychologist*, *61*, 271–285.

Asari, T., Konishi, S., Jimura, K., Chikazoe, J., Nakamura, N., & Miyashita, Y. (2008). Right temporopolar activation associated with unique perception. *NeuroImage*, *41*, 145–152. doi:10.1016/j.pscychresns.2010.01.002

Carey, B. (2004, June 8). Pills or talk? If you're confused, no wonder. *The New York Times*. Retrieved from http://www.nytimes.com/2004/06/08/health/pills-or-talk-if-you-re-confused-no-wonder.html?pagewanted=2

Becker, C. B., Stice, E., Shaw, H., & Woda, S. (2009). Use of empirically supported interventions for psychopathology: Can the participatory approach move us beyond the research-to-practice gap? *Behaviour Research and Therapy*, *47,* 265–274. doi:10.1016/j.brat.2009.02.007

Benowitz, L. I., Bear, D. M., Rosenthal, R., Mesulam, M-M., Zaidel, E., & Sperry, R. W. (1983). Hemispheric specialization in nonverbal communication. *Cortex*, *19*, 5–11.

Bernal, G., & Scharró-del-Rio, M. R. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultural Diversity and Ethnic Minority Psychology*, *7*, 328–342. doi:10.1037/1099-9809.7.4.328

Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor of psychotherapy. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart & soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association.

Bollas, C. (1987). The shadow of the object: Psychoanalysis of the unthought known. New York, NY: Columbia University Press.

Bolte, A., & Goschke, T. (2005). On the speed of intuition: Intuitive judgments of semantic coherence under different response deadlines. *Memory & Cognition*, *33*, 1248–1255. doi:10.3758/BF03193226

Bowlby, J. (1991, Autumn). The role of the psychotherapist's personal resources in the therapeutic situation. *Tavistock Gazette.*

Bromberg, P. M. (2006). *Awakening the dreamer: Clinical journeys.* Mahwah, NJ: Analytic Press.

Burgoon, J. K. (1985). Nonverbal signals. In M. L. Knapp & C. R. Miller (Eds.), *Handbook of interpersonal communication* (pp. 344–390). Thousand Oaks, CA: Sage.

Chambless, D. L. (1999). Empirically supported treatments—What now? *Applied Preventative Psychology*, *8*, 281–284. doi:10.1016/S0962-1849(05)80043-5

Council for Accreditation of Counseling and Related Educational Programs. *2009 Standards*. Retrieved from http://www.cacrep.org

Cozolino, L. (2010). The neuroscience of psychotherapy: Healing the social brain (2nd ed.). New York, NY: Norton.

Duncan, B. L., Miller, S. D., Wampold, B. E,. & Hubble, M. A. (Eds.). (2010). *The heart and soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association.

Erford, B. T. (2012, September). Where's the beef?! *Counseling Today*, *55*(3), 5.

Field, T. A., Farnsworth, E. B., & Nielsen, S. K. (2011). *Do counselors use evidenced-based treatments? Results from a national pilot survey.* Unpublished manuscript.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy.* Baltimore, MD: Johns Hopkins Press.

Grabner, R. H., Fink, A., & Neubauer, A. C. (2007). Brain correlates of self-related originality of ideas: Evidence from event-related power and phase-locking changes in the EEG. *Behavioral Neuroscience*, *121*, 224–230. doi:10.1037/0735-7044.121.1.224

Institute of Medicine. (2001). *Crossing the quality chasm: The new health system for the 21st century.* Washington, DC: National Academy of Sciences.

Keenan, J. P., Rubio, J., Racioppi, C., Johnson, A., & Barnacz, A. (2005). The right hemisphere and the dark side of consciousness. *Cortex*, *41*, 695–704. doi:10.1016/S0010-9452(08)70286-7

Kuchinke, L., Jacobs, A. M., Võ, M. L.-H., Conrad, M., Grubich, C., & Herrmann, M. (2006). Modulation of prefrontal cortex activation by emotional words in recognition memory. *NeuroReport*, *17*, 1037–1041. doi:10.1097/01.wnr.0000221838.27879.fe

La Roche, M. J., & Christopher, M. S. (2009). Changing paradigms from empirically supported treatment to evidence-based practice: A cultural perspective. *Professional Psychology: Research and Practice*, *40*(4), 396–402. doi:10.1037/a0015240

Lieberman, M. D. (2000). Intuition: A social neuroscience approach. *Psychological Bulletin*, *126*, 109–137. doi:10.1037/0033-2909.126.1.109

MacNeilage, P. F., Rogers, L., & Vallortigara, G. (2009, June). Origins of the left and right brain. *Scientific American*, *301*, 160–167.

Magnavita, J. J. (2006). In search of the unifying principles of psychotherapy: Conceptual, empirical, and clinical convergence. *American Psychologist*, *61*, 882–892. doi:10.1037/0003-066X.61.8.882

McGilchrist, I. (2009). The master and his emissary. New Haven, CT: Yale University Press.

Modell, A. H. (2012). Science confirms psychoanalytic theory: Commentary on Howard Shrevin's paper. *Psychoanalytic Review*, *99*, 511–551.

National Board of Certified Counselors. (2000). Gracefully aging at NBCC. *The National Certified Counselor*, *17*(1), 1–2.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy, 48*(1), 98-102. doi:10.1037/a0022161

Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (5th ed.). New York, NY: Wiley.

Raz, A. (2004). Anatomy of attentional networks. *Anatomical Records, 281B,* 21–36.

Rønnestad, M. H., & Skovolt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development*, *30*(1), 5–44. doi:10.1023/A:1025173508081

Schore, A. N. (2012). *The science of the art of psychotherapy.* New York, NY: Norton.

Siegle, G. J., Steinhauer, S. R., Friedman, E. S., Thompson, W. S., & Thase, M. E. (2011). Remission prognosis for cognitive therapy for recurrent depression using the pupil: Utility and neural correlates. *Biological Psychiatry*, *69*, 726–733.

Stern, D. N. (2004). *The present moment in psychotherapy and everyday life.* New York: Norton.

Stoltenberg, C. D., McNeill, B. W., & Delworth, U. (1998). *IDM: An integrated developmental model for supervising counselors and therapists.* San Francisco, CA: Jossey-Bass.

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically supported treatments: Report and recommendations. *Clinical Psychologist*, *48*(1), 2–23.

Volz, K. G., & von Cramon, D. Y. (2008). Cortical regions activated by the subjective sense of perceptual coherence of environmental sounds: A proposal for the neuroscience of intuition. *Cognitive Affective & Behavioral Neuroscience*, *18*, 2077–2087. doi:10.3758/CABN.8.3.318

Wampold, B. E., Minami, T., Baskin, T. W., & Tierney, S. C. (2002). A meta-(re)analysis of the effects of cognitive therapy versus "other therapies" for depression. *Journal of Affective Disorders*, *68*, 159–165.

Weissman, M. M., Verdeli, H., Gameroff, M. J., Bledsoe, S. E., Betts, K., Mufson, L., . . . & Wickramaratne, P. (2006). National survey of psychotherapy training in psychiatry, psychology and social work. *Archives of General Psychiatry*, *63*, 925–934.

Welling, H. (2005). The intuitive process: The case of psychotherapy. *Journal of Psychotherapy Integration*, *15*, 19–47.

Counselors Abroad: Outcomes of an International Counseling Institute in Ireland

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As the counseling profession continues to build an international community, the need to examine cultural competence training also increases. This quantitative study examined the impact of the Diversity and Counseling Institute in Ireland (DCII) on participants' multicultural counseling competencies. Two instruments were utilized to examine participants' cross-cultural competence before and after the study abroad institute. Results indicated that after the institute experience, participants perceived themselves to be more culturally competent, knowledgeable about the Irish culture, skilled in working with clients from Ireland, and aware of cultural similarities and differences. Implications for counselor education and supervision, and future research also are outlined.

***Keywords*: study abroad, multicultural competencies, cross-cultural competence, international, counselor education and supervision, Ireland**

The standards set by the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2009) require programs to provide curricular and experiential opportunities in social and cultural diversity. Specifically, CACREP requires counseling curricula to incorporate diversity training that includes "multicultural and pluralistic trends, including characteristics and concerns within and among diverse groups nationally and internationally" (CACREP, 2009, Section II, Code G2a; p. 10). Endorsement of diversity training by the counselor education accrediting body underscores its importance in counselor training; therefore, counselors-in-training must be provided opportunities to be culturally responsive in their work with clients (McAuliffe & Associates, 2013; Sue & Sue, 2012).

This cultural responsiveness is particularly important given the globalization of the counseling movement and the need for counselors to become globally literate (Hohenshil, Amundson, & Niles, 2013; Lee, 2012). However, counselor education training programs have fostered this multicultural competence with students in myriad ways (Lee, Blando, Mizelle, & Orozco, 2007). For example, multicultural courses have often focused on developing trainees' cross-cultural competencies in the three broad areas of awareness of their own cultural values and biases; knowledge of others' customs, expectations, and worldviews; and culturally appropriate intervention skills and strategies (Sue, Arredondo, & McDavis, 1992).

A body of literature has examined the progress of educational programs in incorporating these aspects of diversity into the curricula. For example, Díaz-Lázaro and Cohen (2001) conducted a study that explored the impact of one specific course in multicultural counseling. They found that cross-cultural contact, such as with guest speakers, helped students develop multicultural knowledge and skills; however, they found no indication that the course impacted students' self-awareness. Guth and McDonnell (2006) examined counseling students'

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perceptions of multicultural and diversity training. Courses were found to contribute somewhat to students' knowledge, but the study found that students gained greater knowledge from personal interactions among peers, interactions with faculty, and other experiential activities outside of coursework. Additional research has shown that multicultural training is significantly related to multicultural competence (Castillo, Brossart, Reyes, Conoley, & Phoummarath, 2007; D'Andrea, Daniels, & Heck, 1991; Dickson, Argus-Calvo, & Tafoya, 2010). A clear message from the literature highlights the importance of personal cross-cultural contact in culturally responsive counseling.

This previous research was limited in that the authors examined only the impact of training offered in the United States, leaving out the potential added value of personal cross-cultural experiences in an international context. Given the impact of direct cross-cultural experiences, a study abroad experience for counselor trainees might be a powerful way to deepen cultural understanding and responsiveness. This quantitative study was designed to examine the outcomes of this counselor trainee study abroad institute on participants' perceptions of their multicultural competence.

Research on Study Abroad Experiences

Study abroad programs are not commonly rigorously researched because "program evaluation is an afterthought to an ongoing program undertaken by extremely busy program administrators" (Hadis, 2005, p. 5). Although data regarding study abroad experiences are primarily anecdotal, the literature does suggest several positive outcomes of a study abroad institute including personal development, intellectual growth and increased global-mindedness (Carlson, Burn, Useem, & Yachimowicz, 1991). Short-term study abroad experiences also were found to produce positive changes in cultural adaptability in students (Mapp, 2012). However, most of the study abroad research has been conducted in disciplines other than counseling, such as business (Black & Duhon, 2006), nursing (Inglis, Rolls, & Kristy, 1998), and language acquisition (Davidson, 2007). Furthermore, the research has mainly focused on the experiences of undergraduate university students and has not examined the experiences of graduate trainees (Drews & Meyer, 1996).

Several studies have been conducted that are relevant to the counseling profession. Kim (2012) surveyed undergraduate and graduate social work students and found that study abroad experiences are a significant predictor of multicultural counseling competency. Jurgens and McAuliffe (2004) also conducted a study that explored the impact of a short-term study abroad experience in Ireland on graduate counseling student participants. The results indicated that this program was helpful in increasing students' knowledge of Ireland's culture, largely due to experiential learning and personal interactions. The current study expands on Jurgens and McAuliffe's research (2004) by further examining the impact of a counseling and diversity institute that was offered in Ireland. The primary research questions for this quantitative study were as follows: (1) Did the study institute have an impact on participants' multicultural counseling competencies? (2) Did this study institute have an impact on participants' multicultural counseling competencies in working with individuals who are Irish?

Method

Participants

Twenty (87%) graduate counseling students and three (13%) professional counselors voluntarily participated in this research study while attending the DCII in Ireland. The sample consisted of 83% women and 17% men; 82% identified themselves as Caucasian/European American, 9% as African American, and 9% did not identify their race. The mean age for the sample was 32 (range: 22–60 years). Regarding sexual orientation, 91% of

the participants indicated they were heterosexual; 4% indicated they were gay; and 4% indicated they were bisexual. Regarding disability status, 87% of the participants reported not having a disability, 9% indicated they had a disability, and 4% did not answer the question.

Instruments

The study assessed participants' cross-cultural counseling competence with the Cross-Cultural Counseling Inventory-Revised (CCCI-R, LaFromboise, Coleman, & Hernandez, 1991). The CCCI-R is a 20-item instrument initially created so that supervisors could evaluate their supervisees' cross-cultural counseling competence. Questions on this instrument are rated on a 6-point Likert-type scale (1 = strongly disagree; 6 = strongly agree). The scale has been found to have high internal consistency and reliability, and high content validity (LaFromboise et al., 1991). Another "recommended use of the CCCI-R is as a tool for self-evaluation" (LaFromboise et al., 1991, p. 387). Therefore, the CCCI-R was slightly modified so that participants could rate themselves to understand perceptions of their own cultural competence, rather than rate other counselors on their cultural competence. Higher scores on this instrument indicate an individual's belief that he or she has greater cultural competence. Sample prompts include the following: "I am aware of my own cultural heritage," "I demonstrate knowledge about clients' cultures," and "I send messages that are appropriate to the communication of clients." In the present study, Cronbach's alpha was used to assess the internal consistency of the CCCI-R and it was reliable at both times of measurement (pretest = .91; posttest = .93).

Four additional Likert-type items were added to the pretest and posttest questionnaires, which asked participants to rate their multicultural awareness, knowledge, and skills related to the Irish culture. The items included were as follows: (1) I am knowledgeable of the culture of Ireland; (2) I possess the skills in working with a client from Ireland; (3) I am aware of the differences between the Irish culture and my own culture; and (4) I am aware of the similarities within the Irish culture and my own culture. Participants rated the extent to which they agreed with each item from 1 (strongly disagree) to 6 (strongly agree). Because of the significant ($p < .01$) correlation among these four items, a single variable was established called Ireland Multicultural Counseling Competencies Scale (IMCCS). In the present study, Cronbach's alpha was used to assess the internal consistency of the IMCCS, which was reliable at both times of measurement (pretest = .88; posttest = .90).

Procedure

At the beginning of the study abroad institute, participants completed a pretest questionnaire that contained a demographic information form, the CCCI-R, and the IMCCS. Participants then participated in the two-week study abroad institute. At the conclusion of the institute, participants completed a posttest questionnaire that contained the CCCI-R and the IMCCS.

Diversity and Counseling Institute in Ireland. Study abroad institutes offered in the counseling profession can further counselors' multicultural competence by immersing trainees in a non-American culture for a period of time. With that intent, the two-week DCII was created to increase participants' cultural awareness, knowledge and responsiveness. The goals of the DCII were to increase participants' (1) awareness of their own cultural background and values; (2) knowledge of the American, Irish, and British cultural perspectives; and (3) knowledge of culturally appropriate counseling strategies. Participants learned about the counseling profession in Ireland from leaders in the Irish mental health field; studied core multicultural issues with nationally known U.S. counseling faculty; were immersed in the Irish culture through tours, lectures, and informal experiences; and visited Irish counseling agencies and social programs.

Results

A *t*-test was performed to examine differences between participants' CCCI-R mean score across time from pretest to posttest (see Table 1 for mean differences and standard deviations). There were significant differences ($p < .0001$) in participants' overall scores on the CCCI-R after they attended the DCII in Ireland, indicating that participants perceived themselves to be more culturally competent by the end of the study abroad experience.

A *t*-test also was utilized to examine differences between participants' IMCCS mean score across time (see Table 1 for the mean difference and standard deviations). There were significant differences ($p < .0001$) in participants' overall scores on the IMCCS after attending the DCII in Ireland. Thus, participants thought they were more knowledgeable about the culture of Ireland, possessed more skills in working with clients from Ireland, had an increased awareness of differences between the Irish culture and their own, and had an increased awareness of similarities between the Irish culture and their own.

Table 1

Mean Difference between Participants' Pre- and Post-Institute Multicultural Competence Scores

Variable	Δ *M* Pretest Posttest	*SD*	*t*	*df*	Sig. (two-tailed)
CCCI-R	.34	.30	5.45	22	.000
IMCCS	1.63	1.08	7.27	22	.000

Note. CCCI-R = Cross-Cultural Counseling Inventory-Revised; IMCCS = Ireland Multicultural Counseling Competencies Scale.

Discussion

Regarding the under-researched topic of intentional study abroad counselor education experiences, this study indicated that such an experience can have a positive impact on counselors' multicultural competency. Previous research on non-counseling study abroad opportunities found that participants experienced personal development, intellectual growth and increased global-mindedness (Carlson et al., 1991). This study begins to address whether a counseling international experience has an effect on counselor multicultural competency.

International study abroad experiences can affect individuals' perspectives on other cultures, as well as on their own. In the case of this research, participants reported an increase in their cultural competence after the intentional study abroad counselor education experience. These results confirm previous social work research that found a positive relationship between studying abroad and multicultural competencies (Kim, 2012). Further research should explore what components of this institute in particular influenced participants' multicultural awareness, knowledge and skills.

The overall multicultural counseling competency improvement demonstrated in this study is encouraging. It is important to note that the institute included both experiences and conceptual material. The learning was perhaps enhanced by the experiential learning theory model used to design the institute (Kolb & Kolb, 2009). In this study abroad institute, experiences included visits to specific counseling and educational programs. Participants then reflected on those experiences through journaling and large group processing. Counselor educators might pursue such international initiatives to trigger counselor cultural self-awareness, increase knowledge of other cultures, and build culturally responsive counseling skills.

Study abroad for counselors might be seen as a "value-added" learning opportunity. While at-home multicultural counselor education has been studied (Cates, Schaefle, Smaby, Maddux, & LeBeauf, 2007; Zalaquett, Foley, Tillotson, Dinsmore, & Hof, 2008), such learning may be enhanced by the experience of being immersed in a foreign culture (Kim, 2012). Prolonged immersion in another culture allows counselors-in-training to gain a more nuanced understanding of the differences and similarities among cultures. Participants reported being more aware than before of differences and similarities between the Irish culture and their own culture. Although not all immersion opportunities happen internationally, the degree to which these participants were immersed was novel and led to a significant increase in culturally relevant knowledge, skills and awareness. The degree to which immersion experiences are effective should continue to be explored within the counseling profession.

Transferability of the learning from study abroad is of course crucial, as it would be insufficient to merely learn the particulars of another counseling culture. In that sense, the overall dislocation of being in a foreign culture may transfer to an increase in trainees' empathy for members of non-dominant cultures in their homelands. It would be difficult to simulate such experiences in the domestic environment. Thus, when designing training experiences, educators could consider the impact of experiential training experiences outside of the home country. While planning these experiences are logistically challenging, the payoff can be impactful (Shupe, 2013).

International study abroad institutes have implications for the counseling community at large. As the profession continues to construct a professional identity and establish its role in the mental health community, counselors must consider the counseling profession as a whole, not solely the parts of the profession within the cultural worldview. Incorporating international experiences into the training practice allows more counselors to communicate and connect as a whole, in order to best develop and advocate for the counseling profession. Furthermore, collaborating with counselors internationally provides counselors-in-training the opportunity to increase their cultural self-awareness, as well as allows counselor educators to examine current training practices and their effectiveness. This assessment may take place through direct observation of international training practices, or more covertly in reflecting on the components of the institute that appeared to impact students.

The results of this study need to be examined in light of several limitations. First, this pre-post design only examined the impact of this study abroad institute. Future research could compare study abroad experiences to other training methods. Future research also could disaggregate the factors that actually contributed to positive outcomes, by investigating the relative contribution of informal encounters, lectures on Irish counseling and social issues, general seminars on culturally alert counseling, and other experiences in the study abroad program. Second, participants volunteered to be part of this study and were predominantly Caucasian/European American and heterosexual women. Future research could seek to replicate these results, using a control group and a more diverse, randomly selected group of participants. Finally, the focus of this research was the impact of a DCII in Ireland. Future research could explore the impact of counseling study abroad programs in other countries. Long term follow-up measures also could be utilized to see if the positive changes in multicultural counseling competencies remain stable over time.

Conclusion

This study was designed to examine the impact of the diversity and counseling study abroad program in Ireland on participants' multicultural competencies. The results indicate that the study abroad experience in Ireland enhanced participants' multicultural counseling competencies. These results provide beginning data

regarding the benefits of this type of study abroad diversity training and encourage counselor educators to pursue and evaluate such experiences.

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

References

Black, H. T. & Duhon, D. L. (2006). Assessing the impact of business study abroad programs on cultural awareness and personal development. *Journal of Education for Business*, *81*, 140–144. doi:10.3200/JOEB.81.3.140-144

Carlson, J. S., Burn, B. B., Useem, J., & Yachimowicz, D. (1991). *Study abroad: The experience of American undergraduates in Western Europe and the United States.* New York, NY: Center for International Education Exchange. (ERIC Document Reproduction Service No. ED 340 322)

Castillo, L. G., Brossart, D. F., Reyes, C. J., Conoley, C. W., & Phoummarath, M. J. (2007). The influence of multicultural training on perceived multicultural counseling competencies and implicit racial prejudice. *Journal of Multicultural Counseling and Development*, *35*, 243–254. doi:10.1002/j.2161-1912.2007.tb00064.x

Cates, J. T., Schaefle, S. E., Smaby, M. H., Maddux, C. D., & LeBeauf, I. (2007). Comparing multicultural with general counseling knowledge and skill competency for students who completed counselor training. *Journal of Multicultural Counseling and Development*, *35*, 26–39. doi:10.1002/j.2161-1912.2007.tb00047.x

Council for Accreditation of Counseling and Related Educational Programs. (2009). *2009 CACREP Standards*. Retrieved from http://www.cacrep.org

D'Andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling & Development*, *70*, 143–150. doi:10.1002/j.1556-6676.1991.tb01576.x

Davidson, D. E. (2007). Study abroad and outcomes measurements: The case of Russian. *The Modern Language Journal*, *91*, 276–280.

Díaz-Lázaro, C. M., & Cohen, B. B. (2001). Cross-cultural contact in counseling training. *Journal of Multicultural Counseling and Development*, *29*, 41–56. doi:10.1002/j.2161-1912.2001.tb00502.x

Dickson, G. L., Argus-Calvo, B., & Tafoya, N. G. (2010). Multicultural counselor training experiences: Training effects and perceptions of training among a sample of predominately Hispanic students. *Counselor Education and Supervision*, *49*, 247–265. doi:10.1002/j.1556-6978.2010.tb00101.x

Drews, D. R., & Meyer, L. L. (1996). Effects of study abroad on conceptualizations of national groups. *College Student Journal*, *30*, 452–461.

Guth, L. J., & McDonnell, K.A. (2006, April). *Counselor education students' perspectives on multicultural and diversity training*. Poster session presented at the American Counseling Association Convention, Montréal, Quebec, Canada.

Hadis, B. F. (2005). Gauging the impact of study abroad: How to overcome the limitations of a single-cell design. *Assessment & Evaluation in Higher Education*, *30*, 3–19. doi:10.1080/0260293042003243869

Hohenshil, T. H., Amundson, N. E., & Niles, S. G. (2013). Introduction to global counseling. In T. H. Hohenshil, N. E. Amundson, & S. G. Niles (Eds.), *Counseling around the world: An international handbook* (pp. 3–8). Alexandria, VA: American Counseling Association.

Inglis, A., Rolls, C., & Kristy, S. (1998). The impact of participation in a study abroad programme on students' conceptual understanding of community healthy nursing in a developing country. *Journal of Advanced Nursing*, *28*, 911–917. doi:10.1046/j.1365-2648.1998.00732.x

Jurgens, J. C., & McAuliffe, G. (2004). Short-term study-abroad experience in Ireland: An exercise in cross-cultural counseling. *International Journal for the Advancement of Counselling, 26,* 147–161.

Kim, W.-J. (2012). Enhancing social work students' multicultural counseling competency: Can travel abroad substitute for

study abroad? *International Social Work*, Advance online publication. doi:10.1177/0020872812454313

Kolb, A. Y. & Kolb, D. A. (2009). Experiential learning theory: A dynamic, holistic approach to management learning, education, and development. In S. J. Armstrong and C. V. Fukami (Eds.), *The SAGE handbook of management learning, education, and development* (pp. 42–68). Los Angeles, CA: Sage.

LaFromboise, T. D., Coleman, H. L. K., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory-Revised. *Professional Psychology: Research and Practice*, *22*(5), 380–388. doi:10.1037/0735-7028.22.5.380

Lee, C. C. (2012, September). The promise of counsel(l)ing's globalization. *Counseling Today,* 14–15.

Lee, W. M. L., Blando, J. A., Mizelle, N. D., & Orozco, G. L. (2007). *Introduction to multicultural counseling for helping professionals* (2nd ed.). New York, NY: Routledge.

Mapp, S. C. (2012). Effect of short-term study abroad programs on students' cultural adaptability. *Journal of Social Work Education*, *48*, 727–737. doi:10.5175/JSWE.2012.201100103

McAuliffe, G. J., & Associates (2013). *Culturally alert counseling: A comprehensive introduction* (2nd ed.). Thousand Oaks, CA: Sage.

Shupe, E. I. (2013). The development of an undergraduate study abroad program: Nicaragua and the psychology of social inequality. *Teaching of Psychology*, *40*, 124–129. doi:10.1177/0098628312475032

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development*, *20*, 64–88. doi:10.1002/j.2161-1912.1992.tb00563.x

Sue, D. W., & Sue, D. (2012). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: John Wiley & Sons.

Zalaquett, C. P., Foley, P. F., Tillotson, K., Dinsmore, J. A., & Hof, D. (2008). Multicultural and social justice training for counselor education programs and colleges of education: Rewards and challenges. *Journal of Counseling & Development*, *86*, 323–329.

Becoming a Supervisor: Qualitative Findings on Self-Efficacy Beliefs of Doctoral Student Supervisors-in-Training

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Counselor education doctoral students are influenced by many factors as they train to become supervisors. One of these factors, self-efficacy beliefs, plays an important role in supervisor development. In this phenomenological, qualitative research, 16 counselor education doctoral students participated in focus groups and discussed their experiences and perceptions of self-efficacy as supervisors. Data analyses revealed four themes associated with self-efficacy beliefs: ambivalence in the middle tier of supervision, influential people, receiving performance feedback, and conducting evaluations. Recommendations for counselor education and supervision, as well as future research, are provided.

***Keywords*: supervision, doctoral students, counselor education, self-efficacy, phenomenological, focus groups**

Counselor education programs accredited by the Council for Accreditation and Related Educational Programs (CACREP) require doctoral students to learn supervision theories and practices (CACREP, 2009). Professional literature highlights information on supervision theories (e.g., Bernard & Goodyear, 2009), supervising counselors-in-training (e.g., Woodside, Oberman, Cole, & Carruth, 2007), and effective supervision interventions and styles (e.g., Fernando & Hulse-Killacky, 2005) that assist with supervisor training and development. Until recently, however, few researchers have studied the experiences of counselor education doctoral students as they prepare to become supervisors (Hughes & Kleist, 2005; Limberg et al., 2013; Protivnak & Foss, 2011) or "the transition from supervisee to supervisor" (Rapisarda, Desmond, & Nelson, 2011, p. 121). Specifically, an exploration of factors associated with the self-efficacy beliefs of counselor education doctoral student supervisors is warranted to expand this topic and enhance counselor education training of supervisor development.

Bernard and Goodyear (2009) described supervisor development as a process shaped by changes in self-perceptions and roles, much like counselors-in-training experience in their developmental stages. Researchers have examined factors that may influence supervisors' development (e.g., experiential learning and the influence of feedback). For example, Nelson, Oliver, and Capps (2006) explored the training experiences of 21 doctoral students in two cohorts of the same counseling program and reported that experiential learning, the use of role-plays, and receiving feedback from both professors and peers were equally as helpful in learning supervision skills as the actual practice of supervising counselors-in-training. Conversely, a supervisor's development may be negatively influenced by unclear expectations of the supervision process or dual relationships with supervisees, which may lead to role ambiguity (Bernard & Goodyear, 2009). For example, Nilsson and Duan (2007) examined the relationship between role ambiguity and self-efficacy with 69 psychology doctoral student supervisors and found that when participants received clear supervision expectations, they reported higher rates of self-efficacy.

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Self-efficacy is one of the self-regulation functions in Bandura's social cognitive theory (Bandura, 1986) and is a factor in Larson's (1998) social cognitive model of counselor training (SCMCT). Self-efficacy, the differentiated beliefs held by individuals about their capabilities to perform (Bandura, 2006), plays an important role in counselor and supervisor development (Barnes, 2004; Cashwell & Dooley, 2001) and is influenced by many factors (Schunk, 2004). Along with the counselor's training environment, self-efficacy beliefs may influence a counselor's learning process and resulting counseling performance (Larson, 1998). Daniels and Larson (2001) conducted a quantitative study with 45 counseling graduate students and found that performance feedback influenced counselors' self-efficacy beliefs; self-efficacy increased with positive feedback and decreased with negative feedback. Steward (1998), however, identified missing components in the SCMCT, such as the role and level of self-efficacy of the supervisor, the possible influence of a faculty supervisor, and doctoral students giving and receiving feedback to supervisees and members of their cohort. For example, results of both quantitative studies (e.g., Hollingsworth & Fassinger, 2002) and qualitative studies (e.g., Majcher & Daniluk, 2009; Nelson et al., 2006) indicate the importance of mentoring experiences and relationships with faculty supervisors to the development of doctoral students and self-efficacy in their supervisory skills.

During their supervision training, doctoral students are in a unique position of supervising counselors-in-training while also being supervised by faculty. For the purpose of this study, the term *middle tier* will be used to describe this position. This term is not often used in the counseling literature, but may be compared to the position of middle managers in the business field—people who are subordinate to upper managers while having the responsibility of managing subordinates (Agnes, 2003). Similar to middle managers, doctoral student supervisors tend to have increased responsibility for supervising future counselors, albeit with limited authority in supervisory decisions, and may have experiences similar to middle managers in other disciplines. For example, performance-related feedback as perceived by middle managers appears to influence their role satisfaction and self-efficacy (Reynolds, 2006). In Reynolds's (2006) study, 353 participants who represented four levels of management in a company in the United States reported that receiving positive feedback from supervisors had an affirming or encouraging effect on their self-efficacy, and that their self-efficacy was reduced after they received negative supervisory feedback. Translated to the field of counselor supervision, these findings suggest that doctoral students who participate in tiered supervision and receive positive performance feedback may have higher self-efficacy.

Findings to date illuminate factors that influence self-efficacy beliefs, such as performance feedback, clear supervisor expectations and mentoring relations. There is a need, however, to examine what other factors enhance or detract from the self-efficacy beliefs of counselor education doctoral student supervisors to ensure effective supervisor development and training. The purpose of this study, therefore, was to build on previous research and further examine the experiences of doctoral students as they train to become supervisors in a tiered supervision model. The overarching research questions that guided this study included: (a) What are the experiences of counselor education doctoral students who work within a tiered supervision training model as they train to become supervisors? and (b) What experiences influenced their sense of self-efficacy as supervisors?

Method

Design

A phenomenological research approach was selected to explore how counselor education doctoral students experience and make meaning of their reality (Merriam, 2009), and to provide richer descriptions of the experiences of doctoral student supervisors-in-training, which a quantitative study may not afford. A qualitative design using a constructivist-interpretivist method provided the opportunity to interact with doctoral

students via focus groups and follow-up questionnaires to explore their self-constructed realities as counselor supervisors-in-training, and the meaning they placed on their experiences as they supervised master's-level students while being supervised by faculty supervisors. Focus groups were chosen as part of the design, as they are often used in qualitative research (Kress & Shoffner, 2007; Limberg et al., 2013), and multiple-case sampling increases confidence and robustness in findings (Miles & Huberman, 1994).

Participants

Sixteen doctoral students from three CACREP-accredited counselor education programs in the southeastern United States volunteered to participate in this study. These programs were selected due to similarity in supervision training among participants (e.g., all were CACREP-accredited, required students to take at least one supervision course, utilized a full-time cohort design), and were in close proximity to the principal investigator. None of the participants attended the first author's university or had any relationships with the authors. Criterion sampling was used to select participants that met the criteria of providing supervision to master's-level counselors-in-training and receiving supervision by faculty supervisors at the time of their participation. The ages of the participants ranged from 27–61 years with a mean age of 36 years (SD = 1.56). Fourteen of the participants were women and two were men; two participants described their race as African-American (12.5%), one participant as Asian-American (6.25%), 12 participants as Caucasian (75%), and one participant as "more than one ethnicity" (6.25%). Seven of the 16 participants reported having 4 months to 12 years of work experience as counselor supervisors (M = 2.5 years, SD = 3.9 years) before beginning their doctoral studies. At the time of this study, all participants had completed a supervision course as part of their doctoral program, were supervising two to six master's students in the same program (M = 4, SD = 1.2), and received weekly supervision with faculty supervisors in their respective programs.

Researcher Positionality

In presenting results of phenomenological research, it is critical to discuss the authors' characteristics as researchers, as such characteristics influence data collection and analysis. The authors have experience as counselors, counselor educators, and clinical supervisors. Both authors share an interest in understanding how doctoral students move from the role of student to the role of supervisor, especially when providing supervision to master's students who may experience critical incidents (with their clients or in their own development). The first author became engaged when she saw the different emotional reactions of her cohort when faced with the gatekeeping process, whether the reactions were based on personality, prior supervision experience, or stressors from inside and outside of the counselor education program. She wondered how doctoral students in other programs experienced the aforementioned situations, what kind of structure other programs used to work with critical incidents that involve remediation plans, and if there were ways to improve supervision training. It was critical to account for personal and professional biases throughout the research process to minimize biases in the collection or interpretation of data. Bracketing, therefore, was an important step during analysis (Moustakas, 1994) to reduce researcher biases. The first author accomplished this by meeting with her dissertation committee and with the second author throughout the study, as well as using peer reviewers to assess researcher bias in the design of the study, research questions, and theme development.

Quality and Trustworthiness

To strengthen the rigor of this study, the authors addressed credibility, dependability, transferability and confirmability (Merriam, 2009). One way to reinforce credibility is to have prolonged and persistent contact with participants (Hunt, 2011). The first author contacted participants before each focus group to convey the nature, scope and reasons for the study. She facilitated 90-minute focus group discussions and allowed participants to add or change the summary provided at the end of each focus group. Further, information was gathered from each participant through a follow-up questionnaire and afforded the opportunity for participants to contact her through e-mail with additional questions or thoughts.

By keeping an ongoing reflexive journal and analytical memos, the first author addressed dependability by keeping a detailed account throughout the research study, indicating how data were collected and analyzed and how decisions were made (Merriam, 2009). The first author included information on how data were reduced and themes and displays were constructed, and the second author conducted an audit trail on items such as transcripts, analytic memos, reflection notes, and process notes connecting findings to existing literature.

Through the use of rich, thick description of the information provided by participants, the authors made efforts to increase transferability. In addition, they offered a clear account of each stage of the process as well as the demographics of the participants (Hunt, 2011) to promote transferability.

Finally, the first author strengthened confirmability by examining her role as a research instrument. Selected colleagues chosen as peer reviewers (Kline, 2008), along with the first author's dissertation committee members, had access to the audit trail and discussed and questioned the authors' decisions, further increasing the integrity of the design. Two doctoral students who had provided supervision and had completed courses in qualitative research, but who had no connection to the research study, volunteered to serve as peer reviewers. They reviewed the focus group protocol for researcher bias, read the focus group transcripts (with pseudonyms inserted) and questionnaires, and the emergent themes, to confirm or contest the interpretation of the data. Further, they reviewed the quotes chosen to support themes for richness of description and provided feedback regarding the textural-structural descriptions as they were being developed. Their recommendations, such as not having emotional reactions to participants' comments, guided the authors in data collection and analysis.

Data Collection

Upon receiving approval from the university's Institutional Review Board, the first author contacted the directors of three CACREP-accredited counselor education programs and discussed the purpose of the study, participants' rights, and logistical needs. Program directors disseminated an e-mail about this study to their doctoral students, instructing volunteer participants to contact the first author about participating in the focus groups.

Within a two-week period, she conducted three focus groups—one at each counselor education program site. Each focus group included five to six participants and lasted approximately 90 minutes. She employed a semi-structured interview protocol consisting of 17 questions (see Appendix). The questions were based on an extensive literature review on counselor and supervisor self-efficacy studies (e.g., Bandura, 2006; Cashwell & Dooley, 2001; Corrigan & Schmidt, 1983; Fernando & Hulse-Killacky, 2005; Gore, 2006; Israelashvili & Socher, 2007; Steward, 1998; Tang et al., 2004). The initial questions were open and general at first, so as to not lead or bias the participants in their responses. As the focus groups continued, the first author explored more specific information about participants' experiences as doctoral student supervisors, focusing questions around their responses (Kline, 2008). Conducting a semi-structured interview with participants ensured that she asked specific questions and addressed predetermined topics related to the focus of the study, while also allowing for freedom to follow up on relevant information provided by participants during the focus groups.

Approximately six to eight weeks after each focus group, participants received a follow-up questionnaire consisting of four questions: (a) What factors (inside and outside of the program) influence your perceptions of your abilities as a supervisor? (b) How do you feel about working in the middle tier of supervision (i.e., working between a faculty supervisor and the counselors-in-training that you supervise)? (c) What, if anything, could help you feel more competent as a supervisor? (d) How can your supervision training be improved? The purpose of the follow-up questions was to explore participants' responses after they gained more experiences as supervisors and to provide a means for them to respond to questions about their supervisory experiences privately, without concern of peer judgment.

Data Analysis

Data analysis began during the transcription process, with analysis occurring simultaneously with the collection of the data. The first author transcribed, verbatim, the recording of each focus group and changed participant names to protect their anonymity. Data analysis was then conducted in three stages: first, data were analyzed to identify significant issues within each focus group; second, data were cross-analyzed to identify common themes across all three focus groups; and third, follow-up questionnaires were analyzed to corroborate established themes and to identify additional, or different themes.

During data analysis, a Miles and Huberman (1994) approach was employed by using initial codes from focus-group question themes. Inductive analysis occurred with immersion in the data by reading and rereading focus group transcripts. It was during this immersion process that the first author began to identify core ideas and differentiate meanings and emergent themes for each focus group. She accomplished data reduction by identifying themes in participants' answers to the interview protocol and focus group discussions until saturation was reached, and displayed narrative data in a figure to organize and compare developed themes. Finally, she used deductive verification of findings with previous research literature. During within-group analysis, she identified themes if more than half (i.e., more than three participants) of a focus group reported similar experiences, feelings or beliefs. Likewise, in across-group analyses, she confirmed themes if statements made by more than half (more than eight) of the participants matched. There were three cases in which the peer reviewers and the first author had differences of opinion on theme development. In those cases, she made changes guided by the suggestions of the peer reviewers. In addition, she sent the final list of themes related to the research questions to the second author and other members of the dissertation committee for purposes of confirmability.

Results

Results of this phenomenological study revealed several themes associated with doctoral students' perceptions of self-efficacy as supervisors (see Figure 1). Cross-group analyses are provided with participant quotes that are most relevant to each theme being discussed. Considerable overlap of four themes emerged across groups: *ambivalence in the middle tier of supervision*, *influential people*, *receiving feedback*, and *conducting evaluations.*

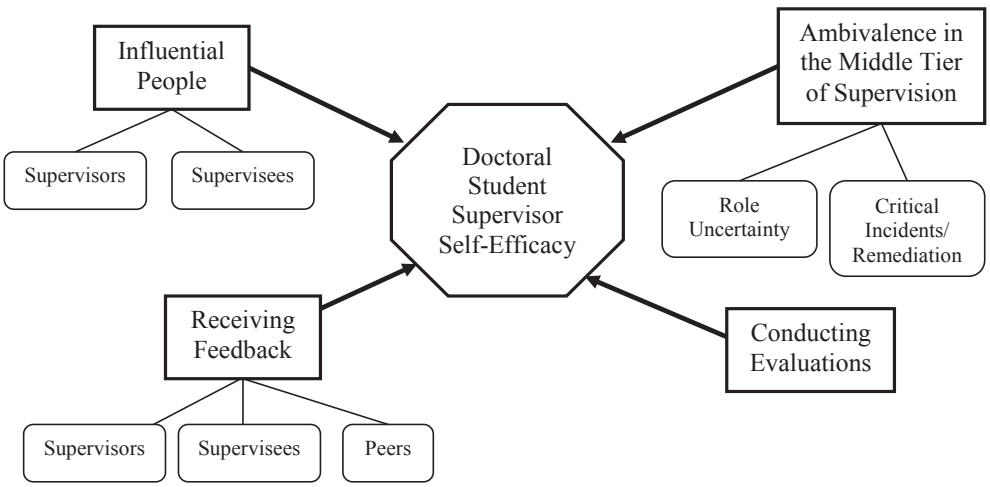

Figure 1. Emergent themes of doctoral student supervisors' self-efficacy beliefs. Factors identified by doctoral student as affecting their self-efficacy as supervisors are represented with directional, bold-case arrows from each theme toward supervisor self-efficacy; below themes are sub-themes in each group connected with non-directional lines.

Ambivalence in the Middle Tier of Supervision

All participants noted how working in the middle tier of supervision brought up issues about their roles and perceptions about their capabilities as supervisors. All 16 participants reported feeling ambivalent about working in the middle tier, especially in relation to their role as supervisors and about dealing with critical incidents with supervisees involving the need for remediation. What follows is a presentation of representative quotations from one or two participants in the emergent sub-themes of role uncertainty and critical incidents/ remediation.

Role Uncertainty. Participants raised the issue of role uncertainty in all three focus groups. For example, one participant described how it felt to be in the middle tier by stating the following:

> I think that's exactly how it feels [to be in the middle] sometimes....not really knowing how much you know, what does my voice really mean? How much of a say do we have if we have big concerns? And is what I recognize really a big concern? So I think kind of knowing that we have this piece of responsibility but then not really knowing how much authority or how much say-so we have in things, or even do I have the knowledge and experience to have much say-so?

Further, another participant expressed uncertainty regarding her middle-tier supervisory role as follows:

> [I feel a] lack of power, not having real and true authority over what is happening or if something does happen, being able to make those concrete decisions...Where do I really fit in here? What am I really able to do with this supervisee?...kind of a little middle child, you know really not knowing where your identity really and truly is. You're trying to figure out who you really are.

Participants also indicated difficulty discerning their role when supervising counselors-in-training who were from different specialty areas such as college counseling, mental health counseling, and school counseling. All participants stated that they had not had any specific counseling or supervision training in different tracks, which was bothersome for nine participants who supervised students in specialties other than their own. For example, one participant stated the following:

> I'm a mental health counselor and worked in the community and I have two school counselor interns, and so it was one of my very first questions was like, what do I do with these people? 'Cause I'm not aware of the differences and what I should be guiding them on anything.

Another participant noted how having more information on the different counseling tracks (e.g., mental health, school, college) would be helpful:

> We're going to be counselor educators. We may find ourselves having to supervise people in various tracks and I could see how it would be helpful for us to all have a little bit more information on a variety of tracks so that we could know what to offer, or how things are a little bit different.

Working in the middle tier of supervision appeared to be vexing for focus group participants. They expressed feelings of uncertainty, especially in dealing with critical incidents or remediation of supervisees. In addition to defining their roles as supervisors in the middle tier, another sub-theme emerged in which participants identified how they wanted to have a better understanding of how remediation plans work and have the opportunity to collaborate with faculty supervisors in addressing critical incidents with supervisees.

Critical Incidents/Remediation. Part of the focus group discussion centered on what critical incidents participants had with their supervisees and how comfortable they were, or would be, in implementing remediation plans with their supervisees. All participants expressed concerns about their roles as supervisors when remediation plans were required for master's students in their respective programs and were uncertain of how the remediation process worked in their programs. Thirteen of the 16 participants expressed a desire to be a part of the remediation process of their supervisees in collaboration with faculty supervisors. They discussed seeing this as an important way to learn from the process, assuming that as future supervisors and counselor educators they will need to be the ones to implement such remediation plans. For example, one participant explained the following:

> If we are in the position to provide supervision and we're doing this to enhance our professional development so in the hopes that one day we're going to be in the position of counselor educators, let's say faculty supervisors, my concern with that is how are we going to know what to do unless we are involved [in the remediation process] now? And so I feel like that should be something that we're provided that opportunity to do it.

Another participant indicated that she felt not being part of the remediation process took away the doctoral student supervisors' credibility:

> I don't have my license yet, and I'm not sure how that plays into when there is an issue with a supervisee, but I know when there is an issue, there is something we have to do if you have a supervisee who is not performing as well, then that's kind of taken out of your hands and given to a faculty. So they're like, 'Yeah you are capable of providing supervision,' but when there's an issue it seems like you're no longer capable.

Another participant noted wanting "to see us do more of the cases where we need to do remediation" in order to be better prepared in identifying critical incidents, thus feeling more capable in the role as supervisor. Discussion on the middle tier proved to be a topic participants both related to and had concerns about. In addition to talking about critical incidents and the remediation process, another emergent theme included people within the participants' training programs who were influential to their self-efficacy beliefs as supervisors.

Influential People

When asked about influences they had from inside and outside of their training programs, all participants identified people and things (e.g., previous work experience, support of significant others, conferences, spiritual meditation, supervision literature) as factors that affected their perceived abilities as supervisors. The specific factors most often identified by more than half of the participants, however, were the influence of supervisors and supervisees in their training programs.

Supervisors. All participants indicated that interactions with current and previous supervisors influenced their self-efficacy as supervisors. Ten participants reported supervisors modeling their supervision style and techniques as influential. For example, in regard to watching supervision tapes of the faculty supervisors, one participant stated that it has "been helpful for me to see the stance that they [faculty supervisors] take and the model that they use" when developing her own supervision skills. Seven participants also indicated having the space to grow as supervisors as a positive influence on their self-efficacy. One participant explained as follows:

> I know people at other universities and it's like boot camp, they [faculty supervisors] break them down and build them up in their own image like they're gods. And I don't feel that here. I feel like I'm able to be who I am and they're supportive and helping me develop who I am.

In addition to the information provided during the focus groups, 11 focus group participants reiterated on their follow-up questionnaires that faculty supervisors had a positive influence on the development of their self-efficacy. For example, for one participant, "a lot of support from faculty supervisors in terms of their accessibility and willingness to answer questions" was a factor in strengthening her perception of her abilities as a counselor supervisor. Participants also noted the importance of working with their supervisees as beneficial and influential to their perceptions of self-efficacy as supervisors.

Supervisees. All participants in the focus groups discussed supervising counselors-in-training as having both direct and vicarious influences on their self-efficacy. One participant stated that having the direct experience of supervising counselors-in-training at different levels of training (e.g., pre-practicum, practicum, internship) was something that "really helped me to develop my ability as a supervisor." In addition, one participant described a supervision session that influenced him as a supervisor: "When there are those 'aha' moments that either you both experience or they experience. That usually feels pretty good. So that's when I feel the most competent, I think as a supervisor." Further, another participant described a time when she felt competent as a supervisor: "When [the supervisees] reflect that they have taken what we've talked about and actually tried to implement it or it's influenced their work, that's when I have felt closest to competence." In addition to working relations with supervisors and supervisees, receiving feedback was noted as an emergent theme and influential to the growth of the doctoral student supervisors.

Receiving Feedback

Of all of the emergent themes, performance feedback appeared to have the most overlap across focus groups. The authors asked participants how they felt about receiving feedback on their supervisory skills. Sub-themes emerged when participants identified receiving feedback from their supervisors, supervisees and peers as shaping to their self-efficacy beliefs as supervisors.

Supervisors. Fifteen participants discussed the process of receiving performance feedback from faculty as an important factor in their self-efficacy. Overall, participants reported receiving constructive feedback as critical to their learning, albeit with mixed reactions. One participant noted that "at the time it feels kind of crappy, but you learn something from it and you're a better supervisor." Some participants indicated how they valued their supervisors' feedback and they preferred specific feedback over vague feedback. For example, as one participant explained, "I kind of just hang on her every word....it is important. I anticipate and look forward to that and am even somewhat disappointed if she kind of dances around an issue." Constructive feedback was most preferred across all participants. In addition to the impact of receiving feedback from supervisors, participants commented on being influenced by the feedback they received from their supervisees.

Supervisees. Thirteen focus group participants reported that receiving performance evaluations from supervisees affected their sense of self-efficacy as supervisors and appeared to be beneficial to all participants. Participants indicated that they were more influenced by specific rather than general feedback, and they preferred receiving written feedback from their supervisees rather than having supervisees subjectively rate their performance with a number. One participant commented that "it's more helpful for me when [supervisees] include written feedback versus just doing the number [rating]...something that's more constructive." Further, a participant described how receiving constructive feedback from supervisees influenced his self-efficacy as a supervisor:

> I'd say it affects me a little bit. I'm thinking of some evaluations that I have received and some of them make me feel like I have that self-efficacy that I can do this. And then the other side, there have been some constructive comments as well, and some of those I think do influence me and help me develop.

Similar to feedback received from supervisors and supervisees, participants reiterated their preference in receiving clear and constructive feedback. Focus group participants also described receiving feedback from their peers as being influential in the development of their supervision skills.

Peers. Eleven participants shared that feedback received from peers was influential in shaping the perception of their skills and how they conducted supervision sessions. Participants described viewing videotapes of supervision sessions in group supervision and receiving feedback from peers on their taped supervision sessions as positive influences. For example, one participant stated that "there was one point in one of our classes when I'd shown a tape and I got some very… specific positive feedback [from peers] that made me feel really good, like made me feel more competent." Another participant noted how much peers had helped her increase her comfort level in evaluating her supervisees: "I had a huge problem with evaluation when we started out….in supervision, my group really worked on that issue with me and I feel like I'm in a much better place."

Performance feedback from faculty supervisors, supervisees, and peers was a common theme in all three focus groups and instrumental in the development of supervisory style and self-efficacy as supervisors. Constructive and specific feedback appeared to more positively influence participants' self-efficacy than vague or unclear subjective rating scales. In addition to receiving performance feedback, another theme emerged when participants identified issues with providing supervisees' performance evaluations.

Conducting Evaluations

Participants viewed evaluating supervisees with mixed emotions and believed that this process affected their self-efficacy beliefs as supervisors. Thirteen participants reported having difficulty providing supervisees with evaluative feedback. For example, one participant stated the following:

> I had a huge problem with evaluation when we started out. It's something I don't like. I feel like I'm judging someone....And after, I guess, my fifth semester....I don't feel like I'm judging them so much as it is a necessity of what we have to do, and as a gatekeeper we have to do this. And I see it more as a way of helping them grow now.

Conversely, one participant, who had experience as a supervisor before starting the doctoral counselor education program stated, "I didn't really have too much discomfort with evaluating supervisees because of the fact that I was a previous supervisor before I got into this program." Other participants, who either had previous experience with supervisory positions or who had been in the program for a longer period of time, confirmed this sentiment—that with more experience the anxiety-provoking feelings subsided.

All focus group participants, however, reported a lack of adequate instruction on how to conduct evaluations of supervisee performance. For example, participants indicated a lack of training on evaluating supervisees' tapes of counseling sessions and in providing formal summative evaluations. One participant addressed how receiving more specific training in evaluating supervisees would have helped her feel more competent as a supervisor:

> I felt like I had different experiences with different supervisors of how supervision was given, but I still felt like I didn't know how to give the feedback or what all my options were, it would have just helped my confidence... to get that sort of encouragement that I'm on the right track or, so maybe more modeling specifically of how to do an evaluation and how to do a tape review.

All focus group participants raised the issue of using Likert-type questions as part of the evaluation process, specifically the subjectivity of interpretation of the scales in relation to supervisee performance and how

supervisors used them differently. For example, a participant stated, "I wish there had been a little bit more concrete training in how to do an evaluation." A second participant expanded this notion:

> I would say about that scale it's not only subjective but then our students, I think, talk to each other and then we've all evaluated them sometimes using the same form and given them a different number 'cause we interpret it differently.... It seems like another thing that sets us up for this weird 'in the middle' relationship because we're not faculty.

Discussions about providing performance evaluations seemed to be one of the most vibrant parts of focus group discussions. Thus, it appears that having the support of influential people (e.g., supervisors and supervisees) and feedback from supervisors, supervisees and peers was helpful. Having more instruction on conducting evaluations and clarifying their role identity and expectations, however, would increase their sense of self as supervisors in the middle tier of supervision.

Discussion

The purpose of this study was to explore what counselor education doctoral students experienced working in the middle tier of supervision and how their experiences related to their sense of self-efficacy as beginning supervisors. Data analysis revealed alignment with previous research that self-efficacy of an individual or group is influenced by extrinsic and intrinsic factors, direct and vicarious experiences, incentives, performance achievements, and verbal persuasion (Bandura, 1986), and that a person's self-efficacy may increase from four experiential sources: mastery, modeling, social persuasion, and affective arousal (Larson, 1998). For example, participants identified factors that influence their self-efficacy as supervisors such as the direct experience of supervising counselors-in-training (mastery) as "shaping," and how they learned vicariously from others in supervision classes. Participants also noted the positive influence of observing faculty supervision sessions (modeling) and receiving constructive feedback by supervisors, supervisees, and peers (verbal persuasion). In addition, participants described competent moments with their supervisees as empowering performance achievements, especially when they observed growth of their supervisees resulting from exchanges in their supervision sessions. Further, participants indicated social persuasion via support from their peers and future careers as counselor supervisors and counselor educators were incentives that influenced their learning experiences. Finally, participants discussed how feelings of anxiety and self-doubt (affective arousal) when giving performance evaluations to supervisees influenced their self-efficacy as supervisors.

Results from this study also support previous research on receiving constructive feedback, structural support, role ambiguity, and clear supervision goals from supervisors as influential factors on self-efficacy beliefs (Bernard & Goodyear, 2009; Nilsson & Duan, 2007; Reynolds, 2006). In addition, participants' difficulty in conducting evaluations due to feeling judgmental and having a lack of clear instructions on evaluation methods are congruent with supervision literature (e.g., Corey, Haynes, Moulton, & Muratori, 2010; Falender & Shafranske, 2004). Finally, participants' responses bolster previous research findings that receiving support from mentoring relationships and having trusting relationships with peers positively influence self-efficacy (Hollingsworth & Fassinger, 2002; Wong-Wylie, 2007).

Implications for Practice

The comments from participants across the three focus groups underscore the importance of receiving constructive and specific feedback from their faculty supervisors. Providing specific feedback requires that faculty supervisors employ methods of direct observation of the doctoral student's work with supervisees (e.g., live observation, recorded sessions) rather than relying solely on self-report. Participants also wanted more

information on how to effectively and consistently evaluate supervisee performance, especially those involving Likert-type questions, and how to effectively supervise master's students who are studying in different areas of concentration (e.g., mental health, school counseling, and college counseling). Counselor educators could include modules addressing these topics before or during the time that doctoral supervisors work with master's students, providing both information and opportunities to practice or role-play specific scenarios.

In response to questions about dealing with critical incidents in supervision, participants across groups discussed the importance of being prepared in handling remediation issues and wanting specific examples of remediation cases as well as clarity regarding their role in remediation processes. Previous research findings indicate teaching about critical incidents prior to engaging in job requirements as effective (Collins & Pieterse, 2007; Halpern, Gurevich, Schwartz, & Brazeau, 2009). As such, faculty supervisors may consider providing opportunities to role-play and share tapes of supervision sessions with master's students in which faculty (or other doctoral students) effectively address critical incidents. In addition, faculty could share strategies with doctoral student supervisors on the design and implementation of remediation plans, responsibilities of faculty and school administrators, the extent to which doctoral student supervisors may be involved in the remediation process (e.g., no involvement, co-supervise with faculty, or full responsibility), and the ethical and legal factors that may impact the supervisors' involvement. Participants viewed being included in the development and implementation of remediation plans for master's supervisees as important for their development even though some participants experienced initial discomfort in evaluating supervisees. This further indicates the importance of fostering supportive working relationships that promote students' growth and satisfaction in supervision training.

Limitations

Findings from this study are beneficial to counselor doctoral students, counselor supervisors, and supervisors in various fields. Limitations, however, exist in this study. The first is researcher perspective. The authors' collective experiences influenced the inclusion of questions related to critical incidents and working in the middle tier of supervision. However, the first author made efforts to discern researcher bias by first examining her role as a research instrument before and throughout conducting this study, by triangulating sources, and by processing the interview protocol and analysis with peer reviewers and dissertation committee members. A second limitation is participant bias. Participants' responses were based on their perceptions of events and recall. Situations participants experienced could have been colored or exaggerated and participants may have chosen safe responses in order to save face in front of their peers or in fear that faculty would be privy to their responses—an occurrence that may happen when using focus groups. The first author addressed this limitation by using follow-up questionnaires to provide participants an opportunity to express their views without their peers' knowledge, and she reinforced confidentiality at the beginning of each focus group.

Recommendations for Future Research

Findings from this study suggest possible directions for future research. The first recommendation is to expand to a more diverse sample. The participants in this study were predominantly White (75%) and female (87.5%) from one region in the United States. As with all qualitative research, the findings from this study are not meant to be generalized to a wider group, and increasing the number of focus groups may offer a greater understanding as to the applicability of the current findings to doctoral student supervisors not represented in the current study. A second recommendation is to conduct a longitudinal study by following one or more cohorts of doctoral student supervisors throughout their supervision training to identify stages of growth and transition as supervisors, focusing on those factors that influence participants' self-efficacy and supervisor development.

Conclusion

The purpose of this phenomenological study was to expand previous research on counselor supervision and to provide a view of doctoral student supervisors' experiences as they train in a tiered supervision model. Findings revealed factors that may be associated with self-efficacy beliefs of doctoral students as they prepare to become counseling supervisors. Recommendations may assist faculty supervisors when considering training protocols and doctoral students as they develop their identities as supervisors.

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References

Agnes, M. (Ed.). (2003). *Webster's new world dictionary* (4th ed.). New York, NY: Wiley.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs, NJ: Prentice Hall.

Bandura, A. (2006). Guide for creating self-efficacy scales. In F. Pajares & T. C. Urdan (Eds.), *Self-efficacy beliefs of adolescents* (pp. 307–337). Greenwich, CT: Information Age.

Barnes, K. L. (2004). Applying self-efficacy theory to counselor training and supervision: A comparison of two approaches. *Counselor Education and Supervision*, *44*, 56–69. doi:10.1002/j.1556-6978.2004.tb01860.x

Bernard, J. M., & Goodyear, R. K. (2009). *Fundamentals of clinical supervision* (4th ed.). Upper Saddle River, NJ: Merrill/Pearson.

Cashwell, T. H., & Dooley, K. (2001). The impact of supervision on counselor self-efficacy. *The Clinical Supervisor*, *20*(1), 39–47. doi:10.1300/J001v20n01_03

Collins, N. M., & Pieterse, A. L. (2007). Critical incident analysis based training: An approach for developing active racial/cultural awareness. *Journal of Counseling & Development*, *85*, 14–23. doi:10.1002/j.1556-6678.2007.tb00439.x

Corey, G., Haynes, R., Moulton, P., & Muratori, M. (2010). *Clinical supervision in the helping professions: A practical guide* (2nd ed.). Alexandria, VA: American Counseling Association.

Corrigan, J. D., & Schmidt, L. D. (1983). Development and validation of revisions in the counselor rating form. *Journal of Counseling Psychology*, *30*, 64–75. doi:10.1037/0022-0167.30.1.64

Council for Accreditation of Counseling and Related Educational Programs. (2009). *2009 CACREP accreditation manual.* Alexandria, VA: Author.

Daniels, J. A., & Larson, L. M. (2001). The impact of performance feedback on counseling self-efficacy and counseling anxiety. *Counselor Education and Supervision*, *41*, 120–130. doi:10.1002/j.1556-6978.2001.tb01276.x

Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach.* Washington, DC: American Psychological Association.

Fernando, D. M., & Hulse-Killacky, D. (2005). The relationship of supervisory styles to satisfaction with supervision and the perceived self-efficacy of master's-level counseling students. *Counselor Education and Supervision*, *44*, 293–304. doi:10.1002/j.1556-6978.2005.tb01757.x

Gore, P. A., Jr. (2006). Academic self-efficacy as a predictor of college outcomes: Two incremental validity studies. *Journal of Career Assessment*, *14*(1), 92–115. doi:10.1177/ 1069072705281367

Halpern, J., Gurevich, M., Schwartz, B., & Brazeau, P. (2009). What makes an incident critical for ambulance workers? Emotional outcomes and implications for intervention. *Work & Stress*, *23*(2), 173–189. doi:10.1080/02678370903057317

Hollingsworth, M. A., & Fassinger, R. E. (2002). The role of faculty mentors in the research training of counseling psychology doctoral students. *Journal of Counseling Psychology, 49*, 324–330. doi:10.1037/0022-0167.49.3.324

Hughes, F. R., & Kleist, D. M. (2005). First-semester experiences of counselor education doctoral students. *Counselor Education and Supervision*, *45*, 97–108. doi:10.1002/ j.1556-6978.2005.tb00133.x

Hunt, B. (2011). Publishing qualitative research in counseling journals. *Journal of Counseling & Development, 89*, 296–300. doi:10.1002/j.1556-6678.2011.tb00092.x

Israelashvili, M., & Socher, P. (2007). An examination of a counselor self-efficacy scale (COSE) using an Israeli sample. *International Journal for the Advancement of Counselling*, *29*, 1–9. doi:10.1007/s10447-006-9019-0

Kline, W. B. (2008). Developing and submitting credible qualitative manuscripts. *Counselor Education and Supervision*, *47*, 210–217. doi:10.1002/j.1556 6978.2008.tb00052.x

Kress, V. E., & Shoffner, M. F. (2007). Focus groups: A practical and applied research approach for counselors. *Journal of Counseling & Development*, *85*(2), 189–195. doi:10.1002/j.1556-6678.2007.tb00462.x

Larson, L. M. (1998). The social cognitive model of counselor training. *The Counseling Psychologist*, *26*(2), 219–273. doi:10.1177/0011000098262002

Limberg, D., Bell, H., Super, J. T., Jacobson, L., Fox, J., DePue, M. K, . . . Lambie, G. W. (2013). Professional identity development of counselor education doctoral students: A qualitative investigation. *The Professional Counselor*, *3*(1), 40–53.

Majcher, J., & Daniluk, J. C. (2009). The process of becoming a supervisor for students in a doctoral supervision training course. *Training and Education in Professional Psychology*, *3*, 63–71. doi:10.1037/a0014470

Merriam, S. B. (Ed.). (2002). *Qualitative research in practice: Examples for discussion and analysis.* San Francisco, CA: Jossey-Bass.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Moustakas, C. E. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Nilsson, J. E., & Duan, C. (2007). Experiences of prejudice, role difficulties, and counseling self-efficacy among U.S. racial and ethnic minority supervisees working with white supervisors. *Journal of Multicultural Counseling and Development, 35*(4), 219–229. doi:10.1002/j.2161-1912.2007.tb00062.x

Nelson, K. W., Oliver, M., & Capps, F. (2006). Becoming a supervisor: Doctoral student perceptions of the training experience. *Counselor Education and Supervision*, *46*, 17–31. doi:10.1002/j.1556-6978.2006.tb00009.x

Protivnak, J. J., & Foss, L. L. (2009). An exploration of themes that influence the counselor education doctoral student experience. *Counselor Education and Supervision*, *48*(4), 239–256. doi:10.1002/j.1556-6978.2009.tb00078.x

Rapisarda, C. A., Desmond, K. J., & Nelson, J. R. (2011). Student reflections on the journey to being a supervisor. *The Clinical Supervisor*, *30*, 109–113. doi:10.1080/07325223.2011.564958

Reynolds, D. (2006). To what extent does performance-related feedback affect managers' self-efficacy? *International Journal of Hospitality Management*, *25*, 54–68. doi:10.1016/j.ijhm.2004.12.007

Schunk, D. H. (2004). *Learning theories: An educational perspective* (4th ed.). Upper Saddle River, NJ: Pearson/Merrill/ Prentice Hall.

Steward, R. J. (1998). Connecting counselor self-efficacy and supervisor self-efficacy: The continued search for counseling competence. *The Counseling Psychologist*, *26*, 285–294. doi:10.1177/0011000098262004

Tang, M., Addison, K. D., LaSure-Bryant, D., Norman, R., O'Connell, W., & Stewart-Sicking, J. A. (2004). Factors that influence self-efficacy of counseling students: An exploratory study. *Counselor Education and Supervision*, *44*, 70–80. doi:10.1002/j.1556-6978.2004.tb01861.x

Wong-Wylie, G. (2007). Barriers and facilitators of reflective practice in counsellor education: Critical incidents from doctoral graduates. *Canadian Journal of Counselling*, *41*(2), 59–76.

Woodside, M., Oberman, A. H., Cole, K. G., & Carruth, E. K. (2007). Learning to be a counselor: A prepracticum point of view. *Counselor Education and Supervision, 47,* 14–28. doi:10.1002/j.1556-6978.2007.tb00035.x

Appendix

Focus Group Protocol

1. How is your program designed to provide supervision training?
2. What factors influence your perceptions of your abilities as supervisors?
   Prompt: colleagues, professors, equipment, schedules, age, cultural factors such as gender, ethnicity, social class, whether you have had prior or no prior experience as supervisors.
3. How does it feel to evaluate the supervisees' performance?
4. How, if at all, do your supervisees provide you with feedback about your performance?
5. How do you feel about evaluations from your supervisees?
   Prompt: How, if at all, do you think or feel supervisees' evaluations influence how you perceive your skills as a supervisor?
6. How, if at all, do your supervisors provide you with feedback about your performance?
7. How do you feel about evaluations from your faculty supervisor?
   Prompt: In what ways, if any, do evaluations from your faculty supervisor influence how you perceive your skills as a supervisor?
8. What strengths or supports do you have in your program that guide you as a supervisor?
9. What barriers or obstacles do you experience as a supervisor?
10. What influences do you have from outside of the program that affect how you feel in your role as a supervisor?
11. How does it feel to be in the middle tier of supervision: working between a faculty supervisor and master's-level supervisee?
    Prompt: Empowered, stuck in the middle, neutral, powerless.
12. What, if any, critical incidents have you encountered in supervision?
    Prompt: Supervisee that has a client who was suicidal or it becomes clear to you that a supervisee has not developed basic skills needed to work with current clients.
13. If a critical incident occurred, or would occur in the future, what procedures did you or would you follow? How comfortable do you feel in having the responsibility of dealing with critical incidents?
14. If not already mentioned by participants, ask if they have been faced with a situation in which their supervisee was not performing adequately/up to program expectations. If yes, ask them to describe their role in any remediation plan that was developed. If no, ask what concerns come to mind when they think about the possibility of dealing with such a situation.
15. Describe a time when you felt least competent as a supervisor.
16. Describe a time when you felt the most competent as a supervisor.
17. How could supervision training be improved, especially in terms of anything that could help you feel more competent as a supervisor?

Mental Health Service Providers: College Student Perceptions of Helper Effectiveness

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Undergraduate perceptions of the overall effectiveness of six types of mental health service providers (MHSPs) were obtained with a survey. Although many mental health services are available to consumers in the United States, research has indicated that these services are underutilized. Perceptions have been linked to therapeutic outcomes and may potentially serve as barriers to treatment. The results of the present study illustrate a range of perceptions and highlight the value of educating future consumers and practitioners about the roles of various MHSPs in providing mental health services. Future research is proposed.

***Keywords*: mental health provider, student perceptions, consumers, underutilized, practitioners**

At the 2013 National Conference on Mental Health, President Obama called for a national discussion on mental health:

> We know that recovery is possible; we know help is available, and yet, as a society, we often think about mental health differently than other forms of health. You see commercials on TV about a whole array of physical health issues, some of them very personal. And yet, we whisper about mental health issues and avoid asking too many questions. In many cases, treatment is available and effective. If there's anybody out there who's listening, if you're struggling, seek help. (The White House, 2013, 3:20)

To address this plea for mental health awareness at the national level, there is a need for research that identifies and targets the barriers that prevent individuals from seeking mental health services. The goal of the present study was to gain more insight regarding perceptions of the effectiveness of MHSPs. Results of this study offer a baseline for future research that could investigate how these perceptions influence help-seeking behaviors.

According to the National Institute of Mental Health (NIMH; n.d.), about one in four American adults has a mental disorder that can be diagnosed. Mental illness is the leading cause of disability (NIMH, 2012), and suicide is the eighth leading cause of death in the United States (Russell, 2010). MHSPs (e.g., counselors, marriage and family therapists [MFTs], psychiatrists, psychiatric nurses, psychologists, social workers) offer critical services to their clients, advocate for mental health awareness, and stress the significance of the de-

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stigmatization of mental illness to the general public. Despite the services available, fewer than 37.9% of adults with mental illnesses receive treatment (Office of Applied Studies, 2009). This statistic reveals some important research questions: Do individuals avoid seeking mental health services because they do not believe the service providers can effectively treat them? Do people seek help from some MHSPs more than others because they believe them to be more effective?

According to World Health Organization's 2001 report, the effectiveness of mental illness and substance abuse treatment has been well documented and has dramatically improved over the past 50 years. The 1995 Consumer Reports survey on the effectiveness of psychotherapy empirically supports the assertion that consumers benefit substantially from psychotherapy (Seligman, 1995). Participants in the study answered questions about the effectiveness of the treatment they received, how satisfied they were with the therapist's treatment of their problems, and how their emotional state changed from the beginning to the end of therapy. Of the 426 participants who were feeling "very poor" when they began therapy, 87% reported that they were feeling "very good" or "good" by the time of the survey. No specific modality of psychotherapy was shown to be more effective than any other. Participants reported that primary care physicians were as effective as the other mental health practitioners in the short term, but significantly less effective in the long term. Those who sought treatment from a mental health professional rather than seeing only a primary care physician reported more improvement in the following domains: ability to relate to others, ability to cope with everyday stress, enjoying life more, personal growth and understanding, self-esteem, and confidence (Seligman, 1995). Still, when individuals are struggling with mental health issues, they most commonly consult their primary care physicians (Mickus, Colenda, & Hogan, 2000; Murstein & Fontaine, 1993).

Research conducted by Deen, Bridges, McGahan, and Andrews (2012) offers insight into the role that cognitive factors play in the utilization of mental health services. Participants in their study were presented with vignettes that described depressive episodes and asked if they would seek help from (a) a medical doctor and (b) a counselor or therapist for the presented problem. Participants also were asked if they believed that seeing a medical doctor or counselor would help alleviate the presented problem. A higher perceived need for medical doctors over counselors or therapists was reported. Medical doctors were perceived by participants as more useful and had more favorable therapeutic outcome expectancies than counselors or therapists (Deen et al., 2012).

Furthermore, a five-year study conducted by Su, Tsai, Hung, and Chou (2011) evaluated non-psychiatric physicians' accuracy in recognizing disorders. In each case, the researchers recorded the primary care physician's impression and referrals based on psychiatric diagnosis and then compared them with a psychiatrist's final diagnosis. When the primary care physician was able to recognize psychiatric diagnostic criteria or common symptoms (e.g., low mood, loss of interest and negative thinking, acute confusion, consciousness disturbance, hallucination), this information was recorded as correct recognition. Five common psychiatric diagnoses were chosen for analysis: (a) depressive disorder (major depressive disorder and dysthymic disorder), (b) anxiety disorders, (c) substance use disorders, (d) delirium, and (e) psychotic disorders (schizophrenia, schizophreniform disorder, and brief psychotic disorder). Su et al. (2011) reported that the overall diagnostic accuracy rate was 41.5%. Substance abuse disorders were the most accurately diagnosed by physicians (70.2%) and psychotic disorders were the least accurately diagnosed (9.7%). The most common psychiatric symptoms that patients report are depressive symptoms, yet the detection of depression by physicians (31.4%) is historically low (Su, et al., 2011).

Although pediatricians are instrumental in assessing and diagnosing the children's mental health and behavioral challenges, they often state that their medical training does not fully prepare them to treat patients with learning disabilities, attention deficit disorders, mental retardation, substance abuse issues, or psychosocial

problems (Russell, 2010). Clients who are seeking mental health services often perceive their primary care physicians and pediatricians as competent in providing mental health services, despite their lack of training on these specific issues. Moreover, many individuals suffer needlessly due to their primary care physicians' lack of education regarding mental disorders (Tse, Wantz, & Firmin, 2010).

MHSPs have tremendous overlap in the populations served, disorders treated, and services offered (Hanna & Bemak, 1997). The helping professions are represented by diverse training standards, licenses, specialties, philosophies and histories (Fall, Levitov, Jennings, & Eberts, 2000). Although professional diversity allows for the treatment of a wide range of issues, this also can cause confusion regarding which type of MHSP a client should consult in a time of need. While perceptions of the competence of helping professionals can greatly affect utilization of services (Firmin, Wantz, Firmin, & Johnson, 2012), a review of the literature indicates that misperceptions are common.

Perceptions of MHSPs and Therapeutic Outcomes

Perceptions of MHSPs are important factors in the treatment outcomes of counseling (Firmin et al., 2012). According to Wampold (2001), client expectancy concerning the effectiveness of counseling accounts for 15% of the therapeutic outcome, and factors that clients carry into counseling (e.g., perceptions of MHSP competence and expertise) account for an astounding 40% of the therapeutic outcome. The therapeutic alliance alone accounts for 30% of the outcome of treatment (Wampold, 2001). Client perceptions of an MHSP's competency in regard to treating specific needs have an effect on the therapeutic alliance as well as clients' ability to facilitate positive changes in their lives. According to Meyer et al. (2002), client expectancy concerning the effectiveness of counseling is critical and often sufficient for inspiring positive change for the client. As far back as 1973, Frank asserted that counseling is most effective when both the client and counselor believe in the effectiveness of the intervention. Based on past analyses of the link between the expectancy factor and the therapeutic alliance, and their effect on treatment outcomes, the authors propose that creating more awareness and more positive perceptions of the overall effectiveness and accessibility of MHSPs would ultimately increase positive outcomes in counseling.

Undergraduate Students as Future Professionals and Help Seekers

College undergraduates' perceptions of MHSPs are important for a number of reasons. First, the future of the helping profession depends on the incoming generation of undergraduate students, who are making decisions regarding which fields they will work in, and who may consider the helping professions. Career choices are related to well-being and overall life satisfaction (Steger & Dik, 2009). According to Roese and Summerville (2005), the most frequently identified life regrets for Americans involve their educational choices. Because educational choices have been consistently linked with life satisfaction, the accuracy of undergraduate perceptions of MHSPs merits more in-depth exploration.

Attending college can be a major life transition for students, accompanied by new pressures, stress, and surfacing mental health concerns. Most mental disorders are identifiable before or during the traditional college age of 18–24 (Kessler et al., 2005). According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2012), about four out of five college students consume alcohol. About half of the college students who drink partake in binge drinking. Around 25% of college students disclosed academic consequences because of their drinking (e.g., missing class, falling behind, performing poorly on assignments, receiving lower grades overall). These statistics indicate an increasing need for mental health and substance abuse counseling among college students. Universities provide a number of resources to their students, yet they are underutilized (Watkins, Hunt, & Eisenberg, 2012). Research focused on undergraduate perceptions of MHSPs could encourage more utilization of MHSP services, potentially motivate more students to join the MHSP workforce, and support a more accurate overall perception and portrayal of the effectiveness and competence of MHSPs.

Since perceptions have been linked to help-seeking behaviors, a primary goal of the present study was to gain insight into how college students perceive the effectiveness of the various MHSPs.

Method

Participants

Data was collected from participants who were enrolled in a general psychology course at a private Midwestern university ($N = 261$). Participants were surveyed regarding their perceptions of MHSPs. The general psychology course provided a sample spanning a cross section of the university's 100 academic majors.

Participants represented the freshman, sophomore, junior and senior class levels (M_{age}= 18.5; range = 17–55 years). Our study included 167 women (64%), 92 men (35%), and two participants that did not report gender (1%). The sample consisted primarily of Caucasian students (91%), while 9% were identified as ethnic minorities. Two participants opted out for undisclosed reasons. Participants reported home residences in 34 U.S. states (including 33% OH, 10% MI, 7% IN, and 6% PA).

Instruments

A self-administered questionnaire was developed for the present study in order to evaluate six MHSPs (e.g., for various clinical situations, source of knowledge, and characteristics). Participants were asked to respond to the following question: In general, what is your opinion about how overall effective each of the following MHSPs (counselors, MFTs, psychiatrists, psychiatric nurses, psychologists, and social workers) would be with helping a mental health client? Response options were based on a 4-point Likert-type scale: 1 (positive), 2 (neutral), 3 (negative), or 4 (unsure). The survey asked each participant to designate which MHSPs he or she would recommend for several clinical situations using a 3-point Likert-type scale: 1 (Yes, I would recommend this MHSP), 2 (No, I would not recommend this MHSP), or 3 (Not sure, not familiar with this MHSP). Participants also were asked to identify a source from which they had learned about the MHSP. A 3-point Likert-type scale was utilized to indicate if the source information was presented in a: 1 (positive), 2 (neutral), or 3 (negative) way. Lastly, participants categorized MHSPs based on the following: personal attributes (e.g., competent, intelligent/smart, and trustworthy); job-related activities (e.g., diagnose and treat mental and emotional disorders, and prescribe medication); requirements (e.g., can be in independent private practice, doctoral degree required to practice, and over-paid); or not familiar with MHSP.

Procedure

An initial pilot study was conducted in order to address and resolve ambiguities before the final survey was administered. A total of 12 students participated in the pilot survey; data obtained from the initial study were not included in the present research.

The survey was administered anonymously and was designed to take 20–25 minutes to complete. MHSPs were presented randomly throughout the survey as suggested by Sarafino's (2005) protocols. IRB approval for the study was obtained prior to data collection and informed consent was obtained. Participants elected to complete, partially complete, or not complete the survey. The survey was administered during regular class time with no extra credit or other incentives awarded for participation, providing little chance for coercion.

Results

Analyses focused on participant perceptions of the overall effectiveness of MHSPs in working with a potential mental health consumer. The following is a ranked list of the MHSPs from most positive to least

positive by the frequency of perceptions: counselors, psychologists, psychiatrists, MFTs, social workers, and psychiatric nurses. A visual comparison of participant responses is provided in Figure 1. The frequency of participants reporting negative perceptions ranked from highest to lowest in the following order: social workers, MFTs, psychiatric nurses, psychiatrists, counselors and psychologists.

When participants were asked to identify their opinions in regard to the overall effectiveness of each of the MHSPs in helping a mental health consumer, participants selected the "don't know" option as follows: psychiatric nurses (17.6%), MFTs (8.8%), psychiatrists (7.3%), psychologists (5.7%), social workers (4.2%), and counselors (3.1%).

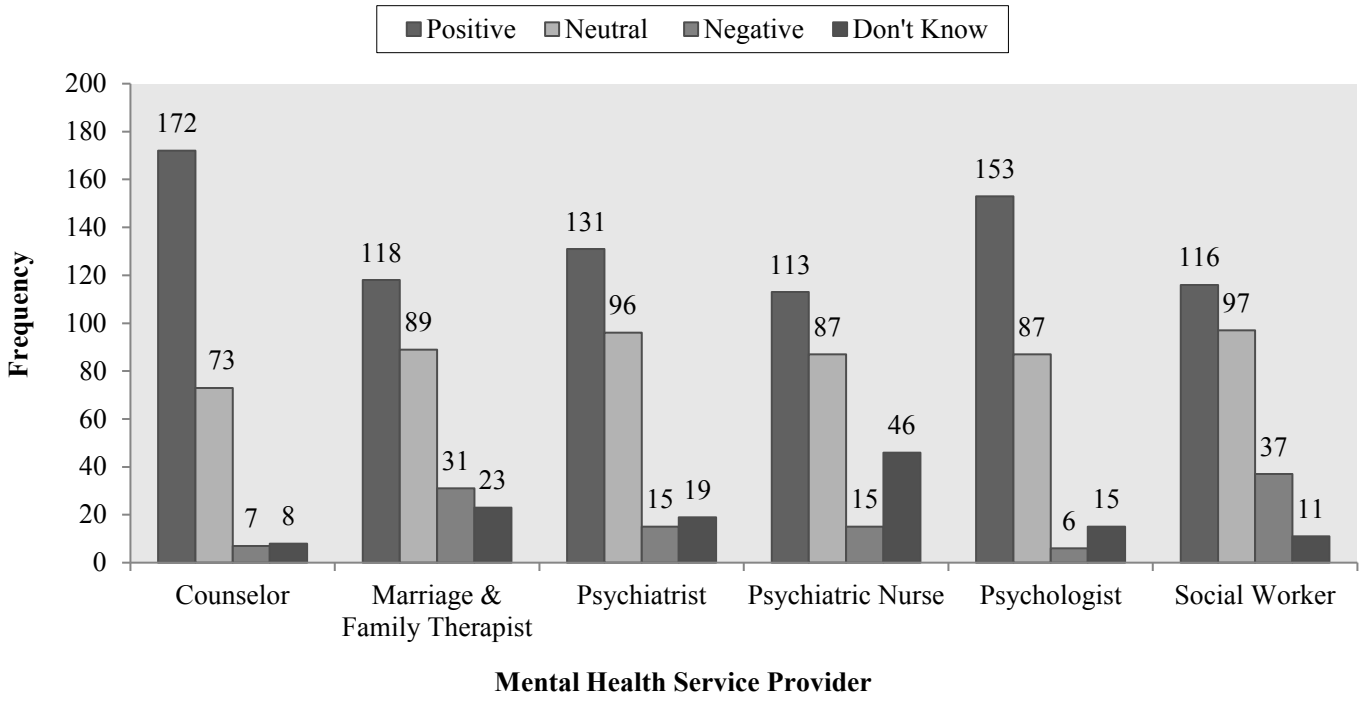

Figure 1. Undergraduate perceptions of the overall effectiveness of MHSPs.

Since the same participants rated each of the MHSP categories, *t*-tests were used to compare category means as represented in Figure 2. As expected, the data suggests significant differences in perceptions of MHSPs' overall effectiveness when comparing the means from each MHSP category. Perceptions of the overall effectiveness of MFTs ($M = 1.63$, $SD = .703$) were significantly more negative than the perceptions of the overall effectiveness of professional counselors (PC; $M = 1.35$, $SD = .532$); $t\,(234) = 5.648$, $p < .001$, as well as the overall effectiveness of psychologists ($M = 1.40$, $SD = .539$); $t\,(226) = 4.05$, $p < .001$. MFT overall effectiveness ($M = 1.63$, $SD = .703$) was perceived to be significantly more positive than psychiatric nurse overall effectiveness ($M = 1.54$, $SD = .624$); $t\,(203) = 2.104$, $p < .05$. Counselor overall effectiveness ($M = 1.35$, $SD = .532$) was perceived to be significantly more positive than psychiatrist overall effectiveness ($M = 1.52$, $SD = .612$); $t\,(238) = -3.589$, $p < .001$. Psychiatrists were perceived as less effective overall ($M = 1.52$, SD 612) than psychologists ($M = 1.40$, $SD = .539$); $t\,(236) = 2.934$, $p < .01$.

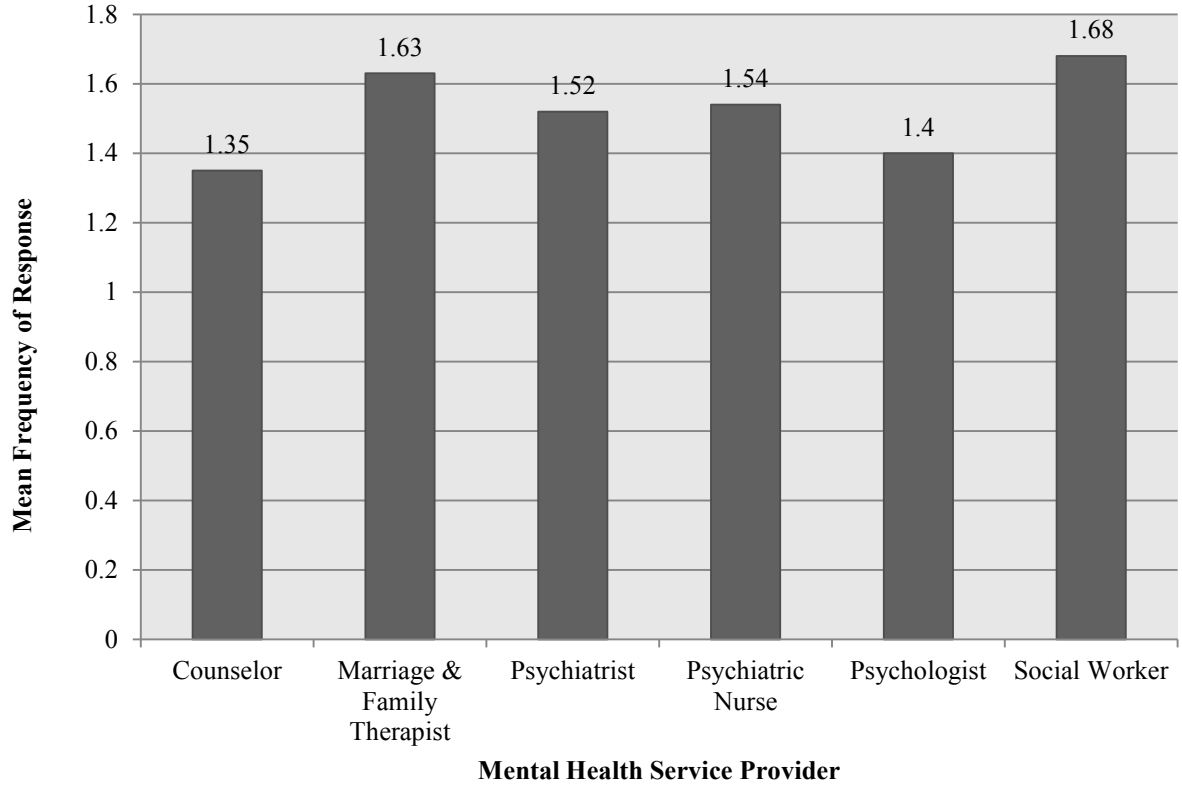

Figure 2. A comparison of the category means of the perceptions of overall effectiveness of MHSPs (lower scores are more positive).

Social workers received the highest percentage of unsure student responses (36.8%), followed closely by psychiatrists (36.4%), and MFTs (34.9%). These findings suggest the need for information and advocacy for these MHSPs in particular. Data from the present study also suggest that social workers have the highest amount of variance in participant responses (.520), while MFTs rank second (.486). For this study, variance is possibly an indication of misinformation and discrepant beliefs regarding the effectiveness of the MHSPs. Counselors had the least amount of variance (.281) when compared to the other MHSPs, suggesting that participants had more similar perceptions of counselor overall effectiveness when compared to the variance in perceptions of the other MHSPs.

Discussion

The U.S. Surgeon General's 1999 report on mental health stated to the American people that "the efficacy of mental health treatment is well-documented," and recommended to "seek help if you have a mental health problem or think you have symptoms of mental illness." (U.S. Department of Health and Human Services (UDHHS; 2000, p. 13). The report further stipulated that stigmatization of mental illness is the greatest obstacle the United States faces in furthering the progress of individuals seeking mental health services (USDHHS, 2000). The present study highlights the need for the advocacy of MHSPs. Specifically, social workers, MFTs, and psychiatric nurses were perceived as significantly less effective overall than psychiatrists, counselors, and psychologists. This coincides with Consumer Reports' 1994 Annual Questionnaire in which 4,000 subscribers who received some kind of mental health care between 1991 and 1994 responded to questions about their mental health care. This survey showed that participants were satisfied seeing social workers, psychologists, or psychiatrists ("Mental Health," 1995). Those seeing a marriage and family therapist were slightly less satisfied

("Mental Health," 1995). Overall, this report provided a positive recommendation to seek MHSPs for mental health issues.

Consumer Reports' 2009 Annual Questionnaire once again queried its subscribers on the efficacy of mental health providers working specifically with depression and anxiety ("Depression & Anxiety," 2010). This survey of 1,544 respondents, who had sought help for depression, anxiety, or other mental health problems between January 2006 and April 2009, found that psychologists, social workers, and licensed professional counselors were all equally helpful in providing relief for depression and anxiety ("Depression and Anxiety," 2010).

Of concern from the present study is that for all MHSP categories, significant percentages of the participants reported a total absence of knowledge regarding MHSP overall effectiveness. This is one reason we recommend that counselors and counseling professional organizations (e.g., AMHCA, ACA, ACCA, CACREP, NBCC) increase their emphasis on professional advocacy.

In a broader sense, research regarding the methods through which people learn about MHSPs could identify more specific opportunities and venues for advocacy. The American College Counseling Association (ACCA) provides marketing strategy suggestions for reaching university faculty, staff, administrators and students: campus publications; campus television and radio shows; flyers posted around campus; e-mails; sponsoring anxiety, depression, and eating disorder screening days; table tents and banners in the cafeteria and student center; sponsoring career counseling week; guest speakers for classes and organizations; distributing brochures around campus; sponsorship and programming for Mental Health Awareness Month; developing mental health "theme of the month" campaigns; placing counseling advertisement kiosks in heavy traffic areas around campus; and hosting an open house (Mattox, 2000). These types of marketing actions are imperative and could be extended beyond university campuses. For example, public service announcements targeted toward specific consumers, mass media campaigns and the use of social networking for advocacy might be effective ways of reaching the increasingly tech-savvy generation. This approach could potentially be instrumental in decreasing the stigmatization of individuals who seek treatment for mental health-related issues and increase the awareness of services that are available.

The Council for Accreditation of Counseling & Related Education Programs (CACREP) could enhance activism for the helping professions by requiring students to demonstrate advocacy at both the master's and doctoral levels. The American Counseling Association (ACA) and the American Mental Health Counselor's Association (AMHCA) can direct ongoing advocacy efforts by increasing the ease of access to information related to the effectiveness of MHSPs for undergraduates. Counseling organizations can provide support for young professionals who are interested in joining the helping profession by empirically validating and improving perceptions of the overall effectiveness of MHSPs.

Limitations and Future Research

Future researchers are encouraged to explore the specific attitudes and perceptions that serve as barriers to the utilization of mental health treatment. Researchers should consider delineating therapeutic outcomes based on the specific type of provider (e.g., counselors, MFTs, psychiatrists, psychiatric nurses, psychologists, social workers). Of particular interest would be comparing the actual therapeutic outcomes of MHSPs to student perceptions of MHSP competence in treating specific mental disorders. The helping professions also could explore the perceptions of the overall effectiveness of MHSPs in comparison to those of primary care physicians.

Participants in the present study were not asked if they had received mental health services themselves. This is an important limitation to consider since perceptions of the effectiveness of MHSPs are likely influenced by firsthand experiences. In much the same way, a lack of familiarity or experience with MHSPs could potentially influence perceptions. The sources by which individuals learn about mental health–related issues could identify specific areas that can be utilized for advocating for the helping professions. For example, do people learn about mental health issues from movies, television, the Internet, commercials, newspapers, books, magazines, classes, friends, family members, firsthand experiences, or other sources? Is the information that individuals receive from these sources providing a foundation for accurate perceptions of the effectiveness of MHSPs? How do the attitudes founded on information from various sources influence help-seeking behavior? Research on these topics might provide further direction for professional advocacy.

Another limitation of the current study is that participants attended college in one geographical location. Though the participants represented 34 of the 50 states and spanned a wide range of academic majors, the results of the present study cannot be generalized to other types of institutions nationwide. All participants in this sample were undergraduate students, and therefore the results cannot be generalized to other populations. Confounding effects associated with the limitations of collecting data from a single university could be reduced by studying a larger and more nationally representative sample of private and public institutions or by comparing and contrasting results from various regions of the country. Perceptions of the general population should be explored for more generalizable results. On a final note, an important limitation of the present study is that only 9% of the participants identified themselves as ethnic minorities. We recommend further investigation of ethnic minority perceptions of MHSPs. Future studies also could focus on socioeconomic status, marital status, sexual orientation, age and gender as moderating variables.

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References

Deen, T. L., Bridges, A. J., McGahan, T. C., & Andrews, A. R. (2012). Cognitive appraisals of specialty mental health services and their relation to mental health service utilization in the rural population. *The Journal of Rural Health*, *28*, 142–151. doi:10.1111/j.1748-0361.2011.00375.x

Depression and anxiety: Readers reveal the therapists and drugs that helped. (2010, July). *Consumer Reports*, *75*(7), 28–31.

Fall, K. A., Levitov, J. E., Jennings, M., & Eberts, S. (2000). The public perception of mental health professions: An empirical examination. *Journal of Mental Health Counseling*, *22*, 122–134.

Firmin, M. W., Wantz, R. A., Firmin, R. L., & Johnson, C. B. (2012). Sources by which students perceive professional counselors' effectiveness. *The Professional Counselor: Research and Practice*, *2*, 33–42.

Frank, J. (1973). *Persuasion and healing: A comparative study of psychotherapy* (2nd ed.). Baltimore, MD: Johns Hopkins University Press.

Hanna, F. J., & Bemak, F. (1997). The quest for identity in the counseling profession. *Counselor Education and Supervision 36*, 194–206. doi:10.1002/j.1556-6978.1997.tb00386.x

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national co-morbidity survey replication. *Archives of General Psychiatry*, *62*, 593–602. doi:10.1001/archpsyc.62.6.593

Mattox, R. (2000). Building effective campus relationships. In D. C. Davis & K. M. Humphrey (Eds.), *College*

counseling: Issues and strategies for a new millennium (pp. 221–237). Alexandria, VA: American Counseling Association.

Mental health: Does therapy help? (1995, November). *Consumer Reports*, *60*(11), 734–739.

Meyer, B., Pilkonis, P. A., Krupnick, J. L., Egan, M. K., Simmens, S. J., & Stosky, S. M. (2002). Treatment expectancies, patient alliance, and outcome. *Journal of Clinical and Consulting Psychology*, *70*, 1051–1055. doi:10.1037/0022-006X.70.4.1051

Mickus, M., Colenda, C. C., & Hogan, A. J. (2000). Knowledge of mental health benefits and preferences for type of mental health providers among the general public. *Psychiatric Services*, *5*1, 199–202. doi:10.1176/appi.ps.51.2.199

Murstein, B. I., & Fontaine, P. A. (1993). The public's knowledge about psychologists and other mental health professionals. *American Psychologist*, *48*(7), 839.

National Institute on Alcohol Abuse and Alcoholism. (2013). *College drinking*. Retrieved from http://pubs.niaaa.nih.gov/publications/CollegeFactSheet/CollegeFactSheet.pdf

National Institute of Mental Health. (n.d.). *The numbers count: Mental disorders in America*. Retrieved from http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml#Intro

Roese, N. J., & Summerville, A. (2005). What we regret most…and why. *Personality and Social Psychology Bulletin*, *31*, 1273–1285. doi:10.1177/0146167205274693

Russell, L. (2010). *Mental health care services in primary care: Tackling the issues in the context of health care reform*. Retrieved from http://www.americanprogress.org/wp-content/uploads/issues/2010/10/pdf/mentalhealth.pdf

Sarafino, E. P. (2005). *Research methods: Using processes and procedures of science to understand behavior.* Upper Saddle River, NJ: Pearson/Prentice Hall.

Seligman, M. E. (1995). The effectiveness of psychotherapy: The *Consumer Reports* study. *The American Psychologist, 50,* 965–974. doi:10.1037/0003-066X.50.12.965

Steger, M. F., & Dik, B. J. (2009). If one is looking for meaning in life, does it help to find meaning in work? *Applied Psychology: Health and Well-Being, 1,* 303–320. doi:10.1111/j.1758-0854.2009.01018.x

Su, J.-A., Tsai, C.-S., Hung, T.-H., & Chou, S.-Y. (2011). Change in accuracy of recognizing psychiatric disorder by non-psychiatric physicians: Five-year data from a psychiatric consultation-liaison service. *Psychiatry and Clinical Neurosciences*, 65, 618–623. doi:10.1111/j.1440-1819.2011.02272.x

Tse, L. M., Wantz, R. A., & Firmin, M. (2010). Perceptions of effectiveness among college students: Toward marriage and family counseling and therapy. *The Family Journal, 18*(3), 269–274. doi:10.1177/1066480710371799

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general*. Bethesda, MD. Retrieved from http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum.

Watkins, D. C., Hunt, J. B., & Eisenberg, D. (2012). Increased demand for mental health services on college campuses: Perspectives from administrators. *Qualitative Social Work*, *11*(3), 319–337. doi:10.1177/1473325011401468

The White House. (2013). *President Obama speaks at the national conference on mental health* [Video file]. Retrieved from http://www.whitehouse.gov/photos-and-video/video/2013/06/03/president-obama-speaks-national-conference-mental-health#transcript

World Health Organization. (2001). *The world health report 2001- mental health: New understanding, new hope.* Geneva, Switzerland. Retrieved from http://www.who.int/whr/2001/en/index.html

A Phenomenological Analysis of Invisibility Among African-American Males: Implications for Clinical Practice and Client Retention

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This article reports the results of a phenomenological study of racial identity development that asked the following questions: How do African-American males cope with invisibility experiences? What role do counselors play in assisting African-American males cope with invisibility experiences? The study involved the use of semi-structured interviews to explore invisibility experiences among seven African-American males. Results identified four thematic codes: self-affirmation, self-awareness, coping strategies in overcoming invisibility, and providing effective counseling to African-American males.

***Keywords*: racial identity development, African-American males, counselors, self-affirmation, self-awareness**

The classic novel *Invisible Man* by Ralph Ellison (1952) explores the philosophical and psychological world of the main character, whose name is left unsaid in the novel to further perpetuate his invisibility. The metaphorical novel demonstrates how racism and racial epithets can harm the mind of the African-American man. Additionally, the novel reveals how the identity of the African-American man is often defined by social prejudice versus the individual self.

Consistent with the lives of many African-American men (Franklin, 1999), the nameless main character in Ellison's novel spends his life searching for justice in the face of injustice. Ellison (1952) makes use of ambiguous struggles to represent the moral, mental and emotional frustration that results from the main character's search for identity in a world that treats him as if he is invisible. The nameless main character represents the lives of many African-American men in American society whose daily struggles with invisibility contribute to feelings of anger, frustration, inferiority and alienation.

With the novel in mind, the authors of this article explore the concept of invisibility among African-American males in today's society and demonstrate the impact that invisibility experiences have on racial identity. An initial discussion of the concept of invisibility is provided. Next, nigrescence theory is used as the theoretical underpinning of racial identity development.

Understanding Invisibility

Invisibility is defined as "an inner struggle with the feeling that one's talents, abilities, personality, and worth are not valued or even recognized because of prejudice and racism" (Franklin, 1999, p. 761). This concept is

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often demonstrated through devaluing, demeaning, disadvantaging and the unfair regard that African-American males are subjected to on a daily basis (Franklin, 1999).

According to Franklin (1999), for some African-Americans, "being able to discern when behavior is racist, and then acting consistent with one's sense of self, is the personal struggle for visibility" (p. 764). Racial experiences influence African-American males' sense of self. Therefore, the negotiation of visibility that some African-American men encounter becomes a process of seeking validation, respect and dignity with or without compromising their identity. On the other hand, limited identity development or a lack of self-concept can result in identity erosion (e.g., alienation, invisibility, identity confusion; Cross & Vandiver, 2003). Moreover, racial identity development can act as a defense against the invisibility syndrome (Parham, 1999).

To that end, Parham (1999) warns that African-American people must be cautious where they seek validation, stating that it is damaging to seek validation from the oppressor, especially when that validation is "disaffirming and dehumanizing" (Parham, 1999, p. 800). In *The Souls of Black Folk*, Du Bois (1903) expounds on this phenomenon by stating the following:

> It is a peculiar sensation, this double-consciousness, this sense of always looking at one's self through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity. One ever feels his two-ness,—an American, a Negro; two souls, two thoughts, two unreconciled strivings; two warring ideals in one dark body, whose dogged strength alone keeps it from being torn asunder (pp. 8–9).

Parham (1999) states that when personal affirmations and basic needs are not met as a result of racism, African-Americans may be prone to exhibit high-risk behaviors.

Nigrescence Theory: Correlations Between Racial Identity and Invisibility

Nigrescence theory has been revisited and revised over the course of 40 years to its current expanded version (Cross, 1991; Cross & Vandiver, 2003). Nigrescence theory expanded (the theory's most current name and version) is utilized for the purpose of this study to provide a foundation for racial identity development and to validate the correlation between racial identity development and invisibility. While other theoretical underpinning could be employed as the foundation for racial identity development (e.g., critical race theory), expanded nigrescence theory was chosen because of its emphasis on psychological themes in the social history of Black/African-American people (Cross & Vandiver, 2003). As such, the first author provides a brief exploration of the experiences of Black people in the context of nigrescence theory in order to provide foundational information to support the correlation between invisibility and racial identity development, and this research.

The extant literature and empirical research relative to Cross's nigrescence theory is immense (Cross, 1991; Cross & Vandiver, 2003). Inasmuch, this discussion moves beyond providing a review of the expanded theory itself. Instead emphasis is placed on central elements of nigrescence theory expanded that align with the goals of the present study.

The term *nigrescence* means "the process of becoming Black" (Cross, 1991). The theory's theme revolves around the processes involved in developing Black racial and cultural identity (Cross, 2003). Core precepts of nigrescence theory expanded include the following: (a) Blackness is viewed as a social identity and not a personality variable; (b) various types of Black identity have resulted in the delineation of a range of identity exemplars; and (c) the best way to conceptualize Black identity variability is through the explications of ideological

types (profiles); with the different types or interpretations of what it means to be Black at the heart of the theory (Cross & Vandiver, 2003).

Being Black/African-American is not just about skin color or the origin of descendants; it is equally related to how Black people define themselves in a society that perpetuates prejudice, racism, microaggression, separation and exclusion (Gibson & Obgu, 1991). According to Cross & Vandiver (2003), the core of nigrescence theory expanded focuses on various ways Black people make sense of themselves as social beings rather than a collection of personality traits.

Both past and present racism may impede African-American males' ability to form an identity that includes "independence, success and achievement" (Oyserman, Gant, & Ager, 1995, p. 1219). However, identity development is essential in the promotion of well-being over the lifespan (Oyserman et al., 1995). Additionally, a well-established sense of self improves the ability to organize and interpret social experiences, regulate affect, control behavior, and develop healthy cognition (Cross & Vandiver, 2003; Oyserman et al., 1995). Without it, African-American males experience misinterpreted social experiences, self-blame, and guilt, which over time can limit education attainment, occupation attainment, and personal fulfillment (Gibson & Ogbu, 1991). It is the correlation between racial identity and invisibility, and the resulting issues, that are at the root of this study.

Research Rationale

The purpose of this phenomenological study is to answer the following research questions: How do African-American men cope with invisibility experiences? What role might counselors play in assisting African-American males cope with invisibility experiences? To answer these questions, the authors explored the lived invisibility experiences of seven African-American males.

Philosophical and Theoretical Underpinning

At the core of the study's purpose is a humanistic and multicultural perspective. Tenets consistent with both humanistic (Scholl, 2008) and multicultural (Sue, Ivey, & Pedersen, 1996) theories are interwoven throughout the study. Specifically, emphasis is placed on empathy, self-awareness, and understanding and valuing all human beings.

With humanism and multiculturalism in mind, a phenomenological approach was utilized in the study to gather the firsthand accounts of the invisibility experiences of African-American males when encountering macro and micro forms of racism. Additionally, a constructivist approach was activated with the purpose of understanding the human experience through narrative conceptions of the phenomena (Hays & Wood, 2011). By utilizing a constructivist perspective, additional attention was placed on putting forth the participants' perspective and ensuring contextual relevance (Hays & Wood, 2011).

Phenomenological research captures the lived experiences of people (Levers et al., 2008). Phenomenological researchers study the essence of a phenomenon and explore how individuals situate themselves in the world based on how they make meaning of their experiences (Levers et al., 2008). Utilizing a phenomenological approach in this study helps professional counselors better understand African-American male invisibility experiences. The data gathered during the study were thematically categorized and used to provide specific recommendations for counselors working with African-American males of all ages in diverse clinical settings.

Primary Researcher Bias and Influence on the Study

As an African-American female who has heard a lifetime of stories about invisibility incidents from African-American males, read about invisibility syndrome (Ellison, 1952; Franklin, 1999), as well as experienced

personal feelings of invisibility, the first author decided to make a conscious effort to suspend self-knowledge about invisibility in order to entirely engage in the experiences of the participants. While bracketing personal experiences was challenging, it was an important step in ensuring that as the researcher, the author (a) treated the participants with empathy, (b) put forward the lived experience of the participants and not personal experience, and (c) maintained the trustworthiness needed to support the essence of the study, while also reporting the findings.

To avoid inferring assumptions or biases related to the topic, the first author used reflexive journaling throughout the data collection, data analysis and reporting of findings. Journaling allowed the author to maintain the trustworthiness, or the ability to ensure that the voices of the participants, and not the author's own, were present in the study (Hunt, 2011). During reflexive journaling, the author wrote about experiences as the primary researcher, including experiences during the interviews, about feelings, thoughts, and reactions to newly discovered information, as well as emerging awareness of the phenomenon. The author often referred back to personal writing with the goal of separating perceptions from the actual information relayed by participants. Reflexive journaling increased the level of self-awareness and allowed the author to maintain trustworthiness throughout the study.

Method

Participants

Purposeful sampling was used in qualitative research to select participants who could provide a description of the phenomenon being studied (Creswell, 2007). A snowball sampling process was used to select participants for the study. That is, initial participants were identified, interviewed, and then asked to provide the names of other individuals who might be interested in participating in the study. Individuals selected as participants had to be willing to recall and describe their experiences related to the phenomenon.

Seven African-American males, ages 34–47, participated in the study. All participants identified as middle class, and five had an educational level beyond high school graduation (four master's level and one doctorate level). Five of the participants were born in the southeast US and two were born in the northeast US. The participants also reported their familial status: one participant was single, five were married with children, and one participant was in a committed live-in relationship.

Data Collection Procedures

The participants' subjective, personal perspective and interpretation of the phenomenon was explored. The participants engaged in semi-structured interviews by responding to interview questions and engaging in discussion related to the phenomenon. The semi-structured interview questions used in this study derived from reviewed literature on invisibility and racial identity development (Cross, 1991; Cross & Vandiver, 2003; Dubois, 1903; Parham, 1999). Interview questions focused on the derivation of the participants' identity development, invisibility experiences (i.e., have you ever felt invisible?), ability to cope with invisibility, overall behaviors resulting from invisibility syndrome, and potential counseling to improve and/or nurture identity development.

Participants signed Institutional Review Board-approved documents prior to participating in interviews for the study. Participants agreed to allow direct information from the interviews to be utilized within the study. Data was collected in April and May 2011. Interviews were held either face-to-face or through telephone conference. Face-to-face interviews took place at various locations (e.g., library, office). Interviews and discussion lasted approximately 1–1.5 hours. All interviews were audio recorded and transcribed.

Data Analysis

A phenomenological model outlined by Wertz (2005) that synthesizes Giorgi's (1985) description-reduction-interpretation model was used for the data analysis of this study. From this well-established philosophy for analyzing phenomenological data, three essential steps became capstones for the data analysis of this study. Those steps were as follows: (a) providing an exhaustive description of the phenomenon, (b) reducing and categorizing the data, and (c) interpretation.

Step 1 was important in that a clear understanding of the phenomenon was presented from the participants' perspective. For example, participants were asked if they had ever felt invisible. This question became the catalyst of the analysis and shaped the foundation of the exploration of the phenomenon. The exhaustive description provides readers an understanding of the essence of the lived experiences and represents a unifying structure of the phenomenon (Wang, 2008).

In step 2, information was categorized and coded, themes were developed and defined, and rich descriptions of the themes based on information gathered from parts of the interviews were constructed. Themes were developed and defined by transcribing the audiotapes, and then participating in rote review and reading of the material. This process led to the delineation of significant information within the interviews, the cross-verification of information gathered among interviews, and the charting of information. From this process, information was reviewed as parts of a whole in order to develop main themes.

For example, during the transcription and review of the data, it became evident that participants relied on self-affirmation to maintain or improve racial identity development. Participants continuously spoke about affirming who they are or having to strongly defend or uphold who they are in public. It was evident that this affirmation was essential to the participants. During cross-verification, it became clear that all participants utilized self-affirmation and believed it to be essential to racial identity development. As a result, self-affirmation became an essential theme when coping with invisibility experiences.

In step 3, data was interpreted in the context of invisibility and racial identity development. During this process themes were consistently revisited with the goal of determining how they related to invisibility and racial identity development. Participants were able to review the codes and themes for clarity after data was analyzed. The interpretation of data provided probable meanings and was utilized in the development of the implications section. Reflexive journaling was an especially important aspect of step 3 as it assisted in the maintenance of trustworthiness.

Results

The data analysis resulted in an exhaustive description of the phenomenon and the emergence of four interconnected themes: self-affirmations, self-awareness, coping with invisibility, and providing effective counseling to African-American males. A personal account of invisibility is provided through the lens of each participant. This is followed by coded descriptions of each thematic code, major and subtheme. The thematic codes, majors and subthemes have been coded and identified below and summarized in Table 1. The findings highlight this thematic information.

Invisibility Experiences

Participant #1. I've felt invisible in the sense that if you don't engage yourself in their [White people's] beliefs, have things in common or join the social crowd you are treated invisible. For me my cultural differences have caused me to be treated invisible. For example, I've been in situations where I felt like White people did

not really want to interact with me if they didn't have to. I can tell this because of there is a level of avoidance even when they are, to some degree, forced into communicating. There's a barrier there. Oftentimes there's a lack of eye contact. Their avoidance makes me feel invisible because at the same time you see how they interact with their own [other White people]. When you do talk with them, they are very diplomatic, very politically correct, very careful. At times, I think this is how they communicate with anyone they don't know, but for me I know it's associated with race. I mean this is something that as an African-American male you deal with pretty regularly.

Table 1

Thematic Overview of Phenomenological Analysis of Invisibility

Thematic Code	Major Theme	Subtheme
Self-affirmation	1.1 Defining themselves through cultural connectivity	1.1.1. African-American male mentorship 1.1.2. Understanding and exploring African-American history and culture 1.1.3. Counseling
Self-awareness	2.1 Increasing consciousness about their individual and societal perceptions, beliefs and attitudes	2.1.1. Self-affirmation 2.1.2. (Racial) identity development
Overcoming invisibility	3.1 Building a social, spiritual and therapeutic support system that is accessible	3.1.1. African-American male mentorship 3.1.2. Resiliency 3.1.3. Religious/spiritual foundation 3.1.4. Counseling
Effectively counseling African-American males	4.1 Counseling therapeutic approach	4.1.1. Authenticity 4.1.2. Unconditional positive regard 4.1.3. Empathetic and understanding 4.1.4. Self-aware

Participant #2. I probably feel invisible the majority of the time. I've learned to cope with it. It's just a part of my reality, but at times it's stressful. Sometimes it's hard for me to assess some of this stuff because it's so normal for me. I'm a faculty member at this university and certain people know me in classes and in my college, but as soon as I walk out of the building I don't perceive that people see me as a professor. Not that people have to recognize that I'm a professor, but I don't think that I'm viewed with the respect that any professional should have in any public space. Going into department stores I feel special when a sales person acknowledges me…I'm grateful and I want to do business with them because they've demonstrated to me that they are culturally competent, kind, a decent person because most times I'm looked over. I prepare myself for what I have to deal with. I'm very capable and competent…negotiating these things [race, invisibility] because I've had to do it. I've even watched my mother do it when I was a child.

Participant #3. I've been ignored at times; times when I felt like my opinion didn't matter. When I was in undergrad at [name of university removed] I was meeting with my advisor. I was sharing with him my concern about pursuing my bachelor's degree in physics and when I was telling him about my experience and how I felt about it, he expressed to me that I may have some type of learning disability. At that point, I felt like okay, in other words he was ignoring the fact that maybe I learned differently or ignoring the fact that there may be other factors and just saying that your main problem is that you have a learning disability. That experience made me think of who I was as a person.

Participant #4. I worked at several predominately White schools and had the certification and licensure to do the job. At the same time, I had White colleagues who hadn't gotten certified at the time. But I felt like a lot of times, I was there and had the credentials to prove my worth, but sometimes I felt like I had to always go that extra mile to prove my skill set. I had to go that extra mile and pander from time to time to prove that I was worth enough or acceptable to be in the circle. For example, one time I was in a situation at a middle school. I had proven that I had done my job to the best of my ability. I had shown more than enough evidence to prove that I could do the job. But after dialoging and debating over and over again, I felt like the person in charge never heard my case, never understood my experience and because of that it made me feel invisible and powerless. Those with privilege a lot time can state a case and they will get exonerated, whereas in my case I felt invisible and powerless because in my case regardless of whatever I did I always felt like I was public enemy number one.

Participant #5. One situation happened when I got busted for drugs. When I got busted I felt like the gentlemen that arrested me made fun of me and they were Caucasian males. They said, "We gotcha now, you will never see the streets again;" they said, "that's what happens to all of y'all; y'all put yourself into a bunch!" They laughed and in so many words told me my life was over.

Participant #6. One time me and my mom went to shop on 34th Street in Manhattan. My mother was hungry so we went inside to eat. So we went inside and set at the counter. The White lady looked at us and she kept on doing what she was doing; she never one time acknowledged us. Eventually, my mom got up. I could see tears in her eyes and we just walked out.

Participant #7. My first experiences with invisibility occurred when I was a small kid, say age 7. I use to go to North Carolina. During that time I would see how proud and bold my grandfather was when he spoke with Black people, but when he spoke with White men he would "cow down" [assume on a more inferiority/invisible position] as I call it. You know he would speak soft, bow his head, not make eye contact. He was expected by them to be this way—invisible. Another example when I was in middle school I remember White boys would look at me and call me and other Black kids names. I mean, we were all different complexions, different heights, 4-inch differences, extreme differences. They would call me Kenny when I was [name removed]. I soon realized that they didn't see me. We [all the Black boys] were the same. They looked through us and simply saw our skin color. It was amazing to me because when I saw them, I could clearly see that they were different: different hair styles, different complexions, different hair colors…. But for them they didn't see any of that. So they really didn't see the person that they were talking to that they respected, they just looked over us and assumed that because we were Black we must all be like the same person. It was an incredible experience.

Thematic Code 1: Self-Affirmation

All seven study participants discussed the process of routinely affirming themselves as African-American males. For them, this process is important in understanding and staying true to who they are as African-American men in a society that often perceives them as less. Self-affirmation theory refers to the process of respond-

ing to threats to an individual's self-worth or self-image with affirming strategies to maintain positive self-image (Lannin, Guyll, Vogel, & Madon, 2013).

Cultural connectivity (1.1). For the participants, three key objectives are essential in affirming who they are as African-American males. Those objectives include (a) contact and communication with other African-American males (1.1.1), (b) understanding and exploring the historical context from which they came (1.1.2), and participating in counseling (1.1.3).

Having contact and communication with other African-American males was clearly articulated by all participants as key in self-affirmation (1.1.1). Being able to communicate and come in contact with other African-American males further affirmed their Blackness and brought about a sense of kindred spirit in a struggle for equity and equality. For the participants, this relationship was often with friends, their father, father figures, and mentors (people they respected, trusted, and often aspired to be). These relationships assisted in preventing societal standards, perceptions and beliefs that are based on White culture to cause identity confusion. Participant #1 stated, "I use other African-American male friends as sounding boards for invisibility experiences. They usually have had the same experience or something similar. They validate my experience and we are able to discuss how we handled it, how/what to think about it—how to handle it in the future."

All seven participants referenced understanding and exploring the historical context from which they came as an important aspect in identity development and self-affirmation (1.1.2). Participant #4 stated, "I am very aware of my Blackness. I affirm it every day…by constantly reflecting on the greatness of my ancestors, on the path that we've trotted and reflecting on the fact that we have an African-American president." All spoke about engaging in culturally relevant events and reading relevant books. All spoke about prominent historical and cultural African-American figures that assisted them in affirming who they are as African-American males. A few reoccurring names include Malcolm X, Martin Luther King, Jr., Marcus Garvey and President Barack Obama. Participants 4 and 5 expressed feelings that they were "standing on the shoulders of African-American men who came before them."

Participants 1–3 referenced counseling as beneficial in affirming who they are as African-American males, while participants 4 and 6 alluded to this (1.1.3). Participant 3 stated, "…I went through his (African-American counselor at the university counseling center) [counseling] program…it led to my metamorphosis. All three participants who articulated counseling as beneficial in the self-affirmation process discussed their strong desire to see an African-American male counselor—if not male, then an African-American female counselor.

Thematic Code 2: Self-Awareness

The self-awareness theme is evident throughout all aspects of the interviews. All seven participants discussed the ongoing process of becoming self-aware as essential in self-affirming and developing a strong identity. Self-awareness occurs when an individual acknowledges biases and understands the impact that they may have on perceptions, beliefs and attitudes (Suthakaran, 2011). Participants discussed how the process of becoming more self-aware assists them in moving from being very defensive when they feel they are being treated as invisible, to becoming more conscious of invisibility treatment in order to appropriately prepare for and deal with it.

Increase consciousness about individual and societal perceptions, beliefs and attitudes (2.1). For participants, self-affirmation (2.1.1) and identity development (2.1.2) are essential to the self-awareness process. All seven participants discussed reading and understanding African-American culture, history and experiences as important to the self-affirmation (2.1.1) and self-awareness process. Participant 6 stated that "learning the truth about Black history, it just builds a confidence in you; knowing the truth helps put things in perspective." All

seven participants discussed thinking differently about and reflecting on past experiences in order to learn, grow, and negotiate invisibility experiences. Additionally, all participants discussed how that process has assisted them in changing who they are emotionally, mentally and spiritually.

Participants acknowledged the process that identity development (2.1.2) plays in achieving self-awareness. According to Franklin (1999), "identity is achieved by successfully resolving the crises inherent in life choices and making purposeful decisions and stable commitments" (p. 772). Participants described racial identity development as the impact the negotiation of racial experiences has on the individual. Participants 4 and 5 stated, "as an African-American male you have to work twice as hard [to be acknowledged and respected]," while participant 7 stated, "you always have to be better than the best [to be acknowledged and respected]." Understanding their role in society and making decision and life choices as a result informs the identity development process.

Thematic Code 3: Coping with Invisibility

According to Franklin (1999), coping with invisibility involves "being able to discern when behavior is racist, and then acting consistent with one's sense of self" (p. 764). This personal struggle for visibility can be challenging and often overwhelming.

Building a social, spiritual and therapeutic support system that is accessible (3.1). For participants, coping with invisibility included (a) African-American male mentorship (3.1.1), (b) resiliency (3.1.2.), (c) establishing and maintaining a strong religious and spiritual foundation (3.1.3), and (d) counseling (3.1.4.).

All seven participants discussed the need to communicate overwhelming feelings of anger and frustration that result from feelings of invisibility to other Black men that they trust and value their opinions of (3.1.1). Communicating with another African-American male is central to coping with feeling of invisibility. Being understood in a world where you are often misunderstood and being able to relate to one another was powerful to all participants and assisted in coping with invisibility.

None of the participants perceived racism and invisibility as something that would soon dissipate. As a result, participants felt that being resilient was essential in coping with invisibility (3.1.2.). One participant discussed how he remained resilient by constantly reminding himself of how his ancestors overcame far worse, while also reflecting on how far this country (the United States) has come since slavery and remaining hopeful that the United States will continue to grow in the years to come. Participant 2 remained resilient by constantly reminding himself that we have a Black president, understanding his struggle as president, and using him as a model for the opportunities that lie before other Black men if they continue to work hard. Participant 2 stated, "when I am feeling low about the state of society I hold on to the fact that President Obama was able to be elected. That's like the miracle that I hold on to." Participant 2 stated, "Being invisible is normal for me. I expect it. I know where I'm going to be visible and where I'm not going to be visible."

Five participants discussed having strong spiritual or religious beliefs (3.1.3). Participant 4 stated "at times I need to pray and ask God for insight on racism and how incidents I experience affect me." Others were hopeful that the future would be brighter than the past for African-American males. Participant 4 alluded to this when he stated, "I know that things will be different when I join God in Heaven." Participant 3 discussed abandoning Christianity for African Islamic religious beliefs. Participant 3 explained that this process has assisted him in connecting with his African culture, and participant 6 discussed his transition from Islamic faith to Catholicism to Protestantism in search of his spiritual calling.

Lastly, all participants acknowledged the process of thinking differently as fundamental in coping with invisibility. All participants acknowledged that by thinking differently African-American males can overcome pitfalls

such as socially unacceptable emotions and behaviors, as well as responding defensively to feelings of invisibility. Furthermore, participants acknowledged how counseling (3.1.4) could assist in this area.

Thematic Code 4: Effectively Counseling African-American Males

The counseling theme is evident throughout all aspects of the interviews. All participants discussed counseling approaches that would be effective in working with African-American males who experience invisibility. The approaches outlined by the participants were humanistic in nature and included (a) authenticity (4.1.1), (b) unconditional positive regard (4.1.2), (c) empathetic understanding (4.1.3), and (d) self-awareness (4.1.4).

All seven participants discussed the need for counselors to be authentic (4.1.1). For participant 4, being authentic meant "avoiding politically correct statements and hiding behind real feeling and thoughts." They discussed the need to feel like the counselor demonstrated unconditional positive regard (4.1.2). The inherent need for acceptance is ignored when African-American males are invisible. When counselors are able to demonstrate unconditional positive regard, it fosters acceptance. Participant 2 stated, "Counselors should support my experience in spite of myself…"

All seven participants discussed the need to feel visible to the counselor. Participants discussed achieving visibility by acknowledging race, culture, ethnicity and other individual and collective attributes, while also validating the experiences of the client. Participants indicated that validation is achieved by being empathetic and understanding toward the client's experience (4.1.3). All participants discussed the need for the counselor to demonstrate empathy. Participant 7 stated, "Listening and being open to the experiences of African-American males and moving beyond book information about African-American males, but instead seeking contact with the group, is important in broadening counselor empathy and understanding." None of the participants sought sympathy, as they all demonstrated strong feelings of pride in themselves and their culture. Instead, the need for empathy and subjective understanding of their experience was essential.

Lastly, four participants discussed the need for both the counselor and client to be self-aware (4.1.4). For these participants, the counselors' self-awareness meant being open about their bia; exploring ways to be change agents (advocates), whether individually or collectively; and being able to openly express emotions in a way that encouraged growth. Participant 4 spoke to all the competencies presented in thematic code four by stating the following:

> Therapists that [have] an Afrocentric worldview or actually went through the struggle themselves [are needed]. You can have what I call an external concept of racism, but until you actually experience it or live it there is no dialogue. So, I would need a therapist, preferably a Black male or Black female, but more or less a male, who has gone through the same struggles…of being a Black male in America. Then I think we can have an open dialogue and try to reach some resolve… [If the counselor were White] it is somewhat possible [for them to provide the same support as a Black counselor] if they have a sense of empathy, a sense of positive regard, they are very objective…they can live through my experience vicariously [congruently] so that they can be understanding…and have an Afrocentric perspective.

Implications

Clinical Practice and Client Retention

This phenomenological study explored the lived invisibility experiences of seven African-American males. The four thematic codes that were extracted from the rich data gathered during the study were used to provide potential implications for clinical practice.

Findings showed that these African-American males encounter varying experiences and levels of invisibility on a daily basis. African-American males' strong sense of self and ability to affirm who they are as individuals and as African-Americans were core conditions of living in a world where they often feel invisible. Additional findings showed that for these participants, coping with invisibility included having a relationship with something or someone higher than themselves (religious or spiritual connection), embracing African-American history and culture, being resilient, connecting with the African-American community, and communicating with and observing other African-American men. Based on the findings, specific counseling theories and techniques as well as additional approaches were outlined as strategies for working with African-American males in clinical practice, and for retaining this population after initial visits.

Conclusions from the findings purported that counselors working with African-American males experiencing invisibility could encompass two fundamental approaches to counseling at the core of their clinical practice: multicultural and person-centered approaches. Encompassing these approaches provides the stability needed to encourage African-American males to participate in counseling, while also encouraging these clients to return to counseling. Building on these approaches, counselors should utilize additional humanistic-existential therapies, such as Adlerian and existentialism.

Specifically, the use of encouragement—fundamental in Adlerian counseling—and the promotion of social connections to foster a sense of belonging produces a stronger sense of self. Existentialism can assist in the quest for meaning and life purpose (Corey, 2001). Findings indicate that African-American males' social connection with other African-American males is pertinent in developing self-awareness, while also learning how to strive in society. Exploring self-awareness, goals, and the process it takes to reach goals during counseling sessions with African-American males can dually assist the client and counselor to better understand the clients' perspectives and life purpose. Additionally, assisting African-American male clients by encouraging relationships with other African-American males can assist with their quest for meaning and value.

Based on the findings, it appears that African-American males would benefit from social learning theoretical perspectives during counseling. Considering Bandura's social learning theory (1997), specific theoretical approaches include observational learning, nurturing intrinsic and extrinsic reinforcers (e.g. pride, the environment), and motivated modeling. Again, this could be encouraged through mentoring, social connections within the African-American community (e.g. volunteerism), and exposure and knowledge about the African-American experience.

Admittedly, many of these theories fall short when considered from a multicultural perspective. However, the additional use of specific techniques, applied appropriately, can become building blocks in working with African-American males. Moreover, counselors should promote resiliency as a means of coping with invisibility. To do this, counselors should consider connecting clients with or encouraging clients to garner an African-American male mentor. African-American males' connection with positive African-American male mentors is highly regarded by all participants in the study and key in coping with invisibility experiences. Additionally, the use of both psychoeducation and bibliotherapy groups geared toward African-American males encourages kinship, skill development, as well as cultural and historical understanding.

Furthermore, when considering the theoretical underpinnings of the study (Nigrescence, humanism and multiculturalism), three premises are put forward for counselors working with this populations: (a) collaborate with the individual as he works to make sense of himself as a social being (Cross, 1991; Cross & Vandiver, 2003); (b) understand and value the individual's subjective experience (e.g., feelings, opinions, values; Scholl, 2008), and (c) work to become more aware of both one's own culture (as the counselor) and the culture of the client in order to remove barriers, build rapport and overcome social stereotypes and bias.

Research

Based on the findings, future research might consider the impact that mentoring, religion and spirituality, cultural belonging, and resiliency have on African-American male racial identity development and African-American males' ability to cope with racial experiences. Potential research questions could include the following: How effective is mentoring in helping African-American males to cope with issues related to racial identity development? How do religion and spirituality assist African-American males in coping with issues related to racial identity development? Is resiliency a learned behavior for African-American males? Investigations in these areas have the potential to yield useful findings.

Limitations of the Study

Caution should be exercised when generalizing the study's findings to all African-American males. First, the study included only seven African-American males. While these seven participants garnered a rich amount of data to support the study, the qualitative nature of the study made generalizing this information across an entire group of people difficult. Quantitatively exploring the same research questions could provide more generalizable data. Second, the majority of the participants were educated, middle-class African-American males. A diverse group of African-American males was not considered in this study; a more diverse participant sample could enhance future research on this topic.

Conclusion

Throughout the study, participants clearly articulated that they did not think the process of feeling invisible would soon dissipate. Therefore, all participants encouraged learning how to cope with invisibility. Counselors can encourage African-American males to cope with invisibility by advocating resiliency, promoting self-awareness and identity development, affirming African-American identity both individually and collectively, fostering African-American male mentorships, teaching African-American males how to negotiate race, and encouraging historical and cultural knowledge and understanding. At the same time, African-American males cannot be taught to cope or change their cognition, behavior, or emotions without counselors advocating and working to change individual, systemic and institutional barriers that lead to feelings of invisibility.

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References

Bandura, A. (1997). *Self-efficacy: The exercise of control.* New York, NY: W. H. Freeman.

Corey, G. (2001). *Theory and practice of counseling and psychotherapy* (6th ed.). Belmont, CA: Brooks/Cole.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Cross, W. E., Jr. (1991). *Shades of black: Diversity in African-American identity*. Philadelphia, PA: Temple University Press.

Cross, W. E., Jr. (2003). Encountering nigrescence. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 30–44). Thousand Oaks, CA: Sage.

Cross, W. E., & Vandiver, B. J. (2003). Nigrescence theory and measurement: Introducing the Cross Racial Identity Scale

(CRIS). In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 371–393). Thousand Oaks, CA: Sage.

Du Bois, W. E. B. (1903). *The souls of Black folk.* New York, NY: Library of America.

Ellison, R. (1952). *Invisible man*. New York, NY: Random House.

Franklin, A. J. (1999). Invisibility syndrome and racial identity development in psychotherapy and counseling African American men. *The Counseling Psychologist*, *27*, 761–793. doi:10.1177/0011000099276002

Gibson, M. A., & Ogbu, J. U. (1991). *Minority status and schooling: A comparative study of immigrant and involuntary minorities.* New York, NY: Garland.

Giorgi, A. (1985). Sketch of a psychological phenomenological method. In A. Giorgi (Ed.), *Phenomenology and psychological research* (pp. 8–22). Pittsburgh, PA: Duquesne University Press.

Hays, D. G., & Wood, C. (2011). Infusing qualitative traditions in counseling research designs. *Journal of Counseling & Development*, *89*(3), 288–295. doi:10.1002/j.1556-6678.2011.tb00091.x

Hunt, B. (2011). Publishing qualitative research in counseling journals. *Journal of Counseling & Development*, *89(3)*, 296–300. doi:10.1002/j.1556-6678.2011.tb00092.x

Lannin, D. G., Guyll, M., Vogel, D. L., & Madon, S. (2013). Reducing the stigma associated with seeking psychotherapy through self-affirmation. *Journal of Counseling Psychology*, *60*, 508–519. doi:10.1037/a0033789

Levers, L. L., Anderson, R. I., Boone, A. M., Cebula, J. V., Edger, K., Kuhn, L., . . . Sindlinger, J. (2008, March). *Qualitative research in counseling. Applying robust methods and illuminating human context*. Program presented at the annual conference of the American Counseling Association, Honolulu, HI. Retrieved from http://counselingoutfitters.com/vistas/vistas08/Levers.htm

Oyserman, D., Gant, L., & Ager, J. (1995). A socially contextualized model of African American identity: Possible selves and school persistence. *Journal of Personality and Social Psychology*, *69*(6), 1216–1232. doi:10.1037/0022-3514.69.6.1216

Parham, T. A. (1999). Invisibility syndrome in African descent people: Understanding the cultural manifestations of the struggle for self-affirmation. *The Counseling Psychologist*, *27*, 794–801. doi:10.1177/0011000099276003

Scholl, M. B. (2008). Preparing manuscripts with central and salient humanistic content. *Journal of Humanistic Counseling, Education and Development*, *47*, 3–8. doi:10.1002/j.2161-1939.2008.tb00043.x

Sue, D. W., Ivey, A. E., & Pedersen, P. B. (1996). *A theory of multicultural counseling & therapy*. Pacific Grove, CA: Brooks/Cole.

Suthakaran, V. (2011). Using analogies to enhance self-awareness and cultural empathy: Implications for supervision. *Journal of Multicultural Counseling and Development*, *39*, 206–217.

Wang, Y.-W. (2008). Qualitative research. In P. P. Heppner, D. M. Kivlighan, & B. E. Wampold. (Eds.), *Research design in counseling* (3rd ed., pp. 256–295). Belmont, CA: Brooks/Cole.

Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology*, *52*(2), 167–177. doi:10.1037/0022-0167.52.2.167

A Relational-Cultural Framework: Emphasizing Relational Dynamics and Multicultural Skill Development

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Increases in diverse clientele have caused counselor education to enhance its focus on multicultural pedagogy, using the Tripartite Model (TM) to impart multicultural learning. While knowledge and awareness are important, it also is important to enhance skill development in counselors-in-training. Counselor educators have a unique opportunity to blend knowledge and awareness with skills learned in counseling techniques courses by incorporating microskills training in the multicultural classroom. Additionally, other theories, such as Relational-Cultural Theory (RCT), can be used as a framework to merge the TM and microskills. This article includes an overview of RCT, a brief history on microskills training and a case study to integrate the two concepts for use in counselor training. The reader should begin to see how microskills, RCT and the TM can serve to enhance skill development in the multicultural classroom.

***Keywords*: microskills, multicultural, Relational-Cultural Theory, counselor education, pedagogy**

Counseling as a profession espouses the need for counselors to be culturally competent, as evidenced by the inclusion of diversity training in preparation standards (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2009) and in ethical standards (American Counseling Association [ACA], 2005). According to the 2009 CACREP standards, an institution must provide instruction that includes "an understanding of the cultural context of relationships, issues, and trends in a multicultural society" (Section II, Code G.2, p. 10). Although the importance of multicultural competence is supported in preparatory and ethical standards, current pedagogical practices may be ineffective as graduates of counseling programs frequently report feeling unprepared to effectively work with culturally diverse clients (Bidell, 2005; Bidell, 2012; Rock, Carlson, & McGeorge, 2010). Therefore, counselor educators need to consider how to more effectively meet the challenge and responsibility of cultivating cultural competence for counselor trainees by focusing on increasing skill development (Cates, Schaefle, Smaby, Maddux, & LeBeauf, 2007; Dickson & Jepsen, 2007; Hays, 2008).

Priester et al. (2008) conducted a content analysis of 64 introductory master's-level multicultural course syllabi to understand the content of contemporary multicultural courses. The authors collected the syllabi by examining counseling program Web sites and contacting the instructor of record. Results indicated high emphasis in multicultural knowledge across syllabi, with over 84% of the syllabi highly emphasizing knowledge and moderate emphasis on self-awareness, with 41% of syllabi emphasizing self-awareness and a significantly lower emphasis of skill acquisition, and with only 12% of syllabi emphasizing skill development. Findings highlight relatively high emphasis on knowledge when working with culturally diverse groups and markedly

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lower levels of skill acquisition, potentially perpetuating the issue of counselor graduates not feeling adequately prepared. Although knowledge and self-awareness are critical components in developing cultural sensitivity, it is imperative to teach counselor trainees skills that will aid them in therapeutically connecting with their clients (West, 2005).

Counselor preparation programs are responsible for training students how to work with clients from all backgrounds; however, multicultural pedagogy has been found to be lacking in key areas (Braden & Shah, 2005), including focusing primarily on obtaining multicultural knowledge and awareness related to working with diverse groups, while failing to reinforce training in discrete skills (Priester et al., 2008). Knowledge alone does not lead to behavior or attitude change among counselor trainees and may actually reinforce culturally insensitive practices (Alberta & Wood, 2009; Arredondo & Toporek, 2004), creating a significant gap in education; while counselors-in-training are taught effective practices for personal multicultural development, they may not be given the necessary skills to use their new knowledge with diverse clients. Therefore, it is imperative to introduce new theories and integrate current theories into counselor education curricula to ensure that students are receiving well-rounded instruction in relation to multicultural competence.

To this end, the purpose of this paper is to highlight the use of RCT (Miller, 1986) as a vehicle to develop skills and integrate existing emphasis of knowledge and awareness in multicultural courses. The authors will begin with a brief overview of multicultural pedagogy and current approaches to multicultural instruction, followed by an introduction to microskills and a brief overview of RCT. The manuscript will close with a case study which integrates the concepts of the TM, microskills, RCT, implications for the field of counseling and conclusions.

Multicultural Pedagogy

As counseling professionals have become more aware of the complexity and interactions of culture on counseling relationships (Daniel, Roysircar, Abeles, & Boyd, 2004), several models have been developed that make recommendations for what constitutes a culturally competent counselor (Buckley & Foldy, 2010; Collins & Arthur, 2010; Sue, 2001). Although these models were pioneered by recognized experts in the field of multiculturalism, many authors agree that the central model in the field remains the TM, developed by Sue, Arredondo and McDavis (1992) (Holcomb-McCoy & Myers, 1999; Mollen, Ridley, & Hill, 2003). The TM has influenced major counseling bodies such as ACA and CACREP, standardizing multicultural content in counselor training ethics and accreditation (Holcomb-McCoy, 2000). Additionally, the TM has largely influenced current literature on multicultural pedagogy, placing considerable emphasis on teaching multicultural knowledge, skills and awareness to counselors-in-training (Hipolito-Delgado, Cook, Avrus, & Bonham, 2011). Essentially, the TM asks that counselors (a) have the necessary cultural knowledge of the population they will be assisting; (b) be aware of any cultural biases that the counselor may have regarding the client's culture and biases their client may have due to the counselor's perceived culture; and (c) have the necessary skills to assist clients of that particular culture, including understanding when to refer to more knowledgeable colleagues.

The TM has been refined on three occasions (1992, 1996, 2001), but past refinements have failed to address some of the major limitations of the model (Arredondo et al., 1996; Sue, 2001; Sue et al. 1992). Criticisms of the model are based on the lack of supporting literature to ground the three-dimensional model, difficulty measuring the factor structure of the model, and lack of relevance for practical application (Constantine, Gloria, & Ladany, 2002). Furthermore, although the TM provides a helpful framework in conceptualizing multiculturalism, it fails to highlight the importance of the therapeutic alliance when working with clients from diverse backgrounds. Extensions and applications of the TM include the development of the multicultural competencies (Sue et al., 1992). While the multicultural competencies highlight the importance of considering culture when devel-

oping the relationships, they fail to offer requisite skills that are necessary when developing relationships with culturally diverse clients. For example, the authors espouse using the model to "promote culturally effective relationships, particularly in interpersonal counseling" (Arredondo et al., 1996, p. 55); however, the competencies emphasize only that diverse relationships should be considered, not how they are to be achieved. Given that the TM is the preeminent model in which most multicultural courses are grounded, emphasis on relationships between the client and counselor and relationships between minority clients and majority society is minimal, highlighting the need for alternate conceptualizations and models that emphasize the therapeutic alliance (West, 2005).

Researchers suggest that often counselors teach clients how to best operate within the majority culture, failing to address the significance of contextual factors (e.g., socioeconomic status, education, literacy) that may be related to client distress (e.g., Comstock et al., 2008). When contextual factors are overlooked, the counselor and client are at increased risk for perpetuating cultural misunderstandings and negative attitudes toward counseling (Hartling, Rosen, Walker, & Jordan, 2000). Specifically, failing to attend to contextual factors may lead to disconnection, feelings of being misunderstood, and potential for weakening the therapeutic alliance, which increases the likelihood for treatment withdrawal (Duffey & Somody, 2011). In sum, there is heightened importance for multicultural pedagogy to increase focus on the relational and contextual factors when working with clients from diverse backgrounds. Therefore, it is imperative to teach counselors-in-training specific skills regarding how to be attentive to contextual factors.

Researchers (Roysircar, Gard, Hubell, & Ortega, 2005; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998) have found that exposure to varied multicultural experiences—both inside and outside of the classroom—increase various aspects of multicultural competence. Sodowsky et al. (1998) assessed multicultural competence while controlling for social desirability, race and attitudes of social inadequacy and locus of control. The authors found that multicultural training variables including minority client load, number of research projects, and multicultural training courses significantly contributed to overall multicultural counseling competency. In another study, Roysircar et al. (2005) used a mentoring program in which counseling students in a multicultural course were exposed to middle school students in an English as a Second Language course to develop trainee multicultural awareness. Counseling students in the study reported increased multicultural awareness as a result of the exposure to different cultures (Roysircar et al., 2005). It can be inferred from these studies that the inclusion of multicultural experiences during counselor training can contribute to student development in regard to the TM.

In sum, counselor educators have adapted to CACREP requirements through the application of several teaching models for multicultural competency including didactic (Abreu, 2001; Kim & Lyons, 2003) and experiential (Platt, 2012; Tomlinson-Clarke & Clarke, 2010) models for teaching multicultural competence. However, the efficacy of many of the existing models is unknown. Therefore, it may be helpful to employ a common standard across counselor education curricula to ensure that counselors-in training are receiving similar emphasis on the development of multicultural knowledge, awareness and skills. This common standard already exists in the microskills training that are used in counseling techniques courses.

Microskills

Microskills training is the primary pedagogy used in counselor education training. Counselors-in-training are taught the building blocks of counseling through discrete skills used to simplify abstract concepts (Mollen, Ridley, & Hill, 2003). The training model was developed as a result of work began by Truax and Carkuff (1967), who noticed that beginning and highly experienced counselors were equally skilled in facilitating therapeutic change, an anomaly given an experienced counselor's increased time in the field. The authors concluded that counseling students were being taught the importance of the relationship in counseling, but not how it is achieved; therefore experienced counselors had the knowledge base but lacked the ability to demonstrate respec-

tive skills. Ivey (1971) continued the work of Truax and Carkuff and coined the term *microskills* or "communication skill units of the [counseling] interview that will help [the student] interact more intentionally with a client" (Ivey & Ivey, 2003, p. 22). Microskills has been the preeminent method of counselor training for over 40 years, with over 450 studies completed on microskills training, highlighting the strong empirical base supporting its utility in counselor education (Ridley, Mollen, & Kelly, 2011). Although microskills are well researched and supported, the need to adapt these core counseling skills when working with diverse clients is not clear. Therefore, we, the authors, propose integrating RCT with microskills training to best meet the needs of diverse mental health clients.

Relational-Cultural Theory: A Fresh Perspective

Counselors are faced with an increased challenge to find ways to relate to diverse clients and build strong therapeutic alliances (Constantine, Hage, Kindaichi, & Bryant, 2007; Owen, Tao, Leach, & Rodolfa, 2011). While it is not feasible for counselors to understand the idiosyncrasies of every culture, it is possible to increase attention to cultural and contextual factors when building the therapeutic alliance (Vasquez, 2007). Furthermore, researchers have suggested that successful counseling must include empathic relationships that are culturally sensitive in nature and that employ techniques grounded in mutual empathy, defined as a mutual exchange of empathic experiences during the counseling session (Comstock, 2005; Duffey & Somody, 2011; Fuertes et al., 2006). Therefore, it is imperative for counselor educators to focus on emphasizing culture and empathy, and how to build therapeutic alliances when teaching counselor trainees to be culturally sensitive. An overview of RCT will be explored as a framework for incorporating the strategies of multicultural pedagogy, strong therapeutic alliance and mutual empathy into counseling with diverse clients.

Overview of RCT's Basic Tenets

Similar to multicultural theories, RCT is grounded in feminist theory. The theory was developed at the Stone Center for Women in 1977 through weekly meetings with Jean Baker Miller, Irene Stiver, Judith Jordan, and Janet Surrey (Jordan, 2008; West, 2005). Miller's (1986) book, *Towards a New Psychology of Women*, solidifies the ideas presented at these meetings and establishes a formal introduction of RCT. Theoretical underpinnings of RCT are grounded in the notion that primary counseling theoretical orientations placed unnecessary blame on the clients for their problems and did not account for the importance of relationships and contextual factors (West, 2005). Therefore, RCT was developed as a theory that emphasizes relationships and external factors, as opposed to focusing on internal pathology and mental illness. RCT states that individuals develop through mutually empowering relationships with others, asserting that the relationship, not autonomy, is the key to growth (Duffey & Somody, 2011). Furthermore, RCT highlights the importance of mutuality and authenticity between client and counselor, both gaining from shared experiences and leaving with a deeper understanding of themselves and the other person's perspective (Duffey & Somody, 2011).This mutual growth experience begins with the formation of relational images (West, 2005).

Relational images, defined as internal relational schemas or beliefs about an individual's relationships, are formed from experiences throughout the lifespan (Miller & Stiver, 1997). Positive or negative images form related connections or disconnections within the individual, resulting in the formation of relational images (Miller & Stiver, 1997; Napier, 2002). As individuals move throughout the lifespan, relational images are either confirmed or denied by various experiences. When an event is mutually empowering, it is referred to as a connection (Miller & Stiver, 1997). Conversely, when a person's experiences are in conflict with their relational images or when they are not mutually beneficial and empowering, they experience disconnections (Napier, 2002). Continuous damage to relational images may lead to negative beliefs including self-blame, isolation and immobilization (Jordan, 2001). Counselors may be at risk of weakening the therapeutic alliance by reinforcing disconnections or by neglecting the cultural context of the client's concerns (Duffey & Somody, 2011).

Disconnections are an expected occurrence and are necessary for growth (Jordan, 2008). However, constant disconnections can damage the client's relational images, possibly leading to counseling as a result of feelings of shame, confusion and decreased self-worth (Napier, 2002). When clients successfully move through disconnections, they may experience relational growth or relational resilience. Relational resilience refers to the ability to alter relational images and rebound from disconnection. Clients who experience relational resilience are more able to reconnect to others by increasing mutuality in relationships such as mutual support and growth (Duffey & Somody, 2011). In summary, RCT suggests that all persons seek connections, but internalized feelings may cause them to continually disengage as a mode of self-protection, resulting in a relational paradox; therefore, counselors can use the therapeutic alliance to reframe disconnections and reconstruct relational images (Miller & Stiver, 1997).

Counselors are well-positioned to facilitate dialogues with clients regarding relational disconnections, by discussing reasons and causes for disconnections and enabling the client to avoid placing complete responsibility or blame on their internal self. RCT suggests that the best way to realign and strengthen new relational images is through the therapeutic alliance (Jordan, 2008). The therapeutic alliance gives the client the opportunity to establish positive connections and repair relational distortions (West, 2005). By establishing a strong therapeutic alliance, the counselor provides an environment in which the client is able to begin reconnecting with his/her true self and demonstrating this behavior outside of counseling (Banks, 2006). Freedburg (2007) suggested that clients benefit when they can see their counselor as a fully dimensional human being, encouraging the client to carry the skills learned in therapy back into the real world. Therefore, the client must see the counselor as a mutually engaging human being who sees the client in a way that others have not.

In addition to emphasizing the therapeutic alliance, the use of mutual empathy in RCT encourages counselors to allow themselves to be affected by their client and share their experiences with clients when appropriate (Duffey & Somody, 2011). Mutual empathy also can be taught and reinforced during clinical internship/practicum. RCT suggests that counselors express their connections with their clients and invite feedback about how this has impacted the client (Comstock et al., 2008). During training counselor educators can illuminate instances where mutual empathy could be implemented in the counseling session. Additionally, RCT can be taught in conjunction with the ideas regarding authenticity in counseling. One-way empathy is considered a barrier that blocks authenticity due to creating a more contrived relationship, whereas counselors should instead strive for a relationship based on mutual respect, maximizing possibilities for relational equality and desires for emotional connectedness (Freedburg, 2007). Abernethy & Cook (2011) state that authenticity in counseling with RCT opens up both the client and the counselor to connect in a safe environment. This safe environment is important for multicultural understanding, as researchers (e.g., Comstock et al. 2008) have indicated that minority clients tend to feel disconnected in therapy due to feelings of being misunderstood by majority culture.

The goal of RCT in therapy is to first change negative self-images through mutual empowerment and mutual empathy (West, 2005). The counselor seeks to understand the reasons for relational disconnections and assist the client in repairing their distorted views of the relational process (Miller & Stiver, 1997). For example, a client's thoughts may change from "I could not make connections, so I am wrong" to "I could not make connections, so the connection is wrong." Change is achieved through genuine and authentic connections between the client and the counselor, grounded in mutual empathy and mutual exchange of ideas on the direction of treatment and goal setting (Duffey & Somody, 2011; West, 2005).

RCT and Counselor Training

RCT is a practical model which counselor educators can use to integrate multicultural knowledge with skill development through the use of mutual empathy to enhance the therapeutic alliance. Given that relationships between the clients and counselors have been found to be one of the most important aspects of the therapeutic

alliance and a consistent predictor of client outcomes, it is clear that there is primacy for the therapeutic alliance when teaching multicultural counseling (Baldwin, Wampold, & Imel, 2007; Castonguay, Constantino, & Holtforth, 2006). RCT emphasizes that individuals grow through their relationships with others and that the primary therapeutic goal is for the client to move out of perceived isolation (Duffey & Somody, 2011). By infusing RCT into multicultural courses, trainees may be better suited to form strong therapeutic alliances and demonstrate culturally appropriate forms of empathy when working with clients from diverse backgrounds. By encouraging counselor trainees to pay increased attention to contextual factors and relationships that may be impacting the client, trainees may have more insight and ability to empathize with their clients (Comstock, 2005; West, 2005). West (2005) suggests that by acknowledging external relationships and contextual factors, clients may feel more engaged in the counseling process, helping to reinforce the therapeutic alliance.

Integrating RCT, the TM, and Microskills Training

Microskills exist as the basis of counselor skill training and are widely used throughout the profession. These skills are carried through the counseling curricula into other courses, reinforcing and developing these basic skills to proficiency. Additionally, counselor educators have attempted to integrate the TM into multicultural training, following accreditation (CACREP, 2009) and ethical code (ACA, 2005) revisions. RCT can be used as a vehicle to blend both microskills and the TM to reinforce and simplify multicultural teaching strategies. Below is an overview of the ways that the TM, microskills and RCT can be combined for multicultural training.

Knowledge

The knowledge portion of the TM encourages multiculturally competent practitioners to gather information regarding the cultural and environmental histories of their clients (Arredondo et al., 1996). This information gathering allows practitioners to create a well-informed picture of client issues for accurate assessments and goal setting. RCT also espouses cultural knowledge through its belief in the client worldview. Client worldviews are important as they give detail to how clients interpret life events and how they form the basis of connections and disconnections (Jordan, 2001).

Understanding worldview can be achieved through targeted, open-ended questioning, which was first introduced during counseling skills courses. Rodriguez and Walls (2000) introduced the concept of culturally educated questioning, in which practitioners use knowledge-based questions to gather information relevant to treatment. Information from previous questions is used to build on more focused questions for a deeper understanding of the client. This concept can be tied into RCT by teaching counseling students to ask future clients questions specific to RCT concepts, including significant relationships and power structures.

Awareness

Multicultural awareness entails understanding how the counselors' cultural history may impact their clients (Arredondo et al., 1996). It is important for practitioners to understand how their multicultural makeup (e.g., race, gender, age) may have a bearing on the counseling relationship due to the client's experiences with these factors outside of counseling, as cultural mistrust has been identified as a barrier to treatment in minority clients (Duncan & Johnson, 2007; Whaley, 2001). RCT encourages practitioners to be aware of the power-over structures, which may exist within the relationships presented by the client (Jordan, 2008). Power-over structures include culturally relevant systemic issues that may affect client functioning, creating constant disconnection due to an effort to assimilate into majority culture (Jordan, 2008). It is important for counselors to be aware of how their role as the counselor and the hierarchical nature of the counselor-client relationship may affect the therapeutic alliance. Therefore, counselor educators can remind students of the importance of the relationship development from the onset of the counseling experience.

Skills

From a microskills perspective, counselor educators can remind students of the necessity of relationship building with clients as a foundation for therapeutic engagement. Rogers (1951) asserts that the counseling relationship is a key component for client growth and should be attained before interventions are begun. Young (2012) asserts that students should begin by establishing liking, respect and trust, which leads to client communication and openness. As reinforcement, RCT encourages practitioners to engage in authenticity with clients to create deeper engagement and to demonstrate positive connections that can be repeated outside of counseling (Jordan, 2008). Through the development of the relationship, clients and counselors work to decrease the hierarchical nature of the relationship. Counselor educators use microskills training to teach counselors-in-training to use empathy as a method for connecting to clients and to understand issues from the client's frame of reference (Ivey & Ivey, 2003). RCT goes a step further with its emphasis on mutual empathy, a technique to allow the client to see, hear and feel that their story has affected the counselor (Jordan, 2001).

Mutual empathy has many similarities to the widely accepted definition of empathy; however, a few key differences exist. Mutual empathy requires that the counselor allow themselves to be affected by the client because detachment may interfere with therapeutic healing (Duffey & Somody, 2011). Mutual empathy is demonstrated by continually checking in with the client through empathic exchange, enabling the counselor to better understand the client's worldviews and inviting the client to react to the mutual exchange. Allowing the client to react to the exchange constitutes the difference between mutual empathy and empathy, with the counselor inviting the client to engage in empathic exchange instead of the counselor simply making empathic statements. Counselor educators can reinforce this behavior in the classroom by teaching students to request client reactions to certain empathic statements. The act of mutual empathy can create a more meaningful relationship by encouraging both client and counselor to fully participate in the exchange and feel the impact that each participant has on the other (Freedburg, 2007). For example, after making an empathic statement, trainees can be requested to respond based on the empathic statement from the client in order to demonstrate mutual empathy.

In conclusion, infusing central tenets of RCT in multicultural pedagogy through the use of microskills may be an effective way to prepare counselor trainees to meet the demands of working with clients from all backgrounds. RCT's synthesis of multicultural knowledge and focus on obtaining skills provides trainees with universal tools for developing strong multicultural competence at every stage of the counseling process. By focusing on the relational aspects of counseling through the use of microskills, trainees will be able to demonstrate culturally sensitive counseling. We provide a brief case illustration to highlight core tenets of RCT in practice.

Case Illustration

James (pseudonym) is a 22-year-old college student at a large university and has entered counseling with feelings of "constant anger" and "frustration" toward his family, friends and professors. James states that his actions are pushing others away, resulting in feelings of isolation. He describes spending much time in his bedroom in order to avoid conflict and reports feeling increasingly depressed. When he does engage with others, he finds that conflict often arises, causing him to either minimize the importance of the issue or withdraw from the offending individual in an effort to refrain from lashing out. James reports that while there are important things he would like to say during these moments, he relents because he does not want to heighten conflict.

Through the course of counseling, James describes varying degrees of emotional connection to his family and friends. He currently lives with his older sister and another roommate in a home owned by his parents. James is of Colombian descent and moved back and forth between his home country and Miami between the ages of 9 and 16. His parents are married, although his mother lives in Miami while his father lives in Colom-

bia in order to maintain the family business. Both of his siblings are pursuing what he considers "successful" careers; his older brother is in law school and his older sister is in medical school. James has one year left to complete his undergraduate degree and is currently studying accounting. His relationships with his parents and siblings are important to him; however, he admits to hiding information, including his visits to therapy and feelings regarding friends and familial issues, as he fears reprisal or invalidation. He also consistently compares himself to his older siblings and feels that he does not live up to his potential within his family. Lastly, James has a fairly large social network, belonging to a coed fraternity for the past 2 years. Although he interacts with several members of the organization, he consistently feels misunderstood or ignored.

RCT Counselor Response

RCT is a broad and flexible framework, which can be employed in a multitude of ways. For the purposes of this article, the authors take a closer look at using worldview/cultural context, authenticity, disconnections, and mutual empathy in order to understand a different way to relate to James. The authors also demonstrate how each of these facets can be incorporated with microskills training.

Worldview/cultural context. In order to set the stage for client conceptualization, the initial focus of the relationship should be the client's cultural context. Exploring the client's worldview will give the practitioner an opportunity to understand the client's cultural context and allow the client to feel heard, which is essential to RCT and the therapeutic alliance. After a few sessions, the counselor notes that James operates in many different areas, creating a rich worldview for the counselor to explore.

It is important at this stage to employ culturally educated questioning to enhance the counselor's multicultural knowledge regarding the client. The counselor asks open-ended questions that are tailored to gather specific information about the client's worldview as more information is shared between the client and counselor. Through exploration of his worldview, James indicates that his primary identification is a student, which colors all of his other worldviews and affects the primacy of other responsibilities contained within his other cultural contexts. James's secondary identification is being a fraternity member. However, due to his studies, there are times when he is forced to forgo fraternity events so that he can be prepared for classes. The stress caused from his failing grades and inability to meet fraternal obligations adds to his anger issues. James also discusses his Colombian heritage and the importance of family, giving insight to his decision making. Exploring James's daily activities, cultural groups and relationships helps build initial rapport and creates an early therapeutic alliance, while also giving insight into possible stressors for James. This alliance is carried through to other parts of the session, as the client feels comfortable giving detail, knowing that his particular worldview will be encouraged and respected.

Connections and disconnections. James feels unheard by his fraternity brothers and inferior to his family members. Deeper investigations into these relationships reveal that James's peers and family members are not able to accept and understand his feelings, creating an empathic disconnect. The results of this disconnect cause James to become aggressive when he cannot get his point across. Using RCT, the counselor and James analyze the disconnection in each of his familial relationships and how they affect his current functioning and relationships with others. For example, James's relationship with his brother is often very tense, causing him to retreat from conflict or release his anger in a nonproductive fashion. These behaviors are repeated when James comes into conflict with others, such as his fraternity brothers.

Next, the counselor helps James identify positive, mutually beneficial connections with others in his social circle. When asked what is different about these relationships, he shares that he feels open to discussing his emotions with these individuals and that his feelings are valued. To help build the therapeutic alliance, the counselor directly asks James what can be done to build a similar, mutually beneficial connection within their coun-

seling sessions. James responds that he wants to feel safe and respected so that he can share his views without judgment. The counselor then seeks to create this type of environment using the tenets of mutual empathy and authenticity.

Counselors should be aware of power-over structures, which can alter how relationships are perceived. When counselor educators teach students to employ multicultural awareness, it is important to remind students of how existing societal structures may determine how students form relationships with members of society. RCT asks that counselors analyze client relationships and how they contribute to functioning with regard to positive and negative aspects of various relationships. Counselors can inquire about the important relationships in their clients' lives and whether these relationships are mutually beneficial.

Mutual empathy and authenticity. While less emphasized in multicultural courses, counselor educators who teach counseling technique courses have the opportunity to reinforce multicultural skill development. Empathy development is taught as a foundational skill in counseling techniques courses, which begins during the initial phases of relationship development. Using RCT, counselor educators can teach the advanced skill of mutual empathy to help deepen the relationship between client and counselor.

In order to move from disconnection to connection, the counselor attempts to create a supportive environment using the RCT concepts of mutual empathy and authenticity by reaffirming the client's story and attempting to accurately reflect the client's emotion. When the client shares something that was particularly difficult, the counselor reflects feeling and shows appreciation for the client's strength in addressing a difficult issue. In order to demonstrate mutual empathy, the counselor shares how he has been affected by James's disclosure and asks how he feels about that action. James affirms being heard and respected, qualities that are necessary for mutually beneficial connection. For example, after James shares a particularly difficult story regarding feeling frustrated by others making decisions for him, the counselor re-affirms his story through empathic response, but then uses mutual empathy to ask how it feels to hear that his frustration is understood. Using RCT allows the client to feel that he is truly understood, and evidence of a more robust therapeutic alliance is seen through James's increased willingness to share and explore themes.

Implications for Counselor Educators

Counselor educators have done much to incorporate multicultural development into counseling curricula. Through CACREP and ACA standards, counselor educators have received a blueprint for developing multiculturally competent practitioners. Counselor educators also have an established method of training through microskills, which are used to help students learn the building blocks of counseling. However, at this time very few counseling theories have sought to bridge both multicultural development and microskills training.

The purpose of this article is to provide a tool for counselor educators to help integrate the TM, (awareness, knowledge, skills) into classroom instruction using microskills training. The TM and RCT have concepts that mirror each other and that, when combined, can create a practical framework for students in progressing toward multicultural competence. When microskills training is used as a vehicle for instruction, students will have a tangible and discrete set of skills to use with diverse clients which may increase self-efficacy, improve the counseling relationship and improve treatment outcomes. Using RCT in multicultural coursework provides counselor educators with an educational tool to better apply the TM and meet the need to increase the emphasis of skills in multicultural courses.

Counseling using RCT principles includes bringing meaning to the client's relationships and exploring his or

her relational images (Jordan, 2001). Additionally, Jordan (2010) states that clients must be aware that they are having an impact on their counselors. Counselor educators have the ability to combine elements of RCT with microskills to enhance multicultural development in students. By linking knowledge, awareness and skills with the RCT elements of emphasis on worldview, power-over structures, and mutual empathy, counselor educators give students tangible skills that can be employed with multicultural clients. Funneling these two concepts through microskills gives counselor educators an available and proven framework to structure student learning.

Suggestions for Future Research

Like all theories, RCT is not without shortcomings. Because RCT is based on relational focus and views on openness between counselor and client, RCT may not be suitable for all counseling relationships. For example, Jordan (2010) states that RCT may not be effective with clients who have sociopathic personalities, due to such clients' avoidance of authentic interactions. If a client is not willing to honestly engage the counselor, mutuality is lost. RCT also requires a level of authenticity that some counselors may not be comfortable with, specifically those with boundary issues. Counselors trained in other theories are taught to keep certain levels of relational distance between themselves and the client. However, Walker (2004) makes note that RCT practitioners strive for a level of relational clarity while avoiding language that implies separateness and objectification.

Currently, research is sparse in the area of using RCT as a method of instruction, most likely because RCT has not yet been operationalized, making it difficult to teach. Previously, the theory has been described as a way of being or an understanding, instead of a direct set of techniques that can be imparted to students. Oakley et al. (2013) have suggested using RCT in a brief model of treatment, stating their intention to develop a manual, which may help counselor educators in teaching the elements of RCT. Researchers should continue to focus on finding ways to clarify the process of RCT; its strong focus on relationships, worldviews and advanced techniques such as mutual empathy could create stronger counselors.

Conclusion

In summary, it is essential for counselors-in-training to be aware of how to put the TM into action. Current multicultural pedagogy primarily emphasizes learning in the knowledge and awareness domains, rarely making skill development a focus during counselor training. Given the changing demographics and increased growth of the minority population in the United States, training counselors to be effective with working with all clients is imperative. Counselor educators are in the unique position to prepare students for multicultural engagement before they begin practice. The infusion of RCT into counseling techniques courses gives counselors-in-training exposure to a different perspective, which incorporates the multicultural competencies with relationship building skills. RCT, with its emphasis on mutual empathy, relationships and contextual factors, enables counselors to gain a greater depth and breadth of minority client experiences, potentially strengthening the therapeutic alliance.

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References

Abernethy, C., & Cook, K. (2011). Resistance or disconnection? A relational-cultural approach to supervisee anxiety and nondisclosure. *Journal of Creativity in Mental Health*, *6*(1), 2–14. doi:10.1080/15401383.2011.560067

Abreu, J. M. (2001). Theory and research on stereotypes and perceptual bias: A didactic resource for multicultural counseling trainers. *The Counseling Psychologist*, *29*(4), 487–512. doi:0.1177/0011000001294002

Alberta, A. J., & Wood, A. H. (2009). A practical skills model for effectively engaging clients in multicultural settings. *The Counseling Psychologist*, *37*(4), 564–579. doi:10.1177/0011000008326231

American Counseling Association. (2005). *ACA code of ethics*. American Counseling Association. Alexandria, VA: Author.

Arredondo, P., & Toporek, R. (2004). Multicultural counseling competencies = ethical practice. *Journal of Mental Health Counseling*, *26*(1), 44–55.

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C, Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, *24*, 42–78. doi:10.1002/j.2161-1912.1996.tb00288.x

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*, 842–852. doi:10.1037/0022-006X.75.6.842

Banks, A. L. (2006). Developing student affect in a university self-defense course. *Physical Educator*, *63*, 8–17.

Bidell, M. P. (2005). The Sexual Orientation Counselor Competency Scale: Assessing attitudes, skills, and knowledge of counselors working with lesbian, gay, and bisexual clients. *Counselor Education and Supervision*, *44*(4), 267–279. doi:10.1002/j.1556-6978.2005.tb01755.x

Bidell, M. P. (2012). Examining school counseling students' multicultural and sexual orientation competencies through a cross-specialization comparison. *Journal of Counseling & Development*, *90*(2), 200–207. doi:10.1111/j.1556-6676.2012.00025.x

Braden, J. P., & Shah, K. G. (2005). A critique of multicultural training in school psychology: Rationale, strategies, and tactics. In C. L. Frisby & C. R. Reynolds (Eds.), *Comprehensive handbook of multicultural school psychology* (pp. 1023–1047). New York, NY: Wiley.

Buckley, T. R., & Foldy, E. G. (2010). A pedagogical model for increasing race-related multicultural counseling competency. *The Counseling Psychologist*, *38*, 691–713. doi:10.1177/0011000009360917

Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, Research, Practice, Training*, *43*, 271–279. doi:10.1037/0033-3204.43.3.271

Cates, J. T., Schaefle, S. E., Smaby, M. H., Maddux, C. D., & LeBeauf, I. (2007). Comparing multicultural with general counseling knowledge and skill competency for students who completed counselor training. *Journal of Multicultural Counseling and Development*, *35*(1), 26–39. doi:10.1002/j.2161-1912.2007.tb00047.x

Collins, S., & Arthur, N. (2010). Culture-infused counseling: A fresh look at a classic framework of multicultural counselling competencies. *Counselling Psychology Quarterly*, *23*, 203–216. doi:10.1080/09515071003798204

Comstock, D. L. (Ed.). (2005). *Diversity and development: Critical contexts that shape our lives and relationships.* Belmont, CA: Thomson Brooks/Cole.

Comstock, D. L., Hammer, T. R., Strentzsch, J., Cannon, K., Parsons, J., & Salazar II, G. (2008). Relational-cultural theory: A framework for bridging relational, multicultural, and social justice competencies. *Journal of Counseling & Development*, *86*, 279–287. doi:10.1002/j.1556-6678.2008.tb00510.x

Constantine, M. G., Gloria, A. M., & Ladany, N. (2002). The factor structure underlying three self-report multicultural counseling competence scales. *Cultural Diversity & Ethnic Minority Psychology*, *8*, 334–345. doi:10.1037/1099-9809.8.4.335

Constantine, M. G., Hage, S. M., Kindaichi, M. M., & Bryant, R. M. (2007). Social justice and multicultural issues: Implications for the practice and training of counselors and counseling psychologists. *Journal of Counseling & Development*, *85*, 24–29. doi:10.1002/j.1556-6678.2007.tb00440.x

Council for Accreditation of Counseling and Related Educational Programs. (2009). *2009 standards for accreditation.* Alexandria, VA: Author.

Daniel, J. H., Roysircar, G., Abeles, N., & Boyd, C. (2004). Individual and cultural-diversity competency: Focus on the therapist. *Journal of Clinical Psychology*, *60*, 755–770. doi:10.1002/jclp.20014

Dickson, G. L., & Jepsen, D. A. (2007). Multicultural training experiences as predictors of multicultural competencies: Students' perspectives. *Counselor Education and Supervision*, *47*(2), 76–95. doi:10.1002/j.1556-6978.2007.tb00040.x

Duffey, T., & Somody, C. (2011). The role of relational-cultural theory in mental health counseling. *Journal of Mental Health Counseling*, *33*, 223–242.

Duncan, L. E., & Johnson, D. (2007). Black undergraduate students attitude toward counseling and counselor preference. *College Student Journal*, *41*, 696–719.

Freedburg, S. (2007). Re-examining empathy: A relational-feminist point of view. *Social Work*, *52*, 251–259. doi:10.1093/sw/52.3.251

Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersh, M., & Cheng, B. (2006). Therapist multicultural competency: A study of therapy dyads. *Psychotherapy: Theory, Research, Practice, Training*, *43*, 480–490. doi:10.1037/0033-3204.44.1.13

Hartling, L. M., Rosen, W. B., Walker, M., & Jordan, J. V. (2004). Shame and humiliation: From isolation to relational transformation. In J. V. Jordan, M. Walker, L. M. Hartling (Eds.), *The complexity of connection: Writings from the Stone Center's Jean Baker Miller Training Institute* (pp. 103–128). New York, NY: Guilford.

Hays, P. A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy*. Washington, DC: American Psychological Association.

Hipolito-Delgado, C. P., Cook, J. M., Avrus, E. M., & Bonham, E. J. (2011). Developing counseling students' multicultural competence through the multicultural action project. *Counselor Education and Supervision*, *50*, 402–421. doi:10.1002/j.1556-6978.2011.tb01924.x

Holcomb-McCoy, C. C. (2000). Multicultural counseling competencies: An exploratory factor analysis. *Journal of Multicultural Counseling and Development*, *28*, 83–97. doi:10.1002/j.2161-1912.2000.tb00609.x

Holcomb-McCoy, C. C., & Myers, J. E. (1999). Multicultural competence and counselor training: A national survey. *Journal of Counseling & Development*, *77*, 294–302. doi:10.1002/j.1556-6676.1999.tb02452.x

Ivey, A. E. (1971). *Microcounseling: Innovations in interviewing training*. Springfield, IL: Charles C. Thomas.

Ivey, A. E., & Ivey, M. B. (2003). *Intentional interviewing and counseling: Facilitating client development in a multicultural society* (5th ed.). Pacific Grove, CA: Brooks/Cole.

Jordan, J. V. (2001). A relational-cultural model: Healing through mutual empathy. *Bulletin of the Menninger Clinic*, *65*, 92–103.

Jordan, J. V. (2008). Recent developments in relational-cultural theory. *Women & Therapy*, *31*, 1–4. doi:10.1080/02703140802145540

Jordan, J. V. (2010). *Relational-cultural therapy.* Washington, DC: American Psychological Association.

Kim, B. S., & Lyons, H. Z. (2003). Experiential activities and multicultural counseling competence training. *Journal of Counseling & Development*, *81*(4), 400–408. doi:10.1002/j.1556-6678.2003.tb00266.x

Miller, J. B. (1986). *Toward a new psychology of women* (2nd ed.). Boston, MA: Beacon Press.

Miller, J. B., & Stiver, I. P. (1997). *The healing connection: How women form relationships in therapy and in life.* Boston, MA: Beacon Press.

Mollen, D., Ridley, C. R., & Hill, C. (2003). Models of multicultural competence: A critical evaluation. In D. B. Pope-Davis, H. L. K. Coleman, W. M. Liu, & R. Toporek (Eds.), *Handbook of multicultural competencies in counseling & psychology* (pp. 21–36). Thousand Oaks, CA: Sage.

Napier, M. B. (2002). *Staying connected: Incorporating a client centered nondirective attitude into the Stone Center's model of relational-cultural therapy* (Doctoral dissertation). Retrieved from PsycINFO database. (Accession No. 2002-95020-134)

Oakley, M. A., Addison, S. C., Piran, N., Johnston, G. J., Damianakis, M., Curry, J.,…Weigeldt, A. (2013). Outcome study of brief relational-cultural therapy in a women's mental health center. *Psychotherapy Research*, *23*(2), 137–151. doi:10.1080/10503307.2012.745956

Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy*, *48*(3), 274–282. doi:10.1037/a0022065

Platt, J. J. (2012). A Mexico City-based immersion education program: Training mental health clinicians for practice with Latino communities. *Journal of Marital and Family Therapy*, *38*(2), 352–364. doi:10.1111/j.1752-

0606.2010.00208.x
Priester, P. E., Jones, J. E., Jackson-Bailey, C. M., Jana-Masri, A., Jordan, E. X., & Metz, A. J. (2008). An analysis of content and instructional strategies in multicultural counseling courses. *Journal of Multicultural Counseling & Development*, *36*, 29–39. doi:10.1002/j.2161-1912.2008.tb00067.x
Ridley, C. R., Mollen, D., & Kelly, S. M. (2011). Beyond microskills: Toward a model of counseling competence. *The Counseling Psychologist*, *39*, 825–864. doi:10.1177/0011000010378440
Rock, M., Carlson, T. S., & McGeorge, C. R. (2010). Does affirmative training matter? Assessing CFT students' beliefs about sexual orientation and their level of affirmative training. *Journal of marital and family therapy*, *36*(2), 171–184. doi:10.1111/j.1752-0606.2009.00172.x
Rodriguez, R. R., & Eugene Walls, N. (2000). Culturally educated questioning: Toward a skills-based approach in multicultural counselor training. *Applied and Preventive Psychology*, *9*(2), 89–99.
Rogers, C. R. (1951). *Client-centered therapy*. Boston, MA: Houghton Mifflin.
Roysircar, G., Gard, G., Hubbell, R., & Ortega, M. (2005). Development of counseling trainees' multicultural awareness through mentoring English as a second language students. *Journal of Multicultural Counseling and Development*, *33*, 17–36. doi:10.1002/j.2161-1912.2005.tb00002.x
Sodowsky, G. R., Kuo-Jackson, P. Y., Richardson, M. F., & Corey, A. T. (1998). Correlates of self-reported multicultural competencies: Counselor multicultural social desirability, race, social inadequacy, locus of control racial ideology, and multicultural training. *Journal of Counseling Psychology*, *45*, 256–264. doi:10.1037/0022-0167.45.3.256
Sue, D.W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, *29*, 790–821. doi:10.1177/0011000001296002
Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development*, *70*, 477–486. doi:10.1002/j.1556-6676.1992.tb01642.x
Tomlinson-Clarke, S. M., & Clarke, D. (2010). Culturally focused community-centered service learning: An international cultural immersion experience. *Journal of Multicultural Counseling and Development*, *38*(3), 166–175. doi:10.1002/j.2161-1912.2010.tb00124.x
Truax, C. B., & Carkhuff, R. R. (1967). *Toward effective counseling and psychotherapy: Training and practice*. Chicago, IL: Aldine.
Vasquez, M. J. T. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist*, *62*, 878–885. doi:10.1037/0003-066X.62.8.878
Walker, M. (2004). How relationships heal. In M. Walker & W. B. Rosen (Eds.), *How connections heal: Stories from relational-cultural therapy* (pp. 3–21). New York, NY: Guilford.
West, C. K. (2005). The map of relational-cultural theory. *Women & Therapy*, *28*(3–4), 93–110. doi:10.1300/J015v28n03_05
Whaley, A. L. (2001). Cultural mistrust: An important psychological construct for diagnosis and treatment of African Americans. *Professional Psychology: Research and Practice*, *32*, 555–562. doi:10.1037/0735-7028.32.6.555
Young, M. E. (2012). *Learning the art of helping: Building blocks and techniques* (5th ed.). New York, NY: Pearson.

Professional Identity of Counselors in Mexico: A Commentary

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The authors conducted an exploratory study using cultural domain analysis to better understand the meaning that advanced students and professional counselors in Mexico give to their professional identity. More similarities than differences were found in the way students and professionals define themselves. The most relevant concepts were empathy, ethics, commitment, versatility, training and support. Students gave more weight to multiculturalism and diversity, whereas professionals prioritized commitment and responsibility at work. Prevention did not appear as a relevant concept, posing challenges for professional counselor training programs in Mexico.

***Keywords*: professional identity, multiculturalism, ethics, prevention, counselor training, Mexico**

In the field of professional counseling, it is important to consider the benefit of developing a strong professional identity. Initiative 20/20: Vision for Counseling's Future, represented by influential organizations such as the American Counseling Association (ACA), the Council for Accreditation of Counseling and Related Educational Programs (CACREP), and the National Board for Certified Counselors (NBCC), identifies principles that must be developed in order to strengthen the counseling profession (ACA, n.d.). These principles include sharing a common professional identity and presenting the counseling profession in a unified way. CACREP (2009) recognizes the relevance of promoting professional development in counseling programs; the organization's standards were written to ensure that counseling student development is congruent with professional identity, as well as the necessary knowledge and skills to practice counseling effectively and efficiently.

In Mexico, steps have been taken toward developing such standards. The Mexican Association for Counseling and Psychotherapy (AMOPP), founded in 2008, has stated in its mission and objectives the promotion of counselor identity and stimulation of professional development (AMOPP, 2014). However, the process of defining professional identity for counselors has complex aspects that imply a great challenge for the Mexican counseling guild (Calva & Jiménez, 2005; Portal, Suck, & Hinkle, 2010).

First, there are few Mexican university programs that train counselors. The only such Mexican graduate program is the master in counseling (maestría en orientación psicológica) at Universidad Iberoamericana, which started in fall 2003 and was awarded CACREP accreditation in 2009. This program prepares students in prevention, evaluation and intervention using an integrative approach that includes theories and techniques, promotion of multicultural sensibility, and a focus on vulnerable populations (Universidad Iberoamericana, n.d.-a). Most students in this master in counseling program have a bachelor's degree in psychology, which makes for a mixed psychologist/counselor identity that is not easy to separate, and that is likely experienced as a psychological specialty by faculty, students and the general public.

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In contrast to countries like the United States and Canada, where a bachelor's degree is awarded first and students professionalize afterward at the graduate level, in Mexico, students professionalize at the undergraduate level, which promotes professional identity at this point. Thus, in Mexico the possibility of studying for an undergraduate professional program in counseling does not exist, which contributes to the difficulty of counseling being recognized as an independent profession.

There are plenty of reasons to study the professional identity of counselors in Mexico. First, counseling awareness within the community could be increased, making counseling accessible to a population that needs quality mental health services. The Mexican Poll of Psychiatric Epidemiology (ENEP) of the National Institute of Psychiatry reveals that 28.6% of the population presents some type of psychiatric disorder at some point in life, mostly anxiety (14.3%), followed by the use of illegal substances (9.2%) and affective disorders (9.1%). Nevertheless, despite this high incidence of mental health problems, only 10% of the population that presents with a mental disorder receives the attention it needs (Medina-Mora et al., 2003).

Secondly, there is limited professional literature in Mexico regarding professional counseling. Searching behavioral science databases revealed only one reference in a Mexican book regarding psychologists' professional identity (Harsh, 1994) and no articles about counselors' professional identity. If the professional identity of counselors in Mexico were more defined, it could help prospective students who are interested in studying counseling. It also could help practicing counselors form a solid base to serve as a platform to strengthen and enrich their professional behavior and clarify their professional identity. Neukrug (2007) has stated that when counselors find out who they are, they will know their limits and relationships with other professions. Therefore, the authors explored the professional identity of counselors in Mexico to better understand their definitive characteristics.

Professional identity, according to Balduzzi and Corrado (2010), is the definition one makes about self in relation to work and an occupational guild. It begins with training, during which professional identity can be promoted or obstructed, and includes interactions with others as well as modeling. Counselors begin to develop professional identity as they are trained (Auxier, Hughes, & Kline, 2003; Brott & Myers, 1999), integrating personal characteristics in the context of a professional community (Nugent & Jones, 2009). Brott and Myers (1999) studied how professional identity is developed among school counseling graduate students in the United States and reported that counselors develop an identity that serves as a reference for professional decisions and assumed roles. These researchers used grounded theory to explain the identity development process of counselors in training. First, students go through a stage of dependence to attain the stage of independence at which the locus of control is internal and the counseling student has the opportunity for self-evaluation without external evaluation. In this advanced stage, experience is integrated with theory, joining personal and professional identities.

To analyze the development of professional identity in counseling students in the United States, Auxier et al. (2003) developed their research from a constructivist model that assumed reality is socially developed, determined by the place where it is elaborated and based on the participants' experience. They developed the model of "recycling identity formation processes" (p. 32). This model explains that for constructing an identity, a person needs to go through (a) conceptual learning via classes and lectures; (b) experiential learning by practices, dynamics and internship; and (c) external evaluation from teachers, supervisors, coworkers and clients.

Nelson and Jackson (2003) wanted to better understand the development of professional identity among Hispanic counseling students in the United States. They conducted a qualitative study and found seven relevant topics: knowledge, personal growth, experience, relationships, achievements, costs, and perceptions of the

counseling profession (Nelson & Jackson, 2003). Although the results were congruent with other findings, such as the need to be accepted and included, relationships such as those available from caring faculty or the support of family and friends were identified as meaningful factors that contribute to formation of a professional identity.

Similarly, du Preez and Roos (2008) used social constructivism to analyze the development of professional identity in South African students between the fourth and last year of their studies as undergraduate counselors. Participants elaborated on visual and written projects regarding their professional development training. Through an analysis of this work, four professional identity themes were identified: capacity for uncertainty, greater self-knowledge, self-reflection and growth (du Preez & Roos, 2008).

Skovholt and Ronnestad (1992) explained that identity development implies progress of attitudes about responsibility, ethical standards, and membership in professional associations. According to the Skovholt and Ronnestad (1992), a counselor's identity differs from other professional identities because a therapeutic self is shaped by a mixture of professional and personal development. The researchers explained that professional identity is a combination of professional self (e.g., roles, decisions, applying ethics) and personal self (e.g., values, morals, perceptions) that create frameworks for decision making, problem-solving patterns, attitudes toward responsibilities, and professional ethics.

In one of the few quantitative investigations on the topic, Yu, Lee and Lee (2007) used the concept of "collective self-esteem" (p. 163) as a synonym for collective and professional identity. They conducted a study to learn whether the collective self-esteem of counselors influences or mediates their work satisfaction and how they relate to clients. The researchers found that "job dissatisfaction is negatively related to greater levels of private collective self-esteem, and in turn, greater private collective self-esteem is positively related to better client relationships" (p. 170). Based on their conclusions, it is important to study the professional identity of counselors in Mexico, who must work from a place of job satisfaction and good client relationships in order to successfully address their clients' social needs.

Hellman and Cinamon (2004) performed a series of semi-structured interviews for 15 professional school counselors with a consensual qualitative research (CQR) strategy to classify counselors through the stages of Super's (1992) career theory: exploration, establishment, maintaining and specialization. The classification was made according to the perceptions the researchers described about counseling, professional identity, work patterns, and resources and barriers at work. In the beginning stages of their career, counselors describe school counseling as a job or a role, but later they consider counseling a profession. Furthermore, counselors start by depending on external recognition, specific techniques, and highly structured programs. As they become more experienced, counselors gain self-confidence and rely more on their professional judgment.

In general, researchers have described subjective experience to explain the development of professional identity. Furthermore, findings suggests that counselors in their identity development gain more self-knowledge, confidence in their abilities and judgment, knowledge and involvement in their profession and its standards, and a combination of personal and professional characteristics and experiences.

Method

Cultural domain with free listing was chosen as the data collection technique. Cultural domain is "the set of concepts chosen by memory through a reconstructive process that allows participants to have an action plan as well as the subjective evaluation of the events, actions or objects, and it has gradually become one of the most

powerful techniques to evaluate the meaning of concepts" (Valdez, 2010, p. 62). It has been accepted in Mexico and applied principally in social psychology and education to define and delineate several concepts such as psychologist (García-Silberman & Andrade, 1994); love, men and women (Hernández & Benítez, 2008); parenting (Medina et al., 2011); the rich and poor (Valdez, 2010); family (Andrade, 1994, 1996; Camacho & Andrade, 1992); and corruption (Avendaño & Ferreira, 1996), among others. This methodology was chosen because "professional identity" is a subjective concept to which different meanings are granted based on personal experiences; the idea was to show the concepts related to the meaning counselors give to their identity.

In this study, the authors posed the following question: What meaning do Mexican counselors give to their professional identity? The dependent variable was professional identity and the attributive variable was level of preparation (student or professional). The study was transversal (data recovery at a unique time frame) and descriptive.

Participants

The participants in the study included advanced students in at least their third semester in the master's counseling program at Universidad Iberoamericana and professional counselors who graduated from the program at least one year ago. Fifteen of 17 advanced students (88.23%) participated, including 3 men and 12 women with an average age of 29.40 years. Twelve of 29 graduates (41%) participated, including 1 man and 11 women, with an average age of 42.75 years.

Survey Development and Procedure

Each participant was asked to list 10 words or brief terms to describe the concept *counselor professional identity.* Afterward, participants were asked to rank each word from 1–10, assigning 1 to the characteristic word considered the most relevant and 10 to the word considered least relevant. Advanced counseling students were given the survey in their classrooms and graduate counselors were sent the survey via e-mail. The surveys were analyzed following Valdez (2010), obtaining the definitions with the semantic weight (M), for both students and professionals, considering the frequency with which the words were mentioned, as well as the assigned rankings. The authors used a mathematical procedure called *el valor M total* [Total M Value] (VMT; Valdez, 2010), which entails multiplying the frequency of occurrence times the weight of each defining word. Next, a cross-multiplication was done, considering the highest VMT as 100% in order to obtain the semantic distance between each concept and the stimulus concept (i.e., counselor professional identity). This procedure is referred to as FMG (Valdez, 2010).

Results

For the students, the defining terms for the stimulus *counselor professional identity*, listed in the order of the frequency and relevance with which the participants used and ranked them, were as follows:

> empathic, understands, sensitive, ethical, honest, sincerity, fair, prepared, knowledge, trained, updated, flexible, adapts, support, help, backup, listening, human, warm, congruence, authentic, mental health, well-being, trustable, integrative, responsible, commitment, intervening, implementing, action, professionalism, respect, tolerance, multicultural, contextualized, diversity, observer, acceptance, non-judgment, structure, organizes, collaboration, design, planning, creativity, patience, goal recognition, positive view, growth, development, contention, service attitude, dedication, different, brief, social commitment, interdisciplinary, reflective, analyzes, guides, communicates, open, wide view, curious, scientific, relationship, psychotherapist, therapist, educates, prudent, diagnoses, prevention,

dynamic, specialized, assertive, personal, practical, resilient, facilitator, personal therapy, strategic and consultant.

Consensually, the researchers separated these concepts into semantic categories, taking into account terms that are synonyms or that have a very similar meaning, leaving 57 definitions. Similarly, those concepts with more semantic weight were detected, resulting in the Semantic Association Memory (SAM) group according to Valdez (2010), which refers to the 15 categories with the most relevance (M total). This process is done considering frequency and weight. This group includes 17 categories since the last 3 present the same value. Table 1 shows terms that counseling students used to define counselor identity, weighted in order of relevance.

Table 1

Counseling Students' Identity

Semantic Defining Categories	VMT	FMG
Empathic, understands, sensitive	76	100%
Ethical	52	68.42%
Honest, sincere, fair	52	68.42%
Prepared, knowledge, updated, trained	44	57.89%
Flexible, adapts	43	56.57%
Support, help, backup	35	46.05%
Listening	33	43.42%
Warm, human	32	42.10%
Congruence, authentic	29	38.15%
Mental health, well-being	25	32.89%
Trustable	25	32.89%
Integrative	23	30.26%
Responsible, commitment	21	27.64%
Intervening, implementing, action	17	22.36%
Professionalism	16	21.05%
Respect, tolerance	16	21.05%
Multicultural, contextualized, diversity	16	21.05%

Note. VMT = Total M Value; FMG = semantic distance between the defining words.

For graduated professional counselors, the defining terms for the stimulus *counselor professional identity*, listed in the order of frequency with which participants used and ranked them, were as follows:

empathic, commitment, dedicated, responsible, ethical, serves vulnerable populations, social service, prepared, experienced, updated, supervised, studious, research, listening, authentic, genuine, congruent, support, assistance, orientation, guidance, honesty, integrity, integrative,

trustable, educates, informative, professional, versatile, adaptable, flexible, active, guide, creative, discipline, work, therapeutic relationship, curious, healthy, motivated, reflective, framing, intelligent, strength, ecological, humble, sensitize, acceptance, verbal, focused, aware, systemic, problem-solving, catalyze, assertiveness, decision-making, practical, positive, growth, development, fair, influence, self-knowledge, respectful, tolerant, reflects, cheerful and certified.

Once more, the defining words were classified into semantic categories, obtaining 48 definitions, as well as detecting those with the most semantic weight, resulting in a SAM group with the 15 most relevant categories. The authors derived these categories by considering higher frequencies and weight. The participants indicated that being *empathic* was the closest concept to counselor professional identity. The authors established *empathic* as FMG = 100, and cross-multiplied the other concepts to obtain their distance. Table 2 shows terms that professional counselors used to define counselor identity, weighted in order of relevance.

Table 2

Professional Counselors' Identity

Semantic Defining Categories	VMT	FMG
Empathic	62	100%
Commitment, dedicated, responsible	54	87.09%
Ethical	48	77.41%
Serves vulnerable population, social service	46	74.19%
Prepared, experienced, updated, supervised, studious, research	36	58.06%
Listening	34	54.83%
Authentic, genuine, congruent	28	45.16%
Support	27	43.54%
Guidance, orientation	24	38.70%
Honesty, integrity	24	38.70%
Integrative	23	37.09%
Trustable	22	35.08%
Educates, informative	22	35.08%
Professional	18	29.03%
Flexible, versatile, adapts	16	25.80%

The resulting defining concepts also were divided into two categories: (a) the way counselors work and (b) the way counselors are. The authors believe it is important to understand how counselors actually perceived their role in their work (e.g., professional behaviors, attitudes, approaches, roles, and functions) and also the way they identify themselves personally (e.g., characteristics and abilities; see Table 3).

Table 3

Counselors' Roles and Characteristics

The Way Counselors Work	The Way Counselors Are
Ethical	Listener
Social service, serves vulnerable population	Empathic, understands, sensitive
Preparation, training, up-to-date, supervision, studying	Committed, dedicated, responsible
	Warm, human
Professionalism	Authentic, genuine, congruent
Educates, informs	Respectful, tolerant
Support, helps	Honest, integrity
Guidance	Trustable
Mental health, well-being	Flexible, versatile, adaptable
Multiculturalism, contextualizes, diversity	
Integrative	

Discussion

It is possible to distinguish professional identity with common themes that begin during counselor training and continue as a process (Auxier et al., 2003; Balduzzi & Corrado, 2010; Brott & Myers, 1999). More similarities than differences were found comparing students and graduates.

For students and professionals, empathy occupies the most relevant place when describing counselor identity. It is interesting to observe how counselors, students and professionals prioritize values and concepts that come from a humanistic approach (e.g., empathy, authenticity, being genuine, congruent, warmth). This finding coincides with what Hansen (2003) expressed in that the counseling profession has its roots in the humanistic model, which is an undeniable part of its identity. This is also congruent with the values that the Universidad Iberoamericana promotes with students.

Ethics appear predominantly in both sets of participants, likely since professional identity and ethics are closely related (Nugent & Jones, 2009; Ponton & Duba, 2009; Skovholt & Ronnestad, 1992). Responsibility and commitment, as well as training and preparation, appear to be important defining words for counseling students and graduates, indicating that these concepts are considered fundamental. Furthermore, students and graduates consider flexibility as one of a counselor's professional identity characteristics, which relates to versatility in counselor roles and functions. Attending to the vulnerable population and social commitment were prominent for graduates, which fortunately matches well with the mission of counseling at their university (Universidad Iberoamericana, n.d.-b).

According to the data, the concept of *prevention* does not emerge as a direct priority that Mexican counselors believe distinguishes them. Students mention this concept, but just once and with low relevance; however, it does not reveal itself at all as a defining term for professionals. This finding does not correlate well with actual course descriptions within the counseling master's degree program (Universidad Iberoamericana, n.d.-a); therefore, changes in the program curricula may be needed. Students identified multiculturalism and diversity in the description of their professional identity; however, graduates did not. This distinction could be related to the recent teaching of this topic in Mexico and is expected to increase in the new generation of graduates.

It is important to note the limitations to this preliminary descriptive study. The sample was limited to 27 participants and no in-depth interviews were done in order to more comprehensively understand student and counselor perceptions. There is no basis for suggesting that the results can be generalized to other counselor populations, given that the study was specific to the particular context of one program at a private university. It is imperative to continue the study of counselor professional identity in Mexico with more participants and in-depth interviews.

There are several implications for Mexican counselor educators in regard to the development of counselor professional identity. First, there is the understanding that counselors are models in their professional activities including writing, affiliations and certification. It is imperative that educators invite students to get involved in national and international associations; promote practice, research and writing; and exalt the relevance of counselor certification.

Prevention—on the one hand a historic activity of many counselors—has proven to be a less important to Mexican counselors. To enhance this concept, the university curricula design may need to emphasize this topic in the thematic content of the program's courses. Practica and internships might as well include prevention strategies in the student's roles and functions. Furthermore, an elective course about prevention program design and implementation could be offered. On the other hand, it may be that prevention is a good idea, but not actually practiced by professional counselors because people tend to not pay for preventive services.

In summary, counseling students and graduates in Mexico share a common professional identity self-described as empathic, ethical, committed, versatile, trained and supportive. Efforts should be made to continue enhancing counseling core values as the profession continues to grow in Mexico, as well as internationally.

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References

American Counseling Association. (n.d.). *20/20: A vision for the future of counseling*. Retrieved from http://www.counseling.org/20-20/index.aspx

Andrade, P. P. (1994). *El significado de la familia* [The meaning of family]. *La Psicología Social en México*, *V*, 83–87.

Andrade, P. P. (1996). *El significado del padre y madre* [The meaning of father and mother]. *La Psicología Social en México*, *VI*, 337–342.

Asociación Mexicana de Orientación Psicológica y Psicoterapia. (2014). *Misión y objetivos* [Mission and objectives]. Retrieved from http://amopp.org/amopp-p/index.php/amoop-menu/mision-menu

Auxier, C. R., Hughes, F. R., & Kline, W. B. (2003). Identity development in counselors-in-training. *Counselor Education and Supervision*, *43*, 25–38. doi:10.1002/j.1556-6978.2003.tb01827.x

Avendaño, S. R., & Ferreira, N. L. (1996). Significado psicológico de corrupción en estudiantes universitarios [Psychological meaning of corruption in college students]. *La Psicología Social en México*, *VI*, 132–136.

Balduzzi, M. M., & Corrado, R. E. (2010). Representaciones sociales e ideología en la construcción de la identidad profesional de estudiantes universitarios avanzados [Social representations and ideology in professional identity of advanced college students]. *Revista Intercontinental de Psicología y Educación*, *12*, 65–83.

Brott, P. E., & Myers, J. E. (1999). Development of professional school counselor identity: A grounded theory. *Professional School Counseling*, *2*, 339–348.

Camacho, V. M., & Andrade, P. P. (1992). El concepto de familia en los adolescentes [The concept of family in adolescents]. *La Psicología Social en México*, *IV*, 295–302.

Council for Accreditation of Counseling and Related Educational Programs. (2009). *2009 CACREP standards*. Retrieved from http://www.cacrep.org/wp-content/uploads/2013/12/2009-Standards.pdf

Calva, G., & Jiménez, N. (2005). En busca de la identidad del orientador psicológico en México [In search of counselor identity in Mexico]. *Temas selectos en Orientación Psicológica*, *1*, 9–15.

du Preez, E., & Roos, V. (2008). The development of counsellor identity: A visual expression. *South African Journal of Psychology*, *38*, 699–709.

García-Silberman, S., & Andrade P. (1994). La imagen del psicólogo en los adolescentes [The psychologist image for adolescents]. In AMEPSO (Ed.), *La Psicología Social en México* (5th ed., pp. 672–678). Mexico City: AMEPSO..

Hansen, J. T. (2003). Including diagnostic training in counseling curricula: Implications for professional identity development. *Counselor Education and Supervision*, *43*, 96–107. doi:10.1002/j.1556-6978.2003.tb01834.x

Hellman, S., & Cinamon, R. G. (2004). Career development stages of Israeli school counsellors. *British Journal of Guidance & Counselling*, *32*, 39–55. doi:10.1080/03069880310001648085

Hernández, C., & Benítez, M. (2008). El amor, las mujeres y los hombres [Love, women and men]. *Archivos Hispanoamericanos de Sexología*, *14*, 103–135.

Medina, J., Fuentes, N., Escobar, S., Valdez, V., Farías, P., Guerrero, I., . . . Manjarrez, A. (2011). Orientación que transmiten los padres a sus hijos adolescentes [Orientation transmitted from parents to their adolescent sons]. *Revista Mexicana de Orientación Educativa*, *8*, 2–9.

Medina-Mora, M. E., Borges, G., Muñoz C. L., Benjet, C., James, J. B., Bautista, C. F., . . . Aguilar-Gaxiola, S. (2003). Prevalence of mental disorders and use of services: Results from the Mexican National Survey of Psychiatric Epidemiology. *Salud Mental*, *26*, 1–16.

Nelson, K. W., & Jackson, S. A. (2003). Professional counselor identity development: A qualitative study of Hispanic student interns. *Counselor Education and Supervision*, *43*, 2–14. doi:10.1002/j.1556-6978.2003.tb01825.x

Nugent, F. A., & Jones, K. D. (2009). *Introduction to the profession of counseling* (5th ed.). Upper Saddle River, NJ: Pearson.

Neukrug, E. (2007). *The world of the counselor: An introduction to the counseling profession* (3rd ed.). Belmont, CA: Brooks-Cole.

Ponton, R. F., & Duba, J. D. (2009). The *ACA Code of Ethics*: Articulating counseling's professional covenant. *Journal of Counseling and Development*, *87*, 117–121. doi:10.1002/j.1556-6678.2009.tb00557.x

Portal, E. L., Suck, A. T., & Hinkle, J. S. (2010). Counseling in Mexico: History, current identity, and future trends. *Journal of Counseling and Development*, *88*, 33–37. doi:10.1002/j.1556-6678.2010.tb00147.x

Skovholt, T. M., & Ronnestad, M. H. (1992). *The evolving professional self: Stages and themes in therapist and counselor development.* Chichester, England: Wiley.

Super, D. E. (1992). Toward a comprehensive theory of career development. In D. H. Montross & C. J Shinkman (Eds.), *Career development: Theory and practice* (2nd ed., pp. 35–64). Springfield, IL: Charles C. Thomas.

Universidad Iberoamericana. (n.d.-a). *Maestría en orientación psicológica* [Master in Counseling]. Retrieved from http://www.uia.mx/web/site/tpl-Nivel2.php?menu=mgPosgrado&seccion=M_orientacionPsicologica

Universidad Iberoamericana. (n.d.-b). *Misión y visión [Mission and vision]*. Retrieved from http://www.uia.mx/web/site/tpl-Nivel2.php?menu=mgPerfil&seccion=mgPerfil

Valdez, J. L. (2010). *Las redes semánticas naturales, usos y aplicaciones en psicología social [Cultural domain, uses and applications in social psychology]*. (4th ed.). Mexico City: Universidad Autónoma del Estado de México.

Yu, K., Lee. S-H., & Lee, S. M. (2007). Counselors' collective self-esteem mediates job dissatisfaction and client relationships. *Journal of Employment Counseling*, *44*, 163–172. doi:10.1002/j.2161-1920.2007.tb00035.x

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