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A Q Methodology Study of Supervisee Roles Within a Counseling Practicum Course



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Counseling students often experience clinical supervision for the first time during their participation in practicum courses. Counseling practicum supervisees new to supervision rely on their supervisors to provide direction and structure in supervision experiences to help them grow professionally and personally. Yet little is known about how students view their roles as new supervisees. Supervisors can benefit from structuring and delivering their courses informed by new supervisees' perspectives on their roles. Accordingly, the authors conducted a Q methodology study with a purposeful sample of seven counseling practicum students, a doctoral co-instructor, and a counseling practicum instructor engaged in a first-semester counseling practicum course. Principal components analysis with varimax rotation of Q-sort data revealed three factors depicting supervisee roles (i.e., Dutiful, Discerning, and Expressive Learners). Implications for applying findings to improve supervision instruction and student learning are discussed, including limitations and future research suggestions.

Keywords: counseling practicum supervisees, supervisee roles, Q methodology, counseling practicum instructors, student learning

Supervision is generally understood as a relational and evaluative process between a senior and junior member of a profession, which is intended to foster the junior member's learning and professional skill development while also ensuring the welfare of clients they serve (Bernard & Goodyear, 2019). Supervision is also a key pedagogical and curricular feature of counseling training programs (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015) within which students develop into entry-level counselors. Although supervision is often considered a hierarchical relationship, supervisees are active participants in the supervision process (Stark, 2017). Thus, as part of counselor training, it is important for counseling students to understand what supervision is and what is expected of them (Bernard & Goodyear, 2019). Counseling students' learning about the supervision process and supervisee roles commonly begins during their participation in field experience courses, the first of which is the counseling practicum course (CACREP, 2015). However, little is known about how counseling practicum supervisees come to understand their roles (Pearson, 2004) and, consequently, how counseling students use their understanding of roles to contribute to the learning process in supervision (Borders, 2019; Stark, 2017). This lack of understanding is compounded by a preponderance of supervision research grounded in expert perspectives and less so from the perspectives of counseling students new to supervision (Stark, 2017).

Thus, there are clear advantages to investigating counseling practicum supervisees' understanding of their supervisee roles, particularly while they are engaged in their first field experience (i.e., practicum) course. First, practicum experiences offer supervisees applied learning environments (CACREP, 2015) where they can apply prior learning under supervision to their work with actual clients (Moate et al., 2017). To that end, this is the first time that these novice supervisees are ethically responsible for their clients' care, which includes adequately conveying their professional needs to their supervisors

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(Bernard & Goodyear, 2019). Second, practicum supervisees may become anxious if they are unsure of their roles and what is expected of them by their supervisors and want to feel competent regardless of their actual competency levels (Ellis et al., 2015). Third and finally, the focus and process of supervision changes over time as supervisees develop (Stoltenberg & McNeill, 2010), including changes to how they function in their expected roles (Bernard & Goodyear, 2019). These early learning experiences are important for supervisees because they shape their understanding of clinical supervision (Borders, 2019), which they will engage in throughout their field placement experiences and post-degree, pre-licensure clinical training (Cook & Sackett, 2018). Therefore, it is important to understand supervisees' initial understanding of their roles within the counseling practicum environment, including the degree to which these views align with or diverge from their supervisors' (Bernard & Goodyear, 2019).

Student Learning and the Counseling Practicum Classroom

For supervision to be a valuable learning experience, it is assumed that supervisees will be able to adequately self-identify and articulate their client concerns as well as their own developmental needs to supervisors (Cook & Sackett, 2018). However, because practicum supervisees have no prior supervision experience, the way in which they come to understand their roles as supervisees is largely informed by the framework created by the instructor within a practicum course. To that end, practicum course instructors may align their course structure and requirements with accreditation standards (e.g., CACREP, 2015) and professional best practices (e.g., Association for Counselor Education and Supervision Best Practices in Clinical Supervision; Borders et al., 2014) in order to ensure that supervisees are informed of their responsibilities. This information is often conveyed to supervisees via an informed consent or supervision contract (Borders et al., 2014) as well as a course syllabus (CACREP, 2015). However, some supervisees may not fully understand the purpose of supervision nor grasp their roles as supervisees, even though they reviewed an informed consent with their supervisors (Cook et al., 2019).

Counseling practicum courses present students with new opportunities to apply learning from content courses (Moate et al., 2017), refine reflective practice (Neufeldt, 2007), and work with actual clients under supervision (Bernard & Goodyear, 2019). During this unique and critical learning time, supervisees are closely monitored by supervisors whose expectations and responsibilities are rooted in both supervisors' and supervisees' roles (Bernard & Goodyear, 2019; CACREP, 2015). Practicum course instructors are charged with facilitating supervisees' learning to develop as professional counselors while safeguarding the welfare of the clients they serve (Borders et al., 2014). Borders (2019) delineated seven process-of-learning principles for use by training supervisors in the supervision classroom. This model is rooted in learning theories, with a particular focus on understanding how supervisors help supervisees in training based on the process of how students learn. We contend that implementation of practicum instruction guided by learning principles could help instructors to scaffold learning processes and teach counseling practicum supervisees about their supervisee roles, which is needed to help them navigate early career challenges (Loganbill et al., 1982).

Ultimately, if supervisees are to be effective with clients, more examination of their understanding of roles and related learning is needed. This information will provide instructors with the necessary knowledge to build effective learning environments and scaffold supervisees' learning experiences in the supervision classroom (Borders, 2019; Moate et al., 2017). Thus, by examining how supervisees understand their supervisee roles, instructors can better teach them how to eventually self-direct their supervision experiences (Stoltenberg & McNeill, 2010) and effectively utilize supervision (Norem et al., 2006; Pearson, 2004), with the goal of transferring learning from supervision to counseling encounters with clients.

Counseling Practicum Supervisee Roles

Novice supervisees (i.e., practicum supervisees) desire to quickly acquire skills so that they can best serve their clients by utilizing the “correct” counseling technique or approach (Stoltenberg & McNeill, 2010). Further, supervisees experience a high degree of anxiety and confusion as they begin to develop their own counseling style and competencies (Rønnestad & Skovholt, 2003). Relatedly, Loganbill et al. (1982) suggested that novice supervisees, like counseling practicum supervisees, regularly feel “stuck” in their work with clients and confused as to how best to make progress with their clients. To that end, supervisees benefit from instructors who provide supportive feedback and explicit instructions in a highly structured supervision environment (Ellis et al., 2015; Loganbill et al., 1982; Stoltenberg & McNeill, 2010) that promotes role clarity (i.e., clearly understanding what is expected and how to meet those expectations).

Failure to determine whether there is alignment between supervisees’ and instructors’ perspectives on roles may yield unintended but potentially detrimental consequences (Stark, 2017). For example, from an educational perspective, instructors can best attend to their students’ learning needs when they understand what it is that their students perceive as being important to their learning (Moate et al., 2017). Furthermore, asking supervisees to engage in evaluations of their performance based on poorly understood roles (Ladany & Friedlander, 1995) could undermine the purposes of clinical supervision (e.g., professional development, client welfare; Borders et al., 2014) and threaten their right to a fair evaluation as students and supervisees (American Counseling Association [ACA], 2014; CACREP, 2015). Providing supervisees with clear information on their roles can assist with reducing nondisclosure (Cook et al. 2019) and lowering anxiety about their performance (Ellis et al., 2015). These practices allow for safeguarding supervisees and clients, fair supervision evaluation practices (Stark, 2017), and assuring quality supervision instruction grounded in student and instructor perspectives and adult learning processes (Borders, 2019).

Much of the current supervision literature contains guidelines for instructors to effectively conduct supervision (Stark, 2017). For example, *Best Practices in Clinical Supervision* (Borders et al., 2014) offers specific recommendations for those providing clinical supervision (i.e., supervisors). The expectations of supervisees are implied in the guiding document (e.g., arrive on time to supervision, engage in the supervision process), but the specific roles and responsibilities for supervisees are not explicitly addressed. Whereas others (e.g., Homrich et al., 2014) have conceptualized standards relevant to supervisees’ roles in clinical supervision, including self-reflection and self-exploration, communicating information truthfully and accurately, and engaging actively in opportunities for personal and professional development. The importance of supervisees’ contributions have also been noted by scholars (e.g., Norem et al., 2006; Stark, 2017; Wilcoxon et al., 2005). For instance, several authors identified supervisee characteristics that are helpful to the learning process in supervision, such as being self-directed, motivated, mature, autonomous, proactive, and open to new learning experiences, all of which are perceived as helping supervisees successfully navigate supervision (Norem et al., 2006; Stark, 2017; Wilcoxon et al., 2005). In an earlier effort to clarify roles and expectations for the supervision process, Munson (2002) identified several supervisee rights, including (a) meeting consistently and regularly with a supervisor, (b) engaging in growth-oriented supervision that considers one’s personal privacy, (c) participating in theoretically grounded supervision, (d) receiving clear evaluation criteria and evaluations informed by direct observation, and (e) having a supervisor who is adequately trained. Additionally, Munson suggested that supervisees ought to be able to speak freely in supervision, need encouragement to integrate prior learning from other counseling classes (which supports Borders, 2019), and should remain open and curious about the learning process. Overall, the author’s work supports the need for providing supervision based on expectations for both supervisor and supervisee performance.

Despite these documented guidelines and expectations, there is a notable lack of input from supervisees' perspectives of their roles and related expectations. This is concerning because instructors need to structure their learning environments grounded in evidence supporting student engagement (Malott et al., 2014), which is strengthened by identifying students' prior learning experiences (Borders, 2019).

The Current Study

Learning to be a supervisee is a process in which counseling students gain experience starting in their practicum courses. It is critical for the supervisor (i.e., instructor) to understand their supervisees' perceptions of their roles in supervision, which have been informed by accreditation requirements (e.g., CACREP, 2015), professional standards (e.g., *Best Practices in Clinical Supervision*, Borders, 2014), and scholarly literature (e.g., Munson, 2002). Yet, supervisors lack access to information from student perspectives for increasing supervisee engagement and meaningfulness of roles, particularly from the counseling practicum course context where students often experience supervision for the first time. In the current study, we sought to understand the expected roles and responsibilities of new supervisees from the perspectives of supervisees within a counseling practicum course. We also included perspectives from the instructional team (i.e., a doctoral student co-instructor, and a counseling practicum instructor) to illustrate the degree of alignment between instructors and students and to illustrate any nuances between instructor and co-instructor views. Using this research, supervisors and counselor educators may be able to offer developmentally appropriate solutions to address supervisee concerns and to provide support to counseling practicum instructors based on both expert and novice perspectives. Accordingly, our study was guided by the following research question: What are counseling practicum supervisees' views of their roles and responsibilities in the practicum classroom environment?

Method

Q methodology is a unique research method containing the depth of qualitative data reduction and the objective rigor of by-person factor analysis (Brown, 1996), which can be used effectively in the classroom setting to facilitate students' subject matter understanding (Watts & Stenner, 2012). Specifically, students' self-perspectives can be revealed in relation to their peers' and instructors' views using Q methodology (Good, 2003). Q methodology has also been used successfully to investigate phenomena in the counselor education classroom (Baltrinic & Suddeath, 2020) and program settings (Baltrinic et al., 2013) that favor both student and instructor views. Accordingly, we selected Q methodology for this study to obtain perspectives from a participant sample of counseling practicum supervisees and their instructional team.

Concourse and Q Sample

Specific steps were taken to develop a rigorous *Q sample*, which is the set of statements used to assist participants with expressing their views on supervisee roles via the Q-sorting process (Brown, 1980). The first step was selecting a *concourse*, which is a collection of opinion statements about any topic (Stephenson, 1978). Many routes of communication contribute to the form and content of a concourse (Brown, 1980). The concourse for this study was composed of statements we took from select supervision literature and documents (i.e., Borders et al., 2014; Homrich et al., 2014; Kangos et al., 2018; Munson, 2002; Stark, 2017). We searched within these sources and selected concourse statements specifically containing supervision experts' views on supervisees' roles. We needed 100% consensus on each statement for it to be included in the concourse. The concourse selection process resulted in over 240 concourse statements, which was too many for the final Q sample (Paige & Morin, 2016).

Second, we proceeded with selecting, evaluating, and reducing the final Q sample items in line with Brown (1980) and Paige and Morin (2016). Initially, we had our first and second authors, Baltrinic and

Cook, eliminate all duplicate, unclear, fragmented, or unrelated statements from the 240 concourse statements, which resulted in 160 statements. Baltrinic and Cook then used a structured sample design (Brown, 1980) to reduce the 160 concourse statements to a representative 48-item Q sample (Brown, 1980; see Appendix). Representativeness of a Q sample refers to whether the subset of items represent the broader population of statements in the concourse. Third, the 48-item Q sample was then evaluated by three experts (two supervision experts and one Q methodology expert) using a content validity index (Paige & Morin, 2016). The expert reviewers rated each of the 48 items on a 4-point scale using three criterion items: 1) Is the statement clear and unambiguous for counselor educators? 2) Is the statement clear and unambiguous for counseling practicum students? and 3) Is the statement distinct from the other statements? Scores across expert reviewers' item ratings were averaged with only scores of 3 (*mostly*) or 4 (*completely*) indicating consensus on the content validity index. Items receiving a score of 3 or 4 were included, items receiving a score of 2 (*somewhat*) were reviewed and modified by our research team for appropriateness, and items receiving a score of 1 (*not at all*) were discarded from the sample. Accordingly, 45 items received scores of 3 or 4. Baltrinic completed additional Q sample refinements for the remaining three items that received scores of 2 ($n = 2$) and 1 ($n = 1$); two items were rewritten to improve clarity, one duplicate item was eliminated, and one new item was added. All refinements were confirmed by the second author before accepting the items in the final Q sample. For the final step, two of the experts completed Q sorts to ensure the final Q sample facilitated the expression of views on supervisee roles. The results of these two pilot Q sorts were not included in the data analysis.

Participant Sample

We followed McKeown and Thomas's (2013) recommendations for selecting an intensive participant sample. Therefore, we purposefully selected an intensive participant sample composed of seven master's-level clinical mental health counseling practicum supervisees, one doctoral co-instructor, and one faculty instructor; all of whom represented a purposeful sample of individuals (Patton, 2015) holding similar theoretical interests and having the ability to provide insight into the topic of investigation (Brown, 1980; McKeown & Thomas, 2013).

Three of the master's-level counseling students identified as male and four identified as female, and their ages ranged from 23 to 37 years old ($M = 30$, $SD = 10.06$). Regarding race/ethnicity, five of the counseling students identified as European American and two identified as African American. The counselor educator and course instructor identified as a European American male. He holds a PhD in Counselor Education with 5 years of counseling experience and 6 years of supervision experience. Additionally, the instructor is a licensed professional counselor and an Approved Clinical Supervisor, and he publishes regularly on the topic of clinical supervision. The doctoral student co-instructor identified as a European American female who has 3 years of clinical experience as a school counselor and 1 year of supervision experience.

Data Collection

After receiving IRB approval, Baltrinic collected the initial consents, demographics, Q sorts, and post-Q sort interview data. The students and course instructors ($N = 9$) were asked to rank-order the 48 items under the following condition of instruction: "Select the statements with which you most agree (+4) to those with which you most disagree (-4) that represent a beginning counselor practicum student's supervisee roles." After completing the Q sorts, each participant was asked to provide written responses for the top three items with which they most and least agreed and were asked to comment on any other items of significance. Baltrinic obtained these post-sort questionnaires in person. The purpose of gathering post-sort data is to provide qualitative context for the factor interpretations (Brown, 1996).

Data Analysis

Nine Q sorts were completed by the instructional team and the counseling practicum students under a single condition of instruction, all of which were entered into the PQMethod software program V. 2.35 (Schmolck, 2014). A 3-factor solution was selected using the principle components method with varimax rotation, which yields the highest number of significant factor loadings and because Baltrinic, who analyzed the data, was blinded from participants' identifying information (Watts & Stenner, 2012). Being blinded to participant information renders approaches such as theoretical rotation moot in favor of varimax rotation, given the lack of contextual information related to factor exemplars (i.e., those participants with the highest factor loading on a factor; McKeown & Thomas, 2013).

Results

Data analysis revealed three significantly different viewpoints (i.e., Factors 1, 2, and 3) on supervisee roles. For Q methodology, factor loadings are not used for factor interpretation. Instead, the individual significant factor loadings associated with each of the factors are weighted and averaged, resulting in an ideal Q sort representing each factor, which are presented chronologically in a *factor array*. Factor arrays contain the scores that are used for factor interpretation (see Appendix). Parenthetical reference to specific Q-sample items and their associated factor scores located in the factor array (e.g., Item 23, +2) will be provided within the factor interpretations below. Select participant quotes from post-sort questionnaires are incorporated into the factor interpretations.

Factor 1: The Dutiful Learner

Factor 1, which we have named the *Dutiful Learner*, represents a conceptualization of supervisee roles as predominantly adhering to the ethical codes, guidelines, and models of ethical behavior (Item 15, +4). One of seven supervisees, the course co-instructor, and the course instructor were significantly associated with Factor 1 (i.e., had factor loadings of .50 or higher; Brown, 1996) with factor loadings of .70, .82, and .70, respectively. Supervisee roles attributed to the Dutiful Learner are understood as aspects of the learning process provided that student learning adheres to the code of ethics. Additionally, supervisee roles were viewed in terms of supervisees following the procedures and policies of their graduate programs (Item 36, +4), which as one participant noted "are really non-negotiable." Supervisee roles, including the demonstration of healthy professional boundaries in supervision sessions and with clients, were also highly preferred by participants aligning with this factor (Item 25, +4). When reflecting on Item 25, the supervisee participant emphasized, "Healthy boundaries are paramount for legally and emotionally protecting oneself." Finally, the Dutiful Learner viewpoint entails emphasis on the importance of supervisees arriving on time for supervision (Item 7, +3), including the need to be prepared for every supervision session (e.g., individual, triadic, group; Item 18, +2).

Participants ascribing to the Dutiful Learner view of supervisee roles were less concerned about the demonstration of awareness of strengths and weaknesses to instructors (Item 1, 0), which according to one participant would "occur as part of the process over time." Dutiful Learners are viewed as favoring ethically guided supervisee roles versus simply being pleasant to work with in supervision (Item 30, -4) or gratuitously asking questions regarding counseling-related issues (Item 32, -3). Dutiful Learner viewpoints may be related to having a sense of responsibility for other supervisees' learning that includes a desire for students to develop a strong ethical compass, which is needed "throughout their development as counselors." For example, according to the co-instructor, who noted in her post-sort interview questionnaire, "It seems items I ranked highest were 'rules' and 'guidelines,' which I feel is influenced by the need to be an ethical practitioner and influenced by being in the co-teacher role."

Overall, supervisees, according to the course instructor, are reminded to “trust the process” in their beginning roles, given it is most critical that they have a “willingness” to learn.

Factor 2: The Discerning Learner

Factor 2 characterized supervisees as having a penchant for seeking feedback, a spirit of willingness, and thoughtful reasoning; therefore, we have named this factor the *Discerning Learner*. For Factor 2, three of the seven supervisees had significant factor loadings (.67, .83, and .58, respectively). In general, the Discerning Learner represents a conceptualization of supervisee roles in which supervisees feel their supervisors provide them with feedback about counseling skills (Item 40, +4), which according to one participant is the “purpose of supervision.” The supervisees whose viewpoints aligned with this factor valued supervisee roles that included asking for help when needed (Item 35, +4), which is related to recognizing and regularly seeking feedback from their supervisors (Item 20, +2). Throughout the supervision process, Discerning Learners are viewed as valuing organization and exercising good judgement when approaching supervision situations (Item 43, +4). Overall, a willingness to work with their supervisors (Item 33, +3) was deemed important given the interpersonal nature of the supervision process.

Further, the Discerning Learner view favored the acquisition of counseling skills as central to supervisee roles. With a focus on skill acquisition, the need to manage ambiguity and uncertainty as a function of their roles was considered less important for Discerning Learners (Item 14, -4). As one participant noted, “The whole point of supervision is to take what the supervisor is telling us and apply it to our practice.” Additionally, for participants whose views aligned to this factor, recognizing and managing anxiety (Item 12, -4) was not considered central to supervisee roles in practicum because anxiety is commonly accepted as “part of the learning process in supervision.” One participant normalized the presence of anxiety and the need to “discuss it in supervision,” further suggesting, “It is good to express anxiety about the supervision process instead of bottling it in.” Overall, supervisees who view supervisee roles from the viewpoint of the Discerning Learner accept anxiety and ambiguity as those things that “should be expected” when using good judgement to acquire and refine counseling skills and initiate discussions about the process in supervision.

Factor 3: The Expressive Learner

Factor 3 favored the personal and interpersonal expression of needs in the interest of learning; therefore, we have named this factor the *Expressive Learner*. Three of seven supervisees had significant factor loadings on Factor 3 (.73, .50, and .63, respectively). Supervisees whose views aligned with the Expressive Learner factor favored supervisee roles emphasizing opportunities to be vulnerable in sessions with their supervisor (Item 34, +4). This factor entailed supervisee acknowledgment of the emotional context for learning and growth; as suggested by one supervisee, “If I don’t feel vulnerable, then I’m not going to have an experience where I truly learn.” Another non-traditional age male supervisee elaborated, “Older students often bring work experience and personal experience to the supervisee role,” which according to another participant (also a non-traditional male student) means that “If a supervisee is unable to be open and honest (despite previous experiences), then no progress is made towards professional growth.” Additionally, managing personal and interpersonal issues was deemed important for supervisee roles (Item 22, +4). As one supervisee noted, “Although it can be difficult to manage various life roles, it is important not to let those life roles interfere.” The Expressive Learner is further conceived as valuing the demonstration of verbal communication skills (Item 28, +3) and having the ability to take multiple perspectives (Item 21, +3), both of which were deemed essential for “welcoming and responding to supervisors’ critical feedback,” especially with challenging cases.

The underlying sentiment of feeling empowered by supervisors (Item 45, +2) was deemed important because “feeling empowered will drive you to continue growing your skills.” Overall, the personal and interpersonal nature of supervision and supervisees’ roles was distinguishing for this factor.

Supervisees ascribing to the Expressive Learner factor expected that the ability to speak freely in supervision (Item 2, -3) is an assumed role of supervisees. As one participant explained, “It is important for me to say exactly what I’m feeling so my supervisor can give me their perspective and help me work through any issues.” Similarly, identifying supervisee developmental needs (Item 9, -4) is viewed as part of all supervision that should be initiated by the instructor at the beginning stage of supervision. For example, as one supervisee noted, “Because I am a student, I want my supervisor to initiate discussions” related to developmental needs “and then guide me with questions.” Finally, active participation in supervision (Item 42, -2) was viewed as less important because it is “expected,” and although supervisees should work collaboratively, “establishing tasks and goals should first be initiated by the supervisor,” a point echoed by all supervisees associated with Factor 3. It seems then that Expressive Learners are interpersonally attuned and focused and most responsive when supervisee roles are activated through initial supervisor prompts.

Discussion

The purpose of the current study was to examine the roles of supervisees as perceived from the multiple viewpoints of counseling practicum supervisees, a doctoral co-instructor, and a faculty instructor. Collectively, our findings reveal three different viewpoints (i.e., factors) of supervisees’ roles and responsibilities. Interestingly, only one of the seven supervisees’ views of these roles aligned with the views of the doctoral co-instructor and practicum course instructor. Even though the instructors acculturated the supervisees to their responsibilities in relatively the same way (e.g., university supervision contract, course syllabus) and used methods that aligned with accreditation guidelines, professional standards, and best practices in supervision, the majority of students still made meaning of these roles as supervisees in ways that differed from the instructors’ viewpoint. At the same time, supervisees deemed it important to convey their own professional competencies to their evaluative supervisors (Cook et al., 2019). As we will discuss below, course instructors who hope to better attend to the learning needs of all students and understand how their students perceive their own roles in clinical supervision can integrate details from the three factors (the Dutiful Learner, the Discerning Learner, and the Expressive Learner) into their instruction practices.

Participants whose views most strongly aligned to the Dutiful Learner factor perceive the most important aspect of supervisee roles as adhering to ethical codes and course requirements. For Dutiful Learners, supervisee roles parallel the concrete expectations often outlined in a supervision contract (Ellis, 2017) or course syllabus. That is, having clear expectations of clinical supervision and an operational understanding of the structural aspects of clinical supervision were endorsed as the strongest expectations of Dutiful Learners. Additionally, participants who conceptualized supervisee roles in terms of Factor 1 believe supervisees will gain insight into their own skills and competencies over time as they develop in their roles (Loganbill et al., 1982). However, having a foundational understanding of how to utilize clinical supervision as well as their rights as supervisees in clinical supervision (Munson, 2002) may be most critical for Dutiful Learners (Stoltenberg & McNeill, 2010). Accordingly, Dutiful Learners may find the explicit instructions for supervision helpful for managing the anxieties and uncertainties that are often experienced by new supervisees (Loganbill et al., 1982). Specific aspects to focus on for Dutiful Learners’ roles would be to review ethical guidelines, course requirements, and strategies for coming prepared to supervision.

Discerning Learners (Factor 2) favor their roles as active participants in the supervision process, which they perceive as a relational process between supervisee and supervisor, and student and instructor. That is, Discerning Learners perceive a collaborative relationship between supervisee and supervisor as being central to their professional development and their counseling work with clients. This factor best reflects the supervisee working alliance (Bordin, 1983), in which creating a strong emotional bond between supervisors and supervisees and mutual agreement on goals and tasks is most important to positive outcomes in supervision (e.g., intentional nondisclosure, role ambiguity; Cook & Welfare, 2018; Ladany & Friedlander, 1995). Discerning Learners also acknowledge that anxiety is a common characteristic of being a supervisee, which is somewhat expected given the participants' developmental level (i.e., novice supervisees; Rønnestad & Skovholt, 2003; Stoltenberg & McNeill, 2010). However, they view acknowledging this anxiety to their supervisors as helpful. Finally, Discerning Learners perceive discussing cultural identities as being relevant to their role as supervisees, although one supervisee stated culture should only be discussed with a client "when relevant to their counseling work."

Expressive Learners (Factor 3) perceive the role of a supervisee as being vulnerable with and openly disclosing information to their supervisor, demonstrating the ability to take multiple perspectives with their clients, and feeling empowered by their supervisors. These findings align with Cook et al. (2018), who investigated supervisees' perceptions of power dynamics in clinical supervision. Further, the Expressive Learner factor represents views most aligned with tenets of feminist supervision (e.g., Porter, 1995; Porter & Vasquez, 1997). Porter (1995) noted that supervisors empower their supervisees by creating a safe environment and valuing their supervisees' perspectives with the goal of facilitating their supervisees' autonomy, although there is substantial evidence that counseling students, such as practicum supervisees, withhold information from their supervisors (e.g., Cook & Welfare, 2018; Cook et al., 2019). Expressive Learners view learning as a self-directed process within supervision, which also suggests they perceive themselves as active contributors to clinical supervision (Stark, 2017). At the same time, Expressive Learners also look to their supervisors to initiate discussion about their developmental needs and to provide insights into their opportunities for professional growth. This viewpoint aligns with that of Stoltenberg and McNeill (2010), who contend that supervisors can help novice supervisees to gain awareness into their own developmental needs through questioning and supportive feedback.

Implications for Practicum Instructors

Practicum course instructors often have the responsibility to teach supervisees about their roles and responsibilities as they align with accreditation standards (i.e., CACREP, 2015), professional standards (i.e., *ACES Best Practices in Clinical Supervision*; Borders et al., 2014), and ethical guidelines (i.e., ACA, 2014). To that end, practicum instructors must convey their expectations for students in their classroom and attend to the diverse learning needs of all their students. Our findings suggest supervisees understand their roles and responsibilities in three different ways, which at times differ from those of the course instructors. Instructors must be able to provide sufficient, appropriate, and meaningful feedback to all supervisees in their class (Borders, 2019) to ensure they are adequately able to successfully navigate supervision in the classroom and in future supervision experiences. Thus, we offer practicum instruction strategies based on the three supervisees' viewpoints of their roles (i.e., factors). For example, instructors can assess supervisees' understanding of their prior experiences with evaluative relationships (i.e., educational, personal, professional; Borders, 2019) and how those experiences might be similar or different to their current experience in the counseling practicum course.

Our findings also connect with evidence-based processes for how students learn. As you may recall from the literature review, Borders (2019) delineated seven principles rooted in learning theories, with a particular focus on understanding how to help supervisees based on the process of how students learn.

These seven principles are connected to our findings and noted in parentheses (e.g., Principle 1) within the text that follows. Specifically, instructors can use characteristics of the three factors, along with the seven learning principles, to inform counseling practicum instruction and doctoral supervision strategies. For example, instructors can help Dutiful Learners identify ethical dilemmas (e.g., risk assessment, mandated reporting, healthy boundaries between client and counselor) and ways to discuss solutions with their supervisors by watching segments of counseling sessions (Principle 1). Instructors can then ask supervisees to use ethical decision-making models to connect practice to theory (Principle 2), and they can help supervisees to identify needed skills, including situations in which these skills are most needed (Principle 4 and 7). Instructors can observe supervisees' skills practice and direct doctoral co-teachers to identify ways for the supervisees to improve practice and convey ethical dilemmas to supervisors (e.g., site supervisor, course instructor). As supervisees understand their roles, they can pursue role-playing ethical dilemmas and learn how to receive and respond to feedback after each role-play within a low-risk classroom setting (Principle 3). Overall, supervisees and doctoral co-teachers should receive scaffolded instructor feedback to help them better correct any errors (Principle 5).

Discerning Learners prefer presenting counseling work to their supervisors and discussing related feedback about their counseling skills, which can be done based on a mutual understanding and appreciation of supervisees' roles. Thus, instructors should consider reviewing with supervisees the counseling skills learned in previous classes (Principle 1; Borders, 2019), including assessing supervisees' comfort level with using specific counseling skills. To that end, instructors can ask supervisees to identify and name specific skills in their counseling work as well as their peers' counseling work during role-plays or actual counseling sessions (Principle 5). Additionally, because Discerning Learners value discussing their anxiety and issues of culture with their supervisors, instructors can include a question about supervisees' anxiety in case presentation forms, which could then be used as a starting point to facilitate any individual or group discussions. Identifying and addressing anxiety (Bernard & Goodyear, 2019) is important because supervisees need to know how to broach difficult topics with clients (Day-Vines et al., 2020), and instructors need to model that broaching for doctoral co-teachers and supervisees (Principle 6).

Of the factors identified in the current study, the Expressive Learners prefer a self-directed role when engaging in their supervision experience. Expressive Learners prefer a learning environment in which disclosure is encouraged, vulnerability is validated, and empowerment is facilitated. Accordingly, instructors need to assess Expressive Learners' motivation level, which is a critical driver for learning new content (Principle 3; Borders, 2019) and for understanding supervisees' capacities to self-direct their learning experiences (Principle 7). Instructors can assist Expressive Learners with developing learning goals that can include strategies for both collaboration and self-direction (Principle 7). Additionally, instructors may use specific supervision techniques, such as interpersonal process recall (Kagan, 1980), to gain insight into supervisees' perceptions of their skills and to encourage their disclosure-related skill acquisition (Principle 4). This is important because Expressive Learners are willing to discuss their concerns when prompted by supervisors. Finally, instructors may also consider using the Power Dynamics in Supervision Scale (Cook et al., 2018) to assess supervisees' perspectives of being vulnerable or empowered.

Limitations and Future Research

Researchers who use Q methodology gather and analyze data to reveal common viewpoints among participants, and in this case within a single counseling practicum course. As such, the Q factors in this study do not generalize (Brown, 1980) similarly to the findings in widescale quantitative studies. We caution readers against interpreting factors as being "better or worse" or "right or wrong" for other practicum courses. However, similar factors may plausibly exist among supervisees' views in other

counselor education practicum courses. In this way, any similarities from our findings to other sites is seen more as a matter of shared experiences rather than generalized findings (Stephenson, 1978). The low number of participants in the current study may be viewed as a limitation. However, similar to Baltrinic and Suddeath (2020), the instructors and student participants in the current study represented a purposeful sample of sole interest (Brown, 1980), revealing robust factors within a counselor education classroom (i.e., the unit of analysis). Nevertheless, future research could include larger numbers of participants across multiple practicum courses, which may increase the potential for revealing the existence of additional factors. Researchers are encouraged to test propositions by having supervisees complete Q-sorts with the current Q sample within and across other counseling subspecialty areas as well. Researchers can also use qualitative or case study methods to investigate supervisees' views from practicum through the completion of internship.

Conclusion

In conclusion, practicum course instructors can incorporate the current findings into their supervision pedagogy. Using student-generated factors can help practicum course instructors guide supervisees to (a) develop skills grounded in a clear understanding of their roles and related approaches to learning, (b) select and incorporate supervisor feedback about the goals and tasks of supervision, and (c) identify areas of growth based on the alignment of supervisees' and instructors' role perspectives.

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References

- American Counseling Association. (2014). *ACA code of ethics*.
- Baltrinic, E. R., & Suddeath E. G. (2020). A Q methodology study of a doctoral counselor education teaching instruction course. *The Professional Counselor*, 10(4), 472–487. <https://doi.org/10.15241/erb.10.4.472>
- Baltrinic, E. R., Waugh, J. A., & Brown, S. R. (2013). Faculty and student perspectives on what helps counselor education doctoral students towards program completion. *Operant Subjectivity: The International Journal of Q Methodology*, 36(4), 253–271. <https://doi.org/10.15133/j.os.2012.014>
- Bernard, J. M., & Goodyear, R. K. (2019). *Fundamentals of clinical supervision* (6th ed.). Pearson.
- Borders, L. D. (2019). Science of learning: Evidence-based teaching in the clinical supervision classroom. *Counselor Education and Supervision*, 58(1), 64–79. <http://doi.org/10.1002/ceas.12124>
- Borders, L. D., Glosoff, H. L., Welfare, L. E., Hays, D. G., DeKruyf, L., Fernando, D. M., & Page, B. (2014). Best practices in clinical supervision: Evolution of a counseling specialty. *The Clinical Supervisor*, 33(1), 26–44. <https://doi.org/10.1080/07325223.2014.905225>
- Bordin, E. S. (1983). A working alliance based model of supervision. *The Counseling Psychologist*, 11(1), 35–42. <https://doi.org/10.1177%2F0011000083111007>
- Brown, S. R. (1980). *Political subjectivity: Applications of Q methodology in political science*. Yale University Press.
- Brown, S. R. (1996). Q methodology and qualitative research. *Qualitative Health Research*, 6(4), 561–567. <https://doi.org/10.1177/104973239600600408>
- Cook, R. M., McKibben, W. B., & Wind, S. A. (2018). Supervisee perception of power in clinical supervision: The Power Dynamics in Supervision Scale. *Training and Education in Professional Psychology*, 12(3), 188–195. <https://doi.org/10.1037/tep0000201>
- Cook, R. M., & Sackett, C. R. (2018). Exploration of prelicensed counselors' experiences prioritizing information for clinical supervision. *Journal of Counseling & Development*, 96(4), 449–460. <https://doi.org/10.1002/jcad.12226>

- Cook, R. M., & Welfare, L. E. (2018). Examining predictors of counselor-in-training intentional nondisclosure. *Counselor Education and Supervision*, 57(3), 211–226. <https://doi.org/10.1002/ceas.12111>
- Cook, R. M., Welfare, L. E., & Sharma, J. (2019). Exploring supervisees' in-session experiences of utilizing intentional nondisclosure. *The Clinical Supervisor*, 38(2), 202–221. <http://doi.org/10.1080/07325223.2019.1608344>
- Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP Standards*. <http://www.cacrep.org/wp-content/uploads/2017/08/2016-Standards-with-citations.pdf>
- Day-Vines, N. L., Cluxton-Keller, F., Agorsor, C., Gubara, S., & Otabil, N. A. A. (2020). The multidimensional model of broaching behavior. *Journal of Counseling & Development*, 98(1), 107–118. <https://doi.org/10.1002/jcad.12304>
- Ellis, M. V. (2017). Clinical Supervision Contract & Consent Statement and Supervisee Rights and Responsibilities. *The Clinical Supervisor*, 36(1), 145–159. <https://doi.org/10.1080/07325223.2017.1321885>
- Ellis, M. V., Hutman, H., & Chapin, J. (2015). Reducing supervisee anxiety: Effects of a role induction intervention for clinical supervision. *Journal of Counseling Psychology*, 62(4), 608–620. <http://doi.org/10.1037/cou0000099>
- Good, J. M. M. (2003). William Stephenson, quantum theory, and Q methodology. *Operant Subjectivity*, 26(4), 142–156. <http://doi.org/10.15133/j.os.2003.009>
- Homrich, A. M., DeLorenzi, L. D., Bloom, Z. D., & Godbee, B. (2014). Making the case for standards of conduct in clinical training. *Counselor Education and Supervision*, 53(2), 126–144. <https://doi.org/10.1002/j.1556-6978.2014.00053.x>
- Kagan, N. (1980). Influencing human interaction—Eighteen years with IPR. In A. K. Hess (Ed.), *Psychotherapy supervision: Theory, research and practice* (pp. 262–283). Wiley.
- Kangos, K. A., Ellis, M. V., Berger, L., Corp, D. A., Hutman, H., Gibson, A., & Nicolas, A. I. (2018). American Psychological Association guidelines for clinical supervision: Competency-based implications for supervisees. *The Counseling Psychologist*, 46(7), 821–845. <http://doi.org/10.1177/0011000018807128>
- Ladany, N., & Friedlander, M. L. (1995). The relationship between the supervisory working alliance and trainees' experience of role conflict and role ambiguity. *Counselor Education and Supervision*, 34(3), 220–231. <https://doi.org/10.1002/j.1556-6978.1995.tb00244.x>
- Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. *The Counseling Psychologist*, 10(1), 3–42. <http://doi.org/10.1177/0011000082101002>
- Malott, K. M., Hridaya Hall, K., Sheely-Moore, A., Krell, M. M., & Cardaciotto, L. (2014). Evidence-based teaching in higher education: Application to counselor education. *Counselor Education and Supervision*, 53(4), 294–305. <https://doi.org/10.1002/j.1556-6978.2014.00064.x>
- McKeown, B., & Thomas, D. B. (2013). *Q methodology* (2nd ed.). SAGE.
- Moate, R. M., Holm, J. M., & West, E. M. (2017). Perceived helpfulness of teachers in clinical courses. *The Professional Counselor*, 7(2), 155–168. <http://doi.org/10.15241/rmm.7.2.155>
- Munson, C. E. (2002). *Handbook of clinical social work supervision* (3rd ed.). Haworth Press.
- Neufeldt, S. A. (2007). *Supervision strategies for the first practicum* (3rd ed.). American Counseling Association.
- Norem, K., Magnuson, S., Wilcoxon, S. A., & Arbel, O. (2006). Supervisees' contributions to stellar supervision outcomes. *Journal of Professional Counseling: Practice, Theory & Research*, 34(1–2), 33–48. <https://doi.org/10.1080/15566382.2006.12033822>
- Paige, J. B., & Morin, K. H. (2016). Q-sample construction: A critical step for a Q-methodological study. *Western Journal of Nursing Research*, 38(1), 96–110. <https://doi.org/10.1177/0193945914545177>
- Patton, M. Q. (2015). *Qualitative research and evaluation methods* (4th ed.). SAGE.
- Pearson, Q. M. (2004). Getting the most out of clinical supervision: Strategies for mental health counseling students. *Journal of Mental Health Counseling*, 26(4), 361–373. <http://doi.org/10.17744/mehc.26.4.tttju8539ke8xuq6>
- Porter, N. (1995). Supervision of psychotherapists: Integrating anti-racist, feminist, and multicultural perspectives. In H. Landrine (Ed.), *Bringing cultural diversity to feminist psychology: Theory, research, and practice* (pp. 163–175). American Psychological Association. <http://doi.org/10.1037/10501-008>
- Porter, N., & Vasquez, M. (1997). Covision: Feminist supervision, process, and collaboration. In J. Worell & N. G. Johnson (Eds.), *Shaping the future of feminist psychology: Education, research, and practice* (pp. 155–171). American Psychological Association. <https://doi.org/10.1037/10245-007>

- Rønnestad, M. H., & Skovholt, 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.
<http://doi.org/10.1177/089484530303000102>
- Schmolck, P. (2014). PQMethod (Version 2.35). [Computer Software]. <http://schmolck.userweb.mwn.de/qmethod>
- Stark, M. D. (2017). Assessing counselor supervisee contribution. *Measurement and Evaluation in Counseling and Development, 50*(3), 170–182. <http://doi.org/10.1080/07481756.2017.1308224>
- Stephenson, W. (1978). Concourse theory of communication. *Communication, 3*(1), 21–40.
- Stoltenberg, C. D., & McNeill, B. W. (2010). *IDM supervision: An integrative developmental model for supervising counselors & therapists* (3rd ed.). Routledge.
- Watts, S., & Stenner, P. (2012). *Doing Q methodological research: Theory, method and interpretation*. SAGE.
- Wilcoxon, S. A., Norem, K., & Magnuson, S. (2005). Supervisees' contributions to lousy supervision outcomes. *Journal of Professional Counseling: Practice, Theory & Research, 33*(2), 31–49.
<https://doi.org/10.1080/15566382.2005.12033816>

Appendix

Q Sample Statements and Factor Array

#	Statement	F1	F2	F3
1	Demonstrates an awareness of their own strengths and weaknesses.	0	3	2
2	Feels able to speak freely in supervision sessions.	1	1	-3
3	Reads up on topics in their area of practice.	-3	-1	-2
4	Communicates information truthfully and accurately.	3	3	0
5	Manages personal wellness (physically, spiritually, psychologically, and socially) with supervisor.	0	-2	1
6	Develops specific realistic and measurable goals for supervision with the supervisor.	1	-2	-1
7	Arrives on time for supervision.	3	-3	0
8	Feels their perspectives and experiences were valued by supervisors in supervision sessions.	0	1	0
9	Identifies their own developmental needs.	-1	0	-4
10	Broaches difficult topics in supervision, such as issues pertaining to culture, race, or ethnicity.	3	0	3
11	Listens attentively to supervisor.	-2	0	-4
12	Recognizes and manages their anxiety about the supervision process.	0	-4	1
13	Initiates discussions related to the supervisory relationship.	-3	-2	-4
14	Manages ambiguity and uncertainty.	1	-4	-1
15	Adheres to the ethical codes, guidelines, and models of ethical behavior.	4	0	2
16	Feels their cultural identities are valued by a supervisor.	2	-4	2
17	Demonstrates a willingness to grow.	2	2	3
18	Prepares for each supervision session relevant to the supervision format (e.g., individual, triadic, group).	2	-2	0
19	Feels able to set goals independently.	-4	-2	-3
20	Recognizes and seeks regular and ongoing feedback.	-2	2	-2
21	Demonstrates an ability to see things from multiple perspectives.	1	0	3
22	Manages personal mental health, emotional problems, stress, and interpersonal issues.	1	1	4
23	Identifies how own biases interfere with development.	2	1	1
24	Collaborates on setting agendas for supervision sessions.	-2	-3	-3
25	Demonstrates healthy professional boundaries in supervision sessions and with clients.	4	2	2
26	Feels their time in supervision sessions is respected by supervisors.	0	-1	-1
27	Raises respectfully any points of disagreement with supervisor's opinions.	-2	-2	0
28	Demonstrates verbal communication skills in supervision.	-1	-1	3
29	Integrates feedback from supervisor into their clinical work.	2	3	2
30	Is pleasant to work with in supervision.	-4	-1	1

#	Statement	F1	F2	F3
31	Maintains an open and curious view of learning.	2	1	-2
32	Asks thoughtful questions in supervision regarding counseling-related issues.	-3	2	4
33	Works willingly with the supervisor.	-1	3	-3
34	Feels like they can be vulnerable in supervision sessions with their supervisor.	0	0	4
35	Asks for help when needed.	1	4	-2
36	Follows the procedures and policies of the graduate program.	4	-1	0
37	Integrates prior learning from other counseling classes such as microskills and theories into clinical work.	-1	2	1
38	Speaks freely and professionally about problem client cases in supervision.	1	1	-1
39	Supports the learning process of others.	-3	-3	0
40	Feels supervisors provide feedback about counseling skills.	-1	4	-1
41	Solicits feedback from peers.	-2	-1	-2
42	Participates actively in supervision sessions.	3	2	-2
43	Uses organized reasoning and good judgement to assess and respond to situations.	0	4	-1
44	Seeks challenges by attempting tasks that are perceived to be difficult.	-4	-3	-1
45	Feels empowered by their supervisor in supervision sessions.	-1	0	2
46	Takes responsibility for consequences of their behavior.	0	1	0
47	Fosters the supervisory relationship including agreement on emotional connection, goals, and tasks.	-2	-1	0
48	Discusses their impairments, blind spots, and other limitations with supervisor.	-1	0	1

Suicide Protective Factors: Utilizing SHORES in School Counseling



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Recently, a mnemonic device, SHORES, was created for counselors to utilize with clients with suicidal ideation. The acronym of SHORES stands for Skills and strategies for coping (S); Hope (H); Objections (O); Reasons to live and Restricted means (R); Engaged care (E); and Support (S). In this manuscript, SHORES is introduced as a way for school counselors to address protective factors against suicide. In addition, the authors review the literature on comprehensive school suicide prevention and suicide protective factors; describe the relevance of a suicide protective factors mnemonic that school counselors can use; and illustrate the mnemonic's application in classroom guidance, small-group, and individual settings.

Keywords: suicide prevention, protective factors, school counselors, SHORES, mnemonic

Rates of youth suicide have increased tremendously in the last decade. A report by the National Center for Health Statistics in 2019 indicated that suicide rates among American youth ages 10–24 increased 56% from 2007 to 2017, making it the second leading cause of death in this age group; during this same time period, the rate almost tripled for those ages 10–14 (Curtin & Heron, 2019). Additionally, the Centers for Disease Control and Prevention (CDC; 2017) reported that suicide is now the ninth leading cause of death for children ages 5–11.

The suicide rates for children as young as 5 can seem alarming and impact school counselors at all grade levels. Sheftall et al. (2016) stated that children who died by suicide in this younger age range were frequently diagnosed with a mental health disorder. In children, this diagnosis was usually attention deficit disorder with or without hyperactivity, and in young adolescents the diagnosis was most often depression or dysthymia. Researchers have also found that certain risk factors, such as childhood trauma, bullying, and academic pressure, can increase suicidal risk for youth (Cha et al., 2018; Jobes et al., 2019; Lanzillo et al., 2018).

Researchers agree that early prevention and intervention is essential to reduce youth suicides (Cha et al., 2018; Lanzillo et al., 2018; Sheftall et al., 2016). Similarly, postvention efforts, or crisis response strategies following a student's suicide, can lessen school suicide contagion and support future prevention efforts (American Foundation for Suicide Prevention [AFSP] et al., 2019). In this article, we review the literature on youth suicide and efforts to address it including leveraging protective factors, and we introduce the relevance of a suicide protective factors mnemonic that school counselors can apply in classroom guidance, small-group, and individual settings (American School Counselor Association [ASCA], 2019).

School Suicide Prevention

Curtin and Heron (2019) called for proactive efforts to help address the rising statistics for youth suicide, and schools are a natural place for prevention, intervention, and postvention to occur. Students

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spend the majority of their waking hours at school and have frequent contact with teachers, counselors, administrators, and peers. School efforts to address suicide risk must include these stakeholders, as well as parents and community members (Ward & Odegard, 2011).

A suicide prevention effort is a strategy intended to reduce the chance of suicide and/or possible harm caused by suicide (U.S. Department of Health and Human Services [HHS], Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). Best practice for suicide prevention in schools includes training all stakeholders, including students (Wyman et al., 2010). This training, frequently referred to as gatekeeper training, should include information about suicide warning signs and risk factors, as well as suicide protective factors, such as seeking help and having social connections. The World Health Organization's (WHO; 2006) booklet for counselors on suicide prevention lists several suicide warning signs, including ones with relevance to school-age youth, such as decreased school achievement, changed sleeping and eating, preoccupation with death, sudden promiscuity, or reprieve from depression (pp. 5–6). Another important component of school suicide prevention is training and practice on how to help a student who exhibits these and/or other suicidal warning signs (AFSP et al., 2019). Institutional efforts, such as forming crisis teams (AFSP et al., 2019), and anti-bullying programs can also contribute to school suicide prevention efforts (HHS, 2012).

Other school prevention efforts involve small-group and whole classroom lessons on resiliency, coping skills, executive functioning skills, and help-seeking behavior (Sheftall et al., 2016). Many programs exist and are beneficial at elementary, middle, and high school levels. The Suicide Prevention Resource Center (SPRC; 2019a) listed many options: Signs of Suicide, More Than Sad, Sources of Strength, and Kognito. Of these examples, only Signs of Suicide contains training for warning signs, suicide risk factors, and suicide protective factors. Some suicide prevention programs are state and population specific, but all include the information needed to help stakeholders to know the risks and signs, and to have a plan on how to help youth with suicidal thoughts. Talking about suicide prevention with all stakeholders promotes increased help-seeking behavior in children and adolescents (Wyman et al., 2010).

School Suicide Intervention

Suicide is an ongoing issue that many school counselors handle via intervention efforts. A suicide intervention effort is a strategy to change the course of an existing circumstance or risk trajectory for suicide (HHS, 2012). School counselors are a natural choice for helping to implement suicide prevention and intervention programs, as they often have training on working with students at risk for suicidal ideation (Gallo, 2018). Additionally, school counselors are ethically responsible to help create a “safe school environment . . . free from abuse, bullying, harassment and other forms of violence” and to “advocate for and collaborate with students to ensure students remain safe at home and at school” (ASCA, 2016, pp. 1, 4). One key component of school suicide intervention is suicide risk assessment. Gallo (2018) researched 200 high school counselors representing 43 states and found that 95% agreed it was their role to assess for suicidal risk, and 50.5% were conducting one or more suicide risk assessments each month. Other aspects of intervention include potential involvement of administrators, parents, and emergency or law enforcement services; referral to outside health care providers; and safety planning, including lethal means counseling (AFSP et al., 2019). School and other counselors are also involved in ongoing check-ins with students, re-entry planning after a mental health crisis, and responses to in-school and out-of-school suicide attempts.

School Suicide Postvention

Suicide postvention involves attending to those “affected in the aftermath of a suicide attempt or suicide death” (HHS, 2012, p. 141). ASCA, in collaboration with AFSP, the Trevor Project, and the

National Association of School Psychologists, released the *Model School District Policy on Suicide Prevention* that outlines policies and practices for districts, schools, and school professionals to protect student health and safety (AFSP et al., 2019). The model policy addresses postvention by summarizing a 7-step action plan involving school counselors and other professionals: 1) get the facts, 2) assess the situation, 3) share information, 4) avoid suicide contagion, 5) initiate support services, 6) develop memorial plans, and 7) postvention as prevention (pp. 11–13). The latest edition of a suicide postvention toolkit for schools (SPRC, 2019a) highlighted counselors' collaborative work for crisis response and suicide contagion; how they help students with coping and memorialization; and their involvement with community, media, and social media.

Addressing factors that protect against suicide is an important component of school district policies to combat suicide (AFSP et al., 2019) and of comprehensive school suicide prevention (Granello & Zyromski, 2018). Leveraging suicide protective factors is one way for school counselors to fulfill professional obligations and recommendations concerning student suicide risk. What remains unclear from the literature is how school counselors explore and enhance protective factors in their suicide prevention, intervention, and postvention efforts.

Suicide Risk and Protective Factors

The SPRC (2019b) defined *suicide risk factors* as “characteristics that make it *more likely* that individuals will consider, attempt, or die by suicide” and *protective factors* as those which make such events less likely (p. 1). High suicide risk involves a combination of risk factors. Examples of suicide risk factors include a prior attempt, mood disorders, alcohol abuse, and access to lethal means, whereas examples of suicide protective factors include connectedness, health care availability, and coping ability (SPRC, 2019b). Protective factors “are considered insulators against suicide,” which can “counterbalance the extreme stress of life events” (WHO, 2006, p. 3). Both risk and protective factors have varying levels of significance depending on the individual and their community (SPRC, 2019b).

Guidance from multiple sources stresses the salience of incorporating attention to suicide risk and protective factors into school counseling. The AFSP et al. (2019) *Model School District Policy on Suicide Prevention* notes risk and protective factors as crucial content in staff development and youth suicide prevention programming. In addition to the risk factors named above, the policy names high-risk groups, such as students who are involved in juvenile or child welfare systems; those who have experienced homelessness, bullying, or suicide loss; those who are lesbian, gay, bisexual, transgender, or questioning; or those who are American Indians/Alaska Natives (AFSP et al., 2019).

School counselors should know suicide protective factors that are specific to school settings and to the ages of students that they serve. The *Model School District Policy on Suicide Prevention* (AFSP et al., 2019) also highlights the role that accepting parents and positive connections within social institutions can play in a student's resiliency. Despite suicide prevention policy guidelines, numerous structured programs, and growing research on youth suicide protective factors, very little guidance is offered on practical methods for school counselors to address students' suicide protective factors. The purpose of this manuscript is to introduce to school counselors a recently published, research-based mnemonic—SHORES (Cureton & Fink, 2019). The acronym of SHORES stands for **S**kills and strategies for coping (**S**); **H**ope (**H**); **O**bjections (**O**); **R**easons to live and **R**estricted means (**R**); **E**ngaged care (**E**); and **S**upport (**S**). SHORES equips school counselors with a promising tool to guide suicide prevention, intervention, and postvention via direct and indirect school counseling services.

SHORES

Cureton and Fink (2019) created a mnemonic device called SHORES for counselors to utilize when working with clients. SHORES represents protective factors against suicide and the letters in the acronym were carefully selected based on support in the literature.

Figure 1

S	Skills and strategies for coping
H	Hope
O	Objections
R	Reasons to live and Restricted means
E	Engaged care
S	Support



Cureton, J. L., & Fink, M. (2019). SHORES: A practical mnemonic for suicide protective factors. *Journal of Counseling and Development*, 97(3), 325–335.

In the following sections, the authors define each part of the acronym and discuss how school counselors may apply SHORES with students. After discussing each of the protective factors in the mnemonic, we present a case example to demonstrate how school counselors may implement the SHORES tool with students in their school.

S: Skills and Strategies for Coping

First, school counselors can explore with students what skills and strategies for coping (S) with adversity they might already have in place, work to strengthen these, and also foster development of new coping skills and strategies. Cureton and Fink (2019) shared that some of the skills and strategies for coping that counter thoughts of suicide include emotional regulation, adaptive thinking, and engaging in one's interests (Berk et al., 2004; Fredrickson & Joiner, 2002; Law et al., 2015). For youth, such engagement includes academic and non-academic pursuits (Taliaferro & Muehlenkamp, 2014). School counselors often meet with students to discuss coping strategies and stress management; therefore, this step can easily be incorporated into working with students demonstrating signs of stress or even suicidal ideation.

Mindfulness skills and strategies may be particularly impactful for schools to incorporate. Research findings support the importance of a student's emotional regulation skills, as dysregulation is associated with children's suicidal thoughts (Wyman et al., 2009) and adolescents' suicide attempts (Pisani et al., 2013). There is substantial research evidence on the positive effect of mindfulness interventions in children and adolescents, particularly for decreasing depression and anxiety (Dunning et al., 2019). Flook et al. (2010) used a school-based mindful awareness program with elementary school children that incorporated sitting meditation; a brief visualized body scan; and games for sensory awareness,

attentional regulation, awareness of others, and awareness of the space around them. They found improvements in elementary school children's metacognition, behavioral regulation, and executive control. Broderick and Jennings (2012) posited that mindfulness practice is an effective coping strategy for adolescents because it "offers the opportunity to develop hardiness in the face of uncomfortable feelings that otherwise might provoke a behavioral response that may be harmful to self and others" (p. 120). Teaching or practicing mindfulness with students might include helping them with body awareness, understanding and working with thoughts and feelings, and reducing harmful self-judgements while increasing positive emotions.

H: Hope

Cureton and Fink (2019) suggested that hope (H) can protect against suicide because it may counterbalance negative emotions and cognitions. Studies have demonstrated that hope can help to safeguard the influence of hopelessness on suicidal ideation and that hope could, in turn, relieve a person's feelings of being a burden and not belonging (Davidson et al., 2009; Huen et al., 2015). Researchers have found that adolescents with hope have lower suicide risk (Wai et al., 2014) and that hope moderates depression and suicidal ideation, even among adolescents who experienced childhood neglect (Kwok & Gu, 2019).

Furthermore, Tucker and colleagues (2013) discovered that establishing hope can also decrease some of the adverse impacts of rumination on suicidal ideation. Classroom guidance lessons could help school counselors to assess if there are individual students who seem to lack hope; these students might be good candidates for small-group or individual counseling. If school counselors wanted to implement a schoolwide comprehensive program, they might look at implementing Hope Squads. Over 300 schools in Utah have implemented peer-to-peer suicide prevention programs called Hope Squads, which work to instill hope and create a school culture of connectedness and belonging (Wright-Berryman et al., 2019). Hope Squads could also be utilized in the final stage of SHORES as a source of Support (S).

Another way that researchers found to decrease suicidal ideation was building hope through goal-setting (Lapierre et al., 2007). School counselors are in a prime position to help with goal-setting and could incorporate the topic of hope when helping students to set goals. One evidence-based intervention that can be utilized by school counselors to help students with goal-setting is Student Success Skills. School counselors teaching the Student Success Skills lessons not only encourage students to set wellness goals, but also teach attitudes and approaches that will help students socially and to reach their academic potential (Villares et al., 2011).

O: Objections

Cureton and Fink (2019) included another supported protective factor: moral or cultural objections (O) to suicide. Researchers have found that individuals with fewer moral objections to suicide were more likely to attempt suicide (Lizardi et al., 2008), while those with a religious objection may have fewer attempts (Lawrence et al., 2016). Ibrahim and colleagues (2019) discovered that the role of religious and existential well-being was a protective factor for suicidal ideation with adolescents.

Research shows that school counselors feel ready to address spirituality with students, and at least one suicide prevention program could help with that focus. Smith-Augustine (2011) found that 86% of the 44 school counselors and school counseling interns who participated in a descriptive study had spirituality and religious issues arise with students, and 88% reported they felt comfortable addressing these issues with students. Although the focus is not on religion, this topic may come up when

discussing spirituality, and school counselors working in public schools will want to be mindful of any restrictions from their district about discussing religion and/or spirituality with students. One evidence-based suicide prevention program that addresses spirituality is Sources of Strength (2017).

Sources of Strength has been used primarily in high school settings, but guidance for its application in elementary schools is also available. While participating in Sources of Strength, youth are asked to reflect on and discuss a range of spiritual practices, ways they are thankful, and how they view themselves as “connected to something bigger” (Sources of Strength, 2017). Wyman and colleagues (2010) discovered that participating in Sources of Strength helped increase students’ perceptions of connectedness at school, in particular with adults in the building. Implementing this program would allow school counselors to seek out those students at risk and have further individual conversations and tailor any necessary interventions to that student’s cultural and religious/spiritual beliefs. School counselors could also refer students and families to therapists outside of the school setting who may be able to further explore spiritual and cultural beliefs and resources.

More research is needed about how cultural objections to suicide impact youth. For instance, there is a longstanding belief that the view in the Black community of suicide as “a White thing” (Early & Akers, 1993) acts as a suicide protective factor. But in the wake of rising suicide rates among Black youth, Walker (2020) challenged this notion, arguing that Black youth are at risk for suicide because mental health stigmas in their communities result in them keeping their distress to themselves. Other researchers (Sharma & Pumariega, 2018) have echoed the concern that guilt and/or shame about suicidal ideation may result in isolation in youth of color, including those from Black, Latinx, Asian, and other cultural groups. Another cultural objection in youth of color that may serve as a protective factor is culturally informed beliefs about death and the afterlife (Sharma & Pumariega, 2018). School counselors can focus on “normalizing suicidal ideation and acceptance of internal and external problematic events” (Murrell et al., 2014, p. 43) and on ways to include family members and other cultural representatives who are accepting of mental health issues in suicide-related conversations and programs with students of color.

R: Reasons to Live and Restricted Means

A fourth protective factor refers to two areas: reasons to live and restricted means (R). Reasons for living (RFL) are considered drives one might have for staying alive when contemplating suicide (Linehan et al., 1983). Bakhiyi et al. (2016) established in a systematic review of research literature that RFL serve as protective factors against suicidal ideation and suicide attempts in adolescents and adults. In a study with over 1,000 Chinese adolescents, the correlation between entrapment and suicidal ideation was moderated by RFL; adolescents with a higher RFL score had lower suicidal ideation even when experiencing high levels of entrapment (Ren et al., 2019). School counselors might consider giving students the RFL Inventory when presenting on suicide prevention or assessing for suicidal ideation, either the adolescent version (Osman et al., 1998) or the brief adolescent version (Osman et al., 1996). School counselors can also heighten students’ awareness of their RFL by asking them what or whom they currently cherish most or would miss or worry about if they suddenly went away.

The second part of this protective factor is restriction (R) of lethal suicide means, such as firearms, poisons, and medications (Cureton & Fink, 2019). There is evidence to support that restriction of means is effective for decreasing suicide (Barber & Miller, 2014; Kolves & Leo, 2017; Yip et al., 2012). For children and adolescents ages 10–19, the most frequent suicide method was hanging, followed by poisoning by pesticides for females and firearms for males. These findings were based on 86,280 suicide cases from 101 countries from 2000–2009 (Kolves & Leo, 2017).

Given this information, it is important for school counselors to not only assess for lethal weapons access but also to inquire about students' access to and awareness of how everyday items might be used to attempt suicide. Although it may be impossible to restrict all means that could be utilized for hanging or poisoning, school counselors can discuss with guardians various ways to reduce access to these means and provide more supervision for any youth exhibiting thoughts of suicide. Kolves and Leo (2017) also discussed the high number of youth who learn about ways to attempt suicide from media and the internet; therefore, restriction, reduction, and supervision of media and internet usage could also be something school counselors suggest to guardians.

E: Engaged Care

Another protective factor across populations is engagement (E) with caring professionals (Cureton & Fink, 2019; SPRC & Rodgers, 2011). School counselors often have hundreds of students on their caseloads, and this can become overwhelming, especially when dealing with crises such as suicide. At the same time, it is imperative that school counselors actively engage with students in a caring and supportive way. Often the school counselor might be the first person to intervene with a suicidal youth; Cureton and Fink (2019) emphasized the importance of the client being able to feel empathy and care from the counselor.

School counselors can view engaged care as an effective and collaborative approach for suicide prevention by working with students and families to leverage a variety of services. According to Ungar et al. (2019), "Students who reported high levels of connectedness to school also reported significantly lower rates of binge drinking, suicide attempts, and poor physical health compared to youth with low scores on school engagement" (p. 620). However, school counselors cannot be solely responsible for the ongoing engaged care of suicidal youth and will need to make referrals to outside counselors and/or physicians. Comprehensive engaged care might include mental health treatment and ongoing support and management from health care providers (Brown et al., 2005; Fleischmann et al., 2008; Linehan et al., 2006). Researchers found that comprehensive services that connect parents, schools, and communities result in decreased suicide attempts when compared to hospitalization for youth (Ougrin et al., 2013).

S: Support

The final element of the SHORES mnemonic emphasizes the importance of students having supportive (S) environments and relationships (Cureton & Fink, 2019). As mentioned above, the school counselor is only one source of support. The support and involvement of family can also serve as a protective factor (Jordan et al., 2012). Diamond et al. (2019) noted that "when adolescents view parents as sensitive, safe, and available, they are more likely to turn to parents for support that can buffer against common triggers for depressive feelings and suicide ideation" (p. 722).

In a study with 176 Malaysian adolescents, support from family and friends was found to be a protective factor against suicidal ideation (Ibrahim et al., 2019). Youth seek support for suicidal thoughts from peers more than from adults (Gould et al., 2009; Michelmores & Hindley, 2012; Wyman et al., 2010). Many suicide prevention programs, such as Hope Squads and Sources of Strength, are addressing the need for positive peer support by incorporating a peer-to-peer component into their interventions (Wright-Berryman et al., 2019; Wyman et al., 2010). Working to increase peer support along with support from school personnel, family, and community could be lifesaving for students contemplating suicide.

Case Example Applying SHORES

The SHORES tool is meant to be comprehensive and can be used in classroom guidance, small-group, and individual counseling. A case example is provided for how SHORES might be employed in a middle school setting; however, this example could be adapted to work with elementary or high school students.

A middle school counselor attended a training on SHORES and incorporates this into her comprehensive school counseling program. Each year when she delivers her lessons on suicide prevention, she brings the SHORES poster to each classroom and shares with her students about protective factors and ways to reach out and seek help if they have a concern about suicide.

During her second lesson on suicide prevention, the school counselor notices that one of her new seventh-grade students, Jesse, seems unusually withdrawn and disengaged. The counselor is reviewing skills and strategies for coping (S) and asks each of the students to write down three to four ways that they have learned to cope with stress. In addition, she asks them to report how well each of these strategies and coping skills are working for them on a scale of 1–10. When she collects the papers, she notices that Jesse has written only one coping skill: “Locking myself in my room away from all of the noise and the pain.” He then stated his coping skill “is a 10 and works great because people will just forget about me and I can disappear.”

The school counselor is concerned about these remarks and decides to bring Jesse in for an individual counseling session. As she is asking Jesse about whether he has hope (H) that things will get better, she learns that his father has been deployed for the past year, his mother recently went to prison, and his grandmother, who is his primary guardian, had a recent health scare. Jesse shares that he is afraid he is going to lose the people closest to him and he feels angry and alone. He states that being a “military brat” who is new to the school makes him feel even more isolated, and he worries what others will think if they find out his mom is a felon.

When the school counselor expresses her concern for his safety and asks if he has ever thought about killing himself, Jesse is adamant that suicide is against his religion and he would never do it. He adds, “My mom would break out of jail and whoop me if she even knew I had thoughts like that.” Although Jesse voices his objections (O) and denies any current suicidal ideation, the school counselor is concerned about his social–emotional well-being and suggests he join a small counseling group she has for students experiencing changes in their families. Jesse agrees to check it out and gets his grandmother to sign a permission form for him to attend.

During his first small counseling group, Jesse is quiet but does confide in the group what is happening in his family and that he has been feeling “depressed.” Two of the other group members share that they also feel depressed. The school counselor asks them to define what they mean by feeling depressed. As they answer, she creates a list on the board of their definitions: “I feel hopeless and alone,” “I sometimes don’t know why I’m even here,” and “Sometimes I want to just fall asleep and never wake up.”

After they explore these definitions and the underlying feelings, the school counselor writes “Reasons to Live” (R) on the whiteboard. She shares that sometimes when kids are feeling depressed or hopeless, it can be helpful to think about the different reasons that they want to live and things they enjoy about their lives. She gives the students time to come up with lists and keeps track of what each of the students came up with during the brainstorming session. Although all of the other students in the group are able to come up with four to five reasons to live, the school counselor notes that Jesse only came up with one: “I get to visit my mom each Sunday.”

The school counselor decides to keep Jesse a few minutes after group to check in on his safety again. First, she asks him if he had other reasons to live before he moved to his new school. Jesse said that he used to play soccer and that he loved it and it made him feel excited each day to be part of the team. The school counselor encourages Jesse to look into joining the school soccer team and offers to talk to the coach to see if this is a possibility.

When asked about suicidal ideation, he is again adamant that he would never do it, but he admits that a couple of years ago it did occur to him that he could take his grandfather’s gun and “end it all.” The school counselor discovers that Jesse’s grandmother kept her late husband’s gun at her house. After discussing this with Jesse and getting his consent to contact his grandmother, she decides to err on the side of caution and follow up. Jesse’s grandmother shares that she does not believe the gun even works anymore and that there are no bullets in the home. However, after speaking with the school counselor about restricting means (R) she decides to donate the gun to a local hunting club.

During this conversation, the grandmother also shares that she is concerned about Jesse, especially his lack of a male role model. She shares that Jesse’s biological father is active military and might only see Jesse once or twice a year, and his grandfather died when he was 2. The school counselor lets the grandmother know that she plans to contact the soccer coach (who is male) about getting Jesse to join the team. After some further conversation, the school counselor and grandmother agree that it would also be helpful for Jesse to have some ongoing engaged care (E) with a counselor outside of school. She also inquires about the family’s religious affiliation because Jesse has mentioned to her that this is important to him. The school counselor compiles a list of Christian male counselors and sends the list home at the end of the day.

Over the next few weeks, Jesse continues to attend the small group. He joined the soccer team and has also been working with an outside counselor. He reports he is feeling more hopeful, even though he still worries about his mom and misses her. The school counselor delivered a classroom lesson on sources of support (S) earlier that week and follows up with each of the students during group. Each member creates a list of current sources of support in their lives and shares it. The school counselor notes that Jesse’s paper is filled with names of people both in and outside of school; he has listed friends at school, on his soccer team, and in his neighborhood; his soccer coach; his mother and grandmother; a neighbor; two teachers; and both of his counselors.

As the small group begins to wrap up toward the end of the school year, the school counselor checks in with Jesse for an individual counseling session. She reminds him about their classroom lesson on skills and strategies for coping (S). Jesse shares that he and his other counselor have been working a lot on mindfulness and that he really enjoys this. With his counselor’s encouragement, Jesse has also pursued a few new interests such as joining a club for military kids and joining an after-school program. When the school counselor revisits the question about reasons to live (R), Jesse shares that he needs more than one sheet of paper to write down all the good things in his life. The school counselor follows

up with Jesse's grandmother to share these updates and promises to continue engaged care (E) with Jesse when he returns for eighth grade.

Implications for School Counseling Practice, Training, and Research

There are implications for the use of and research on this promising tool across counseling specialties, and we focus on school settings in alignment with the scope of this manuscript. Guidelines and recommendations for school counseling practice concerning suicide include attending to both risk factors and protective factors in work with students via comprehensive suicide prevention (ASCA, 2019; Granello & Zyromski, 2018). The SHORES tool has utility as a standard and recognizable component for a comprehensive school suicide prevention program; an adjunct to current interventions such as risk screening and safety planning measures; and a strengths-based framework for prevention, intervention, and postvention. Future research is necessary to explore these applications and their impact.

Although some school suicide prevention programs address suicide protective factors, SHORES offers school counselors a simple and practical tool that they can apply across behavioral elements of a comprehensive school counseling program (ASCA, 2019). This consistent integration may support deeper understanding and broader use among school counselors and other faculty/staff, as well as students. The case example illustrated how SHORES may be applied and useful in classroom, small-group, and individual settings.

School counselors may use interventions such as risk screening and safety planning, and SHORES can fill the gap for suicide protective factors in both. Most suicide risk screening focuses solely on risk factors or does not fully explore suicide protective factors (McGlothlin et al., 2016). The most well-known safety plan template (Stanley & Brown, 2012) does not include all elements of the SHORES mnemonic (Cureton & Fink, 2019). School counselors who add SHORES to their risk screens and safety plans will be engaging in more comprehensive and protective interventions for students who may be at risk for suicide.

SHORES derives from a positive, strengths-based mindset regarding suicide prevention, intervention, and postvention. School counselors can use the tool to guide wellness programming before a suicide by considering how current and future efforts serve to enhance each element of the acronym. School counselors are also key to suicide postvention or response following a suicide (AFSP & SPRC, 2018). A school's suicide postvention plan has three aims (Fineran, 2012), and embedding SHORES into the plan may help minimize distress, reduce contagion, and ease the return to school routines in place before the crisis. Additionally, the SHORES tool addresses several of the assets and barriers for successful school reintegration after a student's psychiatric hospitalization (Clemens et al., 2011), so potential applications also include postvention after suicide attempts.

There are also training implications for SHORES in counselor education and supervision and practitioner professional development. Although school counselors' training on suicide appears to have improved over the last 25 years, Gallo (2018) found that only 50% of high school counselors felt adequately prepared to identify suicidal students and assess their risk. Counselors-in-training have described the specific need for more training on child and adolescent suicide assessment (Cureton & Sheesley, 2017). Counselors-in-training (Cureton & Sheesley, 2017) and educators (Cureton et al., 2018) have also acknowledged the benefit of practicing suicide response in supervised counseling (i.e., internship), as well as the potential to miss opportunities simply because no clients present with suicide risk during such experiences. However, a recent assessment (Cureton et al., 2018) demonstrated that

the counselor education and supervision field has only modest readiness to address the issue of suicide in its master's-level training programs, in part because of negative views about suicide as a topic that is too scary, serious, advanced, and taxing to cover in class (Cureton et al., in press).

The strengths-based, preventative nature of SHORES positions it as a tool that can be easily introduced in classroom role-plays as well as during conversations with students being served during practicum and internship. Reframing these conversations, and more broadly all suicide-related efforts in counseling, as both challenging and potentially positive and life-affirming may partially address the negative stigma within and beyond the counselor education and supervision field (Cureton et al., 2018, in press). Finally, adding SHORES to existing school personnel training offerings like those listed by the SPRC (2019a) would deepen professional development for school counselors and other staff, faculty, and administration.

Future Research

Despite the numerous possibilities to apply the SHORES tool in K–12 and other educational settings (Cureton & Fink, 2019), research is needed to establish its utility and effectiveness. Primary investigations include studies with school counselors who are considering adopting and implementing SHORES in their schools to understand perceptions of its apparent value and barriers to use. Evaluative studies about training offerings and investigations into memory recall of acronym components among school counselors would also aid in conceptualization of true functionality of the SHORES tool.

Research on students' perceptions and outcomes studies are also needed. Students' reactions to and generalized use of the SHORES tool would be beneficial in order to examine its appeal, as would those of families, teachers, and stakeholders. It is also important to explore how to be developmentally appropriate across grade levels. Finally, outcomes studies on SHORES for prevention, intervention, and postvention are necessary to determine its practical worth. For instance, a comparison between a school counseling department's existing safety planning procedure and a SHORES-enhanced procedure would be valuable. Studies about SHORES and counselor self-efficacy to address suicide would also add to the literature.

Conclusion

As rates of youth suicide have increased in recent years, the need for school counselors to adopt tools to better assess suicide risk in their students has taken on more urgency. SHORES provides a strengths-based assessment tool that can be used by school counselors to quickly examine the protective factors that potentially mitigate against suicide in their students. Offering a comprehensive overview of existential, behavioral, and interpersonal factors that have been identified as bolstering defenses against suicidality, each letter of the SHORES acronym is rigorously supported by research and provides clear implications for the tool's utility in K–12 settings. Given that only roughly half of school counselors feel sufficiently prepared to assess suicide risk in their students, the SHORES tool provides a practical resource for screening and safety planning. Even so, more research is needed to illustrate and verify the SHORES tool's ease of use and adoption into other existing school-based approaches to addressing suicide in student populations.

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References

- American Foundation for Suicide Prevention, American School Counselor Association, National Association of School Psychologists, & The Trevor Project. (2019). *Model school district policy on suicide prevention: Model language, commentary, and resources* (2nd ed). <https://afsp.org/model-school-policy-on-suicide-prevention>
- American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). *After a suicide: A toolkit for schools* (2nd ed.). Education Development Center, Inc. <https://sprc.org/resources-programs/after-suicide-toolkit-schools>
- American School Counselor Association. (2016). *Ethical standards for school counselors*. <https://www.schoolcounselor.org/getmedia/f041cbd0-7004-47a5-ba01-3a5d657c6743/Ethical-Standards.pdf>
- American School Counselor Association. (2019). *ASCA school counselor professional standards & competencies*. <https://www.schoolcounselor.org/getmedia/a8d59c2c-51de-4ec3-a565-a3235f3b93c3/SC-Competencies.pdf>
- Bakhiyi, C. L., Calati, R., Guillaume, S., & Courtet, P. (2016). Do reasons for living protect against suicidal thoughts and behaviors? A systematic review of the literature. *Journal of Psychiatric Research*, 77, 92–108. <https://doi.org/10.1016/j.jpsychires.2016.02.019>
- Barber, C. W., & Miller, M. J. (2014). Reducing a suicidal person's access to lethal means of suicide: A research agenda. *American Journal of Preventive Medicine*, 47(3S2), S264–S272. <https://doi.org/10.1016/j.amepre.2014.05.028>
- Berk, M. S., Henriques, G. R., Warman, D. M., Brown, G. K., & Beck, A. T. (2004). A cognitive therapy intervention for suicide attempters: An overview of the treatment and case examples. *Cognitive and Behavioral Practice*, 11(3), 265–277. [https://doi.org/10.1016/S1077-7229\(04\)80041-5](https://doi.org/10.1016/S1077-7229(04)80041-5)
- Broderick, P. C., & Jennings, P. A. (2012). Mindfulness for adolescents: A promising approach to supporting emotion regulation and preventing risky behavior. *New Directions for Youth Development*, 121(136), 111–126. <https://doi.org/10.1002/yd.20042>
- Brown, G. K., Have, T. T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts. *JAMA*, 294(5), 563–570. <https://doi.org/10.1001/jama.294.5.563>
- Centers for Disease Control and Prevention. (2017). WISQARS. *Web-based injury statistics query and reporting system*. <https://www.cdc.gov/injury/wisqars/index.html>
- Cha, C. B., Franz, P. J., Guzmán, E. M., Glenn, C. R., Kleiman, E. M., & Nock, M. K. (2018). Annual research review: Suicide among youth – Epidemiology, (potential) etiology, and treatment. *Journal of Child Psychology and Psychiatry*, 59(4), 460–482. <https://doi.org/10.1111/jcpp.12831>
- Clemens, E. V., Welfare, L. E., & Williams, A. M. (2011). Elements of successful school reentry after psychiatric hospitalization. *Preventing School Failure: Alternative Education for Children and Youth*, 55(4), 202–213. <https://doi.org/10.1080/1045988X.2010.532521>
- Cureton, J. L., Clemens, E. V., Henninger, J., & Couch, C. (2018). Pre-professional suicide training for counselors: Results of a readiness assessment. *International Journal of Mental Health and Addiction*, 18, 27–40. <https://doi.org/10.1007/s11469-018-9898-4>
- Cureton, J. L., Clemens, E. V., Henninger, J., & Couch, C. (in press). Readiness of counselor education and supervision for suicide training: A CQR study. *Journal of Counselor Preparation and Supervision*, 14(3).
- Cureton, J. L., & Fink, M. (2019). SHORES: A practical mnemonic for suicide protective factors. *Journal of Counseling & Development*, 97(3), 325–335. <https://doi.org/10.1002/jcad.12272>
- Cureton, J. L., & Sheesley, A. P. (2017). Suicide competencies: Stories from counseling interns. *Journal of Professional Counseling: Practice, Theory & Research*, 44(2), 14–31. <https://doi.org/10.1080/15566382.2017.12069188>
- Curtin, S. C., & Heron, M. (2019). Death rates due to suicide and homicide among persons aged 10–24: United States, 2000–2017. *NCHS Data Brief*, no 352. National Center for Health Statistics.
- Davidson, C. L., Wingate, L. R., Rasmussen, K. A., & Shish, M. L. (2009). Hope as a predictor of interpersonal suicide risk. *Suicide and Life-Threatening Behavior*, 39(5), 499–507. <https://doi.org/10.1521/suli.2009.39.5.499>
- Diamond, G. S., Kobak, R. R., Krauthamer Ewing, E. S., Levy, S. A., Herres, J. L., Russon, J. M., & Gallop, R. J. (2019). A randomized controlled trial: Attachment-based family and nondirective supportive treatments for youth who are suicidal. *Journal of the American Academy of Child & Adolescent Psychiatry*, 58(7), 721–731. <https://doi.org/10.1016/j.jaac.2018.10.006>

- Dunning, D. L., Griffiths, K., Kuyken, W., Crane, C., Foulkes, L., Parker, J., & Dalgleish, T. (2019). Research review: The effects of mindfulness-based interventions on cognition and mental health in children and adolescents – A meta-analysis of randomized controlled trials. *Journal of Child Psychology and Psychiatry*, 60(3), 244–258. <https://doi.org/10.1111/jcpp.12980>
- Early, K. E., & Akers, R. L. (1993). “It’s a white thing”: An exploration of beliefs about suicide in the African-American community. *Deviant Behavior*, 14(4), 277–296. <https://doi.org/10.1080/01639625.1993.9967947>
- Fineran, K. R. (2012). Suicide postvention in schools: The role of the school counselor. *Journal of Professional Counseling: Practice, Theory & Research*, 39(2), 14–28. <https://doi.org/10.1080/15566382.2012.12033884>
- Fleischmann, A., Bertolote, J. M., Wasserman, D., De Leo, D., Bolhari, J., Botega, N. J., De Silva, D., Phillips, M., Vijayakumar, L., Värnik, A., Schlegel, L., & Thanh, H. T. T. (2008). Effectiveness of brief intervention and contact for suicide attempters: A randomized controlled trial in five countries. *Bulletin of the World Health Organization*, 86(9), 703–709. <https://doi.org/10.2471/BLT.07.046995>
- Flook, L., Smalley, S. L., Kitil, M. J., Galla, B. M., Kaiser-Greenland, S., Locke, J., Ishijima, E., & Kasari, C. (2010). Effects of mindful awareness practices on executive functions in elementary school children. *Journal of Applied School Psychology*, 26, 70–95. <https://doi.org/10.1080/15377900903379125>
- Fredrickson, B. L., & Joiner, T. (2002). Positive emotions trigger upward spirals toward emotional well-being. *Psychological Sciences*, 13(2), 172–175. <https://doi.org/10.1111/1467-9280.00431>
- Gallo, L. L. (2018). The relationship between high school counselors’ self-efficacy and conducting suicide risk assessments. *Journal of Child and Adolescent Counseling*, 4(3), 209–225. <https://doi.org/10.1080/23727810.2017.1422646>
- Gould, M. S., Klomek, A. B., & Batejan, K. (2009). The role of schools, colleges and universities in suicide prevention. In D. W. Wasserman & C. Wasserman (Eds.), *Oxford textbook of suicidology and suicide prevention: A global perspective* (pp. 551–560). Oxford University Press.
- Granello, P. F., & Zyromski, B. (2018). Developing a comprehensive school suicide prevention program. *Professional School Counseling*, 22(1), 1–11. <https://doi.org/10.1177/2156759X18808128>
- Huen, J. M. Y., Ip, B. Y. T., Ho, S. M. Y., & Yip, P. S. F. (2015). Hope and hopelessness: The role of hope in buffering the impact of hopelessness on suicidal ideation. *PLoS ONE*, 10(6), 1–18. <https://doi.org/10.1371/journal.pone.0130073>
- Ibrahim, N., Che Din, N., Ahmad, M., Amit, N., Ghazali, S. E., Wahab, S., Kadir, N., Halim, F. W., & Halim, M. (2019). The role of social support and spiritual wellbeing in predicting suicidal ideation among marginalized adolescents in Malaysia. *BMC Public Health*, 19(1), 1–9. <https://doi.org/10.1186/s12889-019-6861-7>
- Jobes, D. A., Vergara, G. A., Lanzillo, E. C., & Ridge-Anderson, A. (2019). The potential use of CAMS for suicidal youth: Building on epidemiology and clinical interventions. *Children’s Health Care*, 48(4), 444–468. <https://doi.org/10.1080/02739615.2019.1630279>
- Jordan, J., McKenna, H., Keeney, S., Cutcliffe, J., Stevenson, C., Slater, P., & McGowan, I. (2012). Providing meaningful care: Learning from the experiences of suicidal young men. *Qualitative Health Research*, 22(9), 1207–1219. <https://doi.org/10.1177/1049732312450367>
- Kolves, K., & Leo, D. (2017). Suicide methods in children and adolescents. *European Child & Adolescent Psychiatry*, 26(2), 155–164. <https://doi.org/10.1007/s00787-016-0865-y>
- Kwok, S. Y. C. L., & Gu, M. (2019). Childhood neglect and adolescent suicidal ideation: A moderated mediation model of hope and depression. *Prevention Science*, 20(5), 632–642. <https://doi.org/10.1007/s11212-018-0962-x>
- Lanzillo, E. C., Horowitz, L. M., & Pao, M. (2018). Suicide in children. In T. Falcone & J. Timmons-Mitchell (Eds.), *Suicide prevention: A practical guide for the practitioner* (pp. 73–107). <https://doi.org/10.1007/978-3-319-74391-2>
- Lapierre, S., Dubé, M., Bouffard, L., & Alain, M. (2007). Addressing suicidal ideations through the realization of meaningful personal goals. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 28(1), 16–25. <https://doi.org/10.1027/0227-5910.28.1.16>
- Law, K. C., Khazem, L. R., & Anestis, M. D. (2015). The role of emotion dysregulation in suicide as considered through the ideation to action framework. *Current Opinion in Psychology*, 3, 30–35. <https://doi.org/10.1016/j.copsyc.2015.01.014>
- Lawrence, R. E., Oquendo, M. A., & Stanley, B. (2016). Religion and suicide risk: A systematic review. *Archives of Suicide Research*, 20(1), 1–21. <https://doi.org/10.1080/13811118.2015.1004494>

- Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., Korslund, K. E., Tutek, D. A., Reynolds, S. K., & Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, 63(7), 757–766. <https://doi.org/10.1001/archpsyc.63.7.757>
- Linehan, M. M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you are thinking of killing yourself: The Reasons for Living Inventory. *Journal of Consulting and Clinical Psychology*, 51(2), 276–286. <https://doi.org/10.1037//0022-006x.51.2.276>
- Lizardi, D., Dervic, K., Grunebaum, M. F., Burke, A. K., Mann, J. J., & Oquendo, M. A. (2008). The role of moral objections to suicide in the assessment of suicidal patients. *Journal of Psychiatric Research*, 42(10), 815–821. <https://doi.org/10.1016/j.jpsychires.2007.09.007>
- McGlothlin, J., Page, B., & Jager, K. (2016). Validation of the SIMPLE STEPS model of suicide assessment. *Journal of Mental Health Counseling*, 38(4), 298–307. <https://doi.org/10.17744/mehc.38.4.02>
- Michelmores, L., & Hindley, P. (2012). Help-seeking for suicidal thoughts and self-harm in young people: A systematic review. *Suicide and Life-Threatening Behavior*, 42(5), 507–524. <https://doi.org/10.1111/j.1943-278X.2012.00108.x>
- Murrell, A. R., Al-Jabari, R., Moyer, D., Novamo, E., & Connally, M. L. (2014). An acceptance and commitment therapy approach to adolescent suicide. *International Journal of Behavioral Consultation and Therapy*, 9(3), 41–46. <https://doi.org/10.1037/h0101639>
- Osman, A., Downs, W. R., Kopper, B. A., Barrios, F. X., Baker, M. T., Osman, J. R., Besett, T. M., & Linehan, M. M. (1998). The Reasons for Living Inventory for Adolescents (RFL-A): Development and psychometric properties. *Journal of Clinical Psychology*, 54(8), 1063–1078. [https://doi.org/10.1002/\(SICI\)1097-4679\(199812\)54:8<1063::AID-JCLP6>3.0.CO;2-Z](https://doi.org/10.1002/(SICI)1097-4679(199812)54:8<1063::AID-JCLP6>3.0.CO;2-Z)
- Osman, A., Kopper, B. A., Barrios, F. X., Osman, J. R., Besett, T., & Linehan, M. M. (1996). The Brief Reasons for Living Inventory for Adolescents (BRFL-A). *Journal of Abnormal Child Psychology*, 24(4), 433–443. <https://doi.org/10.1007/BF01441566>
- Ougrin, D., Zundel, T., Ng, A. V., Habel, B., & Latif, S. (2013). Teaching therapeutic assessment for self-harm in adolescents: Training outcomes. *Psychology and Psychotherapy: Theory, Research and Practice*, 86(1), 70–85. <https://doi.org/10.1111/j.2044-8341.2011.02047.x>
- Pisani, A. R., Wyman, P. A., Petrova, M., Schmeelk-Cone, K., Goldston, D. B., Xia, Y., & Gould, M. S. (2013). Emotion regulation difficulties, youth–adult relationships, and suicide attempts among high school students in underserved communities. *Journal of Youth and Adolescence*, 42(6), 807–820. <https://doi.org/10.1007/s10964-012-9884-2>
- Ren, Y., You, J., Lin, M.-P., & Xu, S. (2019). Low self-esteem, entrapment, and reason for living: A moderated mediation model of suicidal ideation. *International Journal of Psychology*, 54(6), 807–815. <https://doi.org/10.1002/ijop.12532>
- Sharma, N., & Pumariega, A. J. (2018). Culturally informed treatment of suicidality with diverse youth: General principles. In A. Pumariega & N. Sharma (Eds.), *Suicide among diverse youth: A case-based guidebook* (pp. 21–30). Springer.
- Sheftall, A. H., Asti, L., Horowitz, L. M., Felts, A., Fontanella, C. A., Campo, J. V., & Bridge, J. A. (2016). Suicide in elementary school-aged children and early adolescents. *Pediatrics*, 138(4). <https://doi.org/10.1542/peds.2016-0436>
- Smith-Augustine, S. (2011). School counselors' comfort and competence with spirituality issues. *Counseling & Values*, 55(2), 149–156. <https://doi.org/10.1002/j.2161-007X.2011.tb00028.x>
- Sources of Strength. (2017). *Strength specific campaigns*. <https://sourcesofstrength.org/strength-specific-campaigns>
- Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19(2), 256–264. <https://doi.org/10.1016/j.cbpra.2011.01.001>
- Suicide Prevention Resource Center. (2019a). *Preventing suicide: A community engagement toolkit*. <https://www.sprc.org/resources-programs/preventing-suicide-community-engagement-toolkit>
- Suicide Prevention Resource Center. (2019b). *Understanding risk and protective factors for suicide: A primer for preventing suicide*. <https://www.sprc.org/resources-programs/understanding-risk-protective-factors-suicide-primer-preventing-suicide>

- Suicide Prevention Resource Center, & Rodgers, P. (2011). *Understanding risk and protective factors for suicide: A primer for preventing suicide*. <http://www.sprc.org/sites/default/files/migrate/library/RiskProtectiveFactorsPrimer.pdf>
- Taliaferro, L. A., & Muehlenkamp, J. J. (2014). Risk and protective factors that distinguish adolescents who attempt suicide from those who only consider suicide in the past year. *Suicide and Life-Threatening Behavior*, 44(1), 6–22. <https://doi.org/10.1111/sltb.12046>
- Tucker, R. P., Wingate, L. R., O'Keefe, V. M., Mills, A. C., Rasmussen, K., Davidson, C. L., & Grant, D. M. (2013). Rumination and suicidal ideation: The moderating roles of hope and optimism. *Personality and Individual Differences*, 55(5), 606–611. <https://doi.org/10.1016/j.paid.2013.05.013>
- Ungar, M., Connelly, G., Liebenberg, L., & Theron, L. (2019). How schools enhance the development of young people's resilience. *Social Indicators Research*, 145(2), 615–627. <https://doi.org/10.1007/s11205-017-1728-8>
- U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). *2012 national strategy for suicide prevention: Goals and objectives for action*. www.ncbi.nlm.nih.gov/books/NBK109917
- Villares, E., Lemberger, M., Brigman, G., & Webb, L. (2011). Student Success Skills: An evidence-based school counseling program grounded in humanistic theory. *Journal of Humanistic Counseling*, 50(1), 42–55. <https://doi.org/10.1002/j.2161-1939.2011.tb00105.x>
- Wai, C. M., Talib, M. A., Yaacob, S. N., Tan, J.-P., Awang, H., Hassan, S., & Ismail, Z. (2014). Hope and its relation to suicidal risk behaviors among Malaysian adolescents. *Asian Social Science*, 10(12), 67–71. <https://doi.org/10.5539/ass.v10n12p67>
- Walker, R. (2020, January 17). Black kids and suicide: Why are rates so high, and so ignored? *The Conversation*. <https://theconversation.com/black-kids-and-suicide-why-are-rates-so-high-and-so-ignored-127066>
- Ward, J. E., & Odegard, M. A. (2011). A proposal for increasing student safety through suicide prevention in schools. *The Clearing House: A Journal of Educational Strategies, Issues and Ideas*, 84(4), 144–149. <https://doi.org/10.1080/00098655.2011.564981>
- World Health Organization. (2006). *Preventing suicide: A resource for counsellors*. https://apps.who.int/iris/bitstream/handle/10665/43487/9241594314_eng.pdf;jsessionid=791EEAFBE71ECDD1039FCBF04E3C8711?sequence=1
- Wright-Berryman, J. L., Hudnall, G., Bledsoe, C. J., & Lloyd, M. (2019). Suicide concern reporting among Utah youths served by a school-based peer-to-peer prevention program. *Children & Schools*, 41(1), 35–44. <https://doi.org/10.1093/CS/CDY026>
- Wyman, P. A., Brown, C. H., LoMurray, M., Schmeelk-Cone, K., Petrova, M., Yu, Q., Walsh, E., Tu, X., & Wang, W. (2010). An outcome evaluation of the Sources of Strength suicide prevention program delivered by adolescent peer leaders in high schools. *American Journal of Public Health*, 100(9), 1653–1661. <https://doi.org/10.2105/AJPH.2009.190025>
- Wyman, P. A., Gaudieri, P. A., Schmeelk-Cone, K., Cross, W., Brown, C. H., Sworts, L., West, J., Burke, K. C., & Nathan, J. (2009). Emotional triggers and psychopathology associated with suicidal ideation in urban children with elevated aggressive-disruptive behavior. *Journal of Abnormal Child Psychology*, 37(7), 917–928. <https://doi.org/10.1007/s10802-009-9330-4>
- Yip, P. S. F., Caine, E., Yousuf, S., Chang, S.-S., Wu, K. C.-C., & Chen, Y.-Y. (2012). Means restriction for suicide prevention. *The Lancet*, 379(9834), 2393–2399. [https://doi.org/10.1016/S0140-6736\(12\)60521-2](https://doi.org/10.1016/S0140-6736(12)60521-2)

Self-Reported Symptoms of Burnout in Novice Professional Counselors: A Content Analysis



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This study explored the self-reported symptoms of burnout in a sample of 246 novice professional counselors. The authors inductively analyzed 1,205 discrete units using content analysis, yielding 12 categories and related subcategories. Many emergent categories aligned with existing conceptualizations of burnout, while other categories offered new insights into how burnout manifested for novice professional counselors. Informed by these findings, the authors implore counseling scholars to consider, in their conceptualization of counselor burnout, a wide range of burnout symptoms, including those that were frequently endorsed symptoms (e.g., negative emotional experience, fatigue and tiredness, unfulfilled in counseling work) as well as less commonly endorsed symptoms (e.g., negative coping strategies, questions of one's career choice, psychological distress). Implications for novice professional counselors and supervisors are offered, including a discussion about counselors' experiences of burnout to ensure they are providing ethical services to their clients.

Keywords: novice professional counselors, burnout, content analysis, conceptualization, symptoms

The term *high-touch professions* refers to the fields that require professionals to provide ongoing and intense emotional services to clients (Maslach & Leiter, 2016). Although such work can be highly rewarding, these professionals are also at risk for burnout (Bardhoshi et al., 2019). In counseling, professionals are called to provide ongoing and intensive mental health services to clients with trauma histories (Foreman, 2018) and complicated needs (Freadling & Foss-Kelly, 2014). The risk of burnout is exacerbated by the fact that counselors often work in professional environments that are highly demanding and lack resources to serve their clients (Freadling & Foss-Kelly, 2014; Maslach & Leiter, 2016).

The consequences of burnout for counselors and clients can be considerable (Bardhoshi et al., 2019). Potential impacts include a decline in counselors' self-care, strain of personal relationships, and damage to their overall emotional health (Bardhoshi et al., 2019; Cook et al., 2020; Maslach & Leiter, 2016). Unaddressed burnout might also lead to more serious professional issues like impairment (e.g., substance use, mental illness, personal crisis, or illness; Lawson et al., 2007). Thus, self-monitoring symptoms of burnout is of the utmost importance for counselors to ensure they are providing ethical services to their clients (American Counseling Association [ACA], 2014).

Although burnout is an occupational risk to all counselors (e.g., Bardhoshi et al., 2019; J. Lee et al., 2011; S. M. Lee et al., 2007), novice professional counselors may be especially vulnerable to burnout (Thompson et al., 2014; Westwood et al., 2017; Yang & Hayes, 2020). In the current study, we define novice professional counselors as those who are currently engaged in supervision for licensure in their respective states. Novice professional counselors face a multitude of challenges, such as managing large caseloads, working long hours for low wages, and receiving limited financial support for client care (Freadling & Foss-Kelly, 2014). Even though their professional competencies are still developing

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(Freadling & Foss-Kelly, 2014; Rønnestad & Skovholt, 2013), these counselors receive minimal direct oversight from a supervisor (Cook & Sackett, 2018). However, to date, no study has exclusively examined novice professional counselors' descriptions of their experiences of burnout. Input from these counselors is important to understand their specific issues of counselor burnout. Other helping professionals have studied a rich context of practitioners' burnout experiences. For example, Warren et al. (2012) examined open-ended text responses of people who treated clients with eating disorders and found nuanced contributors to burnout among these providers, including patient descriptors (e.g., personality, engagement in treatment), work-related descriptors (e.g., excessive work hours, inadequate resources), and therapist descriptors (e.g., negative emotional response, self-care). Accordingly, we employed a similar approach to examine the open-ended qualitative responses of 246 novice professional counselors' self-reported symptoms of burnout.

Conceptual Framework of Burnout

Burnout is defined as "a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job" (Maslach & Leiter, 2016, p. 103). Although there are multiple conceptual frameworks of burnout (e.g., Kristensen et al., 2005; S. M. Lee et al., 2007; Maslach & Jackson, 1981; Shirom & Melamed, 2006; Stamm, 2010), the predominant model used to study burnout is the one developed by Maslach and Jackson (1981), which is measured by the Maslach Burnout Inventory (MBI). Informed by qualitative research, Maslach and Jackson (1981) developed the MBI and conceptualized burnout for all human service professionals as a three-dimensional model consisting of Exhaustion, Depersonalization, and Decreased Personal Accomplishment. Exhaustion is signaled by emotional fatigue, loss of energy, or feeling drained. Depersonalization is characterized by cynicism or negative attitudes toward clients, while Decreased Personal Accomplishment is indicated by a lack of fulfillment in one's work or feeling ineffective. This conceptualization of burnout has been used to develop several versions of the MBI that are targeted for different professions (e.g., human services, education) and for professionals in general.

Despite the prominence of the MBI model in the burnout literature (Koutsimani et al., 2019), other scholars (e.g., Kristensen et al., 2005; Shirom & Melamed, 2006) have argued for a different conceptualization of burnout, noting several shortcomings of Maslach and Jackson's (1981) three-dimensional model. Shirom and Melamed (2006) criticized the lack of theoretical framework of the MBI and noted that the factors were derived via factor analysis. They developed the Shirom-Melamed Burnout Measure (Shirom & Melamed, 2006), a measure informed by the Conservation of Resources theory (Hobfoll, 1989), which measures burnout as a depletion of physical, emotional, and cognitive resources using two subscales: Physical Fatigue and Cognitive Weariness.

Kristensen et al. (2005) also criticized the utility of the MBI for numerous reasons, including the lack of theoretical underpinnings of the instrument. Therefore, they developed the Copenhagen Burnout Inventory to capture burnout in professionals across disciplines, most notably human service professionals. From Kristensen et al.'s perspective, the underlying cause of burnout is physical and psychological exhaustion, which occurs across three domains: Personal Burnout (i.e., burnout that is attributable to the person themselves), Work-Related Burnout (i.e., burnout that is attributable to the workplace), and Client-Related Burnout (i.e., burnout that is attributable to their work with clients; Kristensen et al., 2005).

Stamm (2010) conceptualized the construct of professional quality of life for helping professionals, which included three dimensions: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Burnout, as theorized by Stamm, is marked by feelings of hopelessness, frustration, and anger, as

well as a belief that one's own work is unhelpful to others, which results in a decline in professional performance. The experience of burnout may also be caused by an overburdening workload or working in an unsupportive environment (Stamm, 2010). Stamm's model is reflected in the Professional Quality of Life Scale (ProQOL), and this instrument has been used by counseling scholars (e.g., Lambert & Lawson, 2013; Thompson et al., 2014).

A reason for variations in the conceptualization of burnout is that it manifests differently across professions (Maslach & Leiter, 2016). The only counseling-specific model of burnout is conceptualized by S. M. Lee et al. (2007), who developed the Counselor Burnout Inventory (CBI). The CBI was informed by the three dimensions of the MBI and additionally captured the unique work environment of professional counselors and its impact on their personal lives. As such, the CBI poses a five-dimensional model consisting of Exhaustion, Incompetence, Negative Work Environment, Devaluing Client, and Deterioration in Personal Life. In recent years, the CBI has been the instrument predominantly used by researchers to study counselor burnout (e.g., Bardhoshi et al., 2019; Fye et al., 2020; J. Lee et al., 2011).

The Current Study

J. Lee et al. (2011) noted the challenges of studying counselor burnout across diverse samples. They encouraged scholars to examine burnout within homogenous samples of counselors in order to offer more nuanced implications for each group. Prior scholarship (e.g., Freadling & Foss-Kelly, 2014; Thompson et al., 2014) suggested that novice professional counselors may be at risk of burnout, and despite the aforesaid vulnerabilities (e.g., low wages, work with high need clients, professional competency limitations), their self-reported manifestation of burnout symptoms have yet to be studied.

We acknowledge the critical importance of studying burnout in the profession of counseling. However, repeatedly relying on data from similar instruments to measure burnout may fail to capture new or relevant information about the phenomenon (Kristensen et al., 2005) for human service professionals (e.g., Maslach & Jackson, 1981) or professional counselors (e.g., S. M. Lee et al., 2007). Alternatively, content analysis, which focuses on the analysis of open-ended qualitative text (Krippendorff, 2013), may better capture the intricacies of burnout that could not be measured using quantitative instruments (e.g., Warren et al., 2012). Thus, we aimed to address the following research question: What are novice professional counselors' self-reported symptoms of burnout?

Methodology

Participants

Participants in the current study were 246 postgraduate counselors who were currently receiving supervision for licensure. The age of participants ranged from 23 to 69, averaging 36.91 ($SD = 10.15$) years. The majority of participants identified as female ($n = 195$, 79.3%), while 22 participants identified as male (8.9%), four identified as non-binary (1.6%), nine indicated that they did not want to disclose their gender (3.7%), and 16 participants did not respond to the item (6.5%). The participants' race/ethnicity was reported as follows: White ($n = 186$; 75.6%), Multiracial ($n = 15$, 6.1%), Latino/Hispanic ($n = 7$, 3.3%), Black ($n = 6$, 2.4%), Asian ($n = 6$, 2.4%), American Indian or Alaska Native ($n = 3$, 0.8%), Native Hawaiian or Pacific Islander ($n = 1$, 0.4%), and Other ($n = 7$, 3.3%), while 15 participants declined to respond to the item (6.1%). The self-reported race/ethnicity demographic information is comparable to all counselors in the profession, based on DataUSA (2018). The participants' client caseload ranged from 1 to 650 ($M = 41.88$; $Mdn = 30.0$; $SD = 53.74$). On average, participants had worked as counselors for 5 years ($Mdn = 3.3$; $SD = 4.87$). The provided percentages may not total to 100 percent because of rounding and because participants were afforded the option to select more than one response.

Procedure

To answer our research question, we used data from a larger study of novice professional counselor burnout, which included both quantitative and qualitative data. After receiving IRB approval, we obtained lists of names and email addresses of counselors engaged in supervision for licensure from the licensing boards in seven states: Florida, Nebraska, New Mexico, Oregon, Utah, Washington, and Wisconsin. We aimed to recruit a nationally representative sample by purposefully choosing at least one state from each of the ACA regions. In addition, states were selected based upon our ability to obtain a list of counselors who were engaged in supervision for licensure from the respective licensure boards. We were able to survey at least one state from each ACA region except the North Atlantic Region. After removing invalid email addresses, we invited 6,874 potential participants by email to complete an online survey in Qualtrics. This survey was completed by 560 counselors, yielding a response rate of 8.15%. This response rate is consistent with other studies that employed a similar design (Gonzalez et al., 2020). All participants were asked, Do you believe you are currently experiencing symptoms of burnout?, to which participants responded (a) yes or (b) no. Participants who responded *yes* were then prompted with the direction, Describe your symptoms of burnout, using an open-ended text box, which did not have a character limit. A total of 246 participants (43.9%) responded *yes* and qualitatively described their symptoms of burnout. On average, participants provided 30.31 words ($SD = 36.30$). We answered our research question for the current study using only the qualitative data, which aligns with the American Psychological Association's Journal Article Reporting Standards for Qualitative Research (JARS-Qual; Levitt et al., 2018).

Data Analysis

To answer our research question, we analyzed participants' open-ended responses using content analysis, which allows for systematic and contextualized review of text data (Krippendorff, 2013). As recommended by Krippendorff (2013), we followed the steps of conducting content analysis: unitizing, sampling, recording, and reducing. We first separated the responses of the 246 participants into discrete units. For example, "feeling exhausted and back pain" was coded as two units: (a) feeling exhausted and (b) back pain. This process resulted in a total of 1,205 discrete units. We reduced our data into categories using an inductive approach, which allowed for new categories to emerge from the data without an a priori theory (Krippendorff, 2013). Although there are multiple conceptualizations of burnout (Maslach & Jackson, 1981; S. M. Lee et al., 2007) that could have informed our analysis (i.e., deductive approach; Krippendorff, 2013), we chose an inductive approach to capture the conceptualization of burnout for novice professional counselors—generating categories based on participants' explanations of their own symptoms of burnout (Kondracki et al., 2002).

To that end, we developed a codebook by randomly selecting roughly 10% of the discrete units to code as a pretest. Our first and third authors, Ryan M. Cook and Janelle L. Jones, independently reviewed the discrete units, met to discuss and develop categories and corresponding definitions, and coded the pretest data together to enhance reliability. This process yielded a codebook that consisted of 12 categories. Cook and Jones then used the codebook (categories and definitions) to independently code the remaining 90% of the data across three rounds (i.e., 30% increments). After each round, Cook and Jones met to discuss discrepancies and to reach consensus on the final codes. The overall agreement between Cook and Jones was 97% and the interrater reliability was acceptable (Krippendorff $\alpha = .80$; Krippendorff, 2013), which was calculated using ReCal2 (Freelon, 2013). At the end of the coding process, Cook and Jones reviewed their notes for each code and further organized them into subcategories based on commonalities. The second author, Heather J. Fye, served as the auditor (see Researcher Trustworthiness section) and reviewed the entire coding process.

Researcher Trustworthiness

The research team consisted of four members, three counselor educators and one counselor education and supervision doctoral student. The first and third authors, Cook and Jones, served as coders, while the second author, Fye, served as the auditor and the fourth author, Eric R. Baltrinic, served as a qualitative consultant. The counseling experience of the four authors ranged from 4 to 18 years, and the supervision experience of the authors ranged from 3 to 9 years. Cook, Fye, and Baltrinic are licensed professional counselors and three of the authors are credentialed as either a National Certified Counselor or Approved Clinical Supervisor.

We all acknowledged our personal experiences of burnout to some degree as practicing counselors as well as observing the consequences of burnout to our students and supervisees. All members of the research team had prior experience studying counselor burnout. Although these collective experiences enriched our understanding of the subject matter, we also attempted to bracket our assumptions and biases throughout the research process. To increase the trustworthiness of the coding process, the auditor, Fye, reviewed the codebook, categories and subcategories, discreteness, and two coders' notes coding process after the pretest and rounds of coding. Fye provided feedback on the category definitions, coding process, and coding decisions during the analysis process.

Results

Using an inductive approach, 12 categories and related subcategories emerged from the 1,205 discrete self-reported symptoms of burnout. Full results, including the 12 categories and subcategories, as well as the frequencies of the categories and subcategories, are presented in the Appendix. We discuss each category in detail and provide illustrative examples of each category using direct participant quotes (Levitt et al., 2018).

Negative Emotional Experience

Of the 1,205 coded units, 218 units (18.1%) were coded into the category *negative emotional experience*. This category reflected participants' descriptions of experiencing negative feelings related to their work as counselors (e.g., anxiety, depression, irritability) or unwanted negative emotions (e.g., crying spells). This category included 15 subcategories, and the units coded into these subcategories reflected the participants' descriptions of a wide range of negative feelings. For example, one participant reported she was "struggling to feel happy," while another participant shared that she "is carrying a heavy burden [that] no one understands or is aware of." Some participants also reported crying spells. One participant shared she "has fits of crying," while another reported she "[cries] in the bathroom at work."

Fatigue and Tiredness

The category *fatigue and tiredness* was coded 195 times (16.2%) and included four subcategories. This category captured participants' descriptions of feeling exhausted, fatigued, or tired. Units coded into this category included the participants' indications that they feel exhausted, despite sleeping well. For example, one participant described feeling perpetually exhausted—"nothing recharges my batteries"—while another participant stated that her fatigue worsened as the week progressed: "[I feel] more and more exhausted throughout the week."

Unfulfilled in Counseling Work

The category *unfulfilled in counseling work* captured the participants' descriptions of no longer deriving joy at work, dread in going to work or completing work-related responsibilities, or lacking motivation to do work. This category was coded 140 times (11.6%) and subcategories included five

subcategories. Avoidance of burdensome administrative responsibilities (e.g., paperwork) were commonly reported units that were captured in this category. For example, a participant noted “putting off doing notes.” Units also captured in this category reflected participants’ self-report of no longer feeling motivated or deriving joy from their work, which ultimately led some participants to stop seeking training. For instance, a participant described herself as “going through the motions at work,” and another added that she was no longer “motivated to improve [her] skills.”

Unhealthy Work Environment

Across all coded units, 128 units (10.6%) were coded in the category *unhealthy work environment*, which included 15 subcategories. This category captured participants’ descriptions of their work environment that contribute to a counselor experiencing burnout. For example, units captured in this category commonly described participants’ reports of working long hours with few or no breaks throughout the day, and participants feeling pressured to take on additional clients. Some participants described managing large client caseloads or caseloads with “high risk or high needs” clients. The units reflecting participants’ perceived lack of supervisor support were also coded into this category. For example, a participant noted that she was “scared to make a mistake or ask questions about doing my job,” while another participant described a supervisor as not “supportive or trustworthy.” Finally, units that signaled participants’ feelings of being inadequately compensated were coded into this category, such as this participant’s response: “I do not get paid enough for the work that I do.”

Physical Symptoms

The category *physical symptoms* reflected participants’ descriptions of physical ailments, physical manifestations of burnout (e.g., soreness, pain), physical illnesses, or physical descriptors (e.g., weight gain, weight loss). There were 107 coded units (8.9%) that referenced physical symptoms. The seven subcategories captured in this category reflected a wide range of physical ailments. The most commonly coded units were participants’ descriptions of headaches, illnesses, and weight changes, although some less commonly coded units reflected more serious physical and medical issues. For example, a participant noted, “I have TMJ [temporomandibular joint dysfunction] pain most days from clenching my jaw,” while another participant stated that she “recently began to have debilitating stomach symptoms, which were identified as small ulcerations.”

Negative Impact on Personal Interest or Self-Care

Across all coded units, 101 units (8.4%) were coded in the category *negative impact on personal interest or self-care*, which included eight subcategories. This category reflected the participants’ descriptions of reduced self-care or inability to engage in self-perceived healthy behaviors (e.g., cannot fall asleep), or lacking personal interest. Units coded in this category most commonly reflected participants’ experience of sleep issues—difficulty either falling asleep or staying asleep. Other units reflected participants’ lessening desire to engage in once-enjoyable activities. For example, one participant noted, “I find myself knowing that I need more time for play, rest, recovery, socializing, and personal interests, but [I am] feeling confused about how to fit that in.” Another participant described her self-care as unconstructive: “It often feels like no amount of self-care is helpful, which makes it more difficult to engage in any self-care.”

Self-Perceived Ineffectiveness as a Counselor

We coded 127 units (10.5%) into the category *self-perceived ineffectiveness as a counselor*, which included six subcategories. This category reflected the participants’ descriptions of their self-perceived decrease in self-efficacy as a counselor, difficulty in developing or maintaining therapeutic relationships with clients, decreased empathy toward clients, or questioning of their own abilities as counselors (e.g., ability to

facilitate change). For example, one participant noted that she did not “have as much empathy for clients as before,” while another participant expressed, “I often feel like clients are being demanding and trying to waste my time.” Units coded into this category also reflected participants’ feelings of inadequacy or struggles to develop a meaningful professional relationship with clients. One participant stated that she must “reach very deep every morning for the presence of mind and spirit to pay close attention and to care deeply for each of these people.” Although less frequently coded, some units described participants’ feelings of compassion satisfaction or self-reported secondary traumatic stress. For example, one participant shared that she was “personally disturbed” by her work.

Cognitive Impairment

Across all coded units, 75 units (6.2%) were coded in the category *cognitive impairment*, and this category included seven subcategories. The units coded into this category reflected the participants’ descriptions of their cognitive abilities being negatively impacted in different ways. For example, one participant described “feeling like I am in a fog at work,” while another participant shared that she found it “hard to concentrate at work.” Some units captured in this category reflected participants’ rumination of clients or work; for example, one participant noted “shifting my attention to ruminating about dropouts at times, when I need to be present with a [current] client.”

Negative Impact on Personal Relationships

The category *negative impact on personal relationships* captured 63 coded units (5.2%). Participants’ descriptions of strained relationships as a result of their self-reported burnout were coded into this category, which included three subcategories. For example, one participant described “not [feeling] available for emotional connects with others in my personal life,” while another participant said that they “lashed out sometimes at family members after a stressful day of work.” Another example of the negative impact on personal relationships was a participant’s description of “struggling to find joy at home with my wife and two kids.”

Negative Coping Strategies

We coded 22 units (1.8%) into the category *negative coping strategies*. This category included five subcategories that captured participants’ descriptions of using unhealthy or negative coping strategies to cope with burnout. Units coded into this category described participants’ use of a variety of negative coping strategies. For example, participants noted an increase in “alcohol consumption” or “smoking.” Relatedly, a participant expressed one of her coping strategies was “the excessive use of Netflix,” while another participant stated that she was “not eating or eating way too much.”

Questioning of One’s Career Choice

Units that reflected participants’ descriptions of the questioning of one’s career choice and potential or planned desire to leave the profession were coded into the category *questioning of one’s career choice*. There were 21 coded units (1.7%) for this category, which included two subcategories. An example of units coded into this category is a participant who stated that she has “thoughts that I have made a mistake in pursuing this line of work.” Another participant shared feelings of “wanting to quit [my] job.” Some units coded into this category captured participants who were already making plans to leave their jobs or the field. For example, one participant shared that she “recently put in [my] notice at agency,” while another participant stated plans to leave the profession “within one year.”

Psychological Distress

The least number of units were coded into the category *psychological distress*, which was coded eight times (0.7%) and included two subcategories. This category captured the participants’ discussions of

a mental health diagnosis, which they attributed as a symptom of burnout, or suicidal ideations. For example, one participant shared, "I have been diagnosed with major depressive disorder and my job is a factor," while another participant stated, "I sought therapy for myself and I had to increase my anti-depressant medication." Finally, two participants endorsed experiencing suicidal ideations at some previous point related to their burnout.

Discussion

The content analysis yielded insights of self-reported burnout symptoms by capturing the phenomenon in novice professional counselors' own words. Many of the 12 categories that emerged from the data generally aligned with prior conceptualizations of burnout for human service professionals (e.g., Maslach & Jackson, 1981) and counselors (S. M. Lee et al., 2007), while some categories provided novel insights into how burnout manifested in this sample. Further, we observed trends in common self-reported descriptors of burnout for novice professional counselors (negative emotional experiences) to the least commonly endorsed descriptors (psychological distress). We assert that these findings enrich the scholarly understanding of the burnout phenomenon in novice professional counselors.

Discussion of the Conceptual Framework of Burnout

Maslach and Jackson (1981) emphasized in their earlier work that exhaustion and fatigue are core features of burnout, and the category of *fatigue and tiredness* was the second most commonly coded category (16.2% of all coded units) in our study. Our findings reaffirm exhaustion (or fatigue or tiredness) as a central feature of burnout, and specifically self-reported symptoms of burnout in novice professional counselors. Scholars (e.g., Kristensen et al., 2005; Maslach & Jackson, 1981; Shirom & Melamed, 2006) have conceptualized that the interconnectedness between the emotional, physical, and psychological fatigue of burnout is different. Shirom and Melamed (2006) distinguished emotional, physical, and cognitive resources, while Kristensen et al. (2005) made no distinction between physical and psychological exhaustion. Stamm (2010) also viewed exhaustion as a feature of burnout but did not specify how this exhaustion manifested in human service professionals. In the current study, we chose to distinguish emotional, physical, and cognitive symptoms to best capture the participants' experiences in their own words (Kondracki et al., 2002). However, we found supportive evidence that novice professional counselors' burnout included emotional, physical, and cognitive symptoms. Our findings suggest that all three components should be examined to adequately capture this phenomenon.

The category *negative emotional experience*, which reflected participants' reports of experiencing negative feelings associated with their work as counselors, was the most commonly endorsed symptom of burnout (18.1% of all coded units). In other models of burnout (e.g., Kristensen et al., 2005; Shirom & Melamed, 2006), feelings or emotions are most often conceptualized as emotional exhaustion, emotional fatigue, or emotional distress. However, the participants in the current study richly described their negative emotional experiences, as captured in the subcategories, with irritability, anxiety, depression, and stress being the most commonly endorsed negative emotions. These findings most closely align with Stamm's (2010) conceptualization of burnout, which suggested that feelings of hopelessness, anger, frustration, and depression are evidence of burnout. Relatedly, a similar content analysis performed with eating disorder treatment professionals also found that their participants most frequently described emotional distress (61% of their sample, $n = 94$) as a way in which their worry for clients impacts their personal and professional lives (Warren et al., 2012). Scholars (e.g., Maslach & Leiter, 2016) have postulated about the relationship between workplace burnout and affectional distress (e.g., depression, anxiety, stress); however, such an investigation has yet to be conducted in the

profession of counseling. Our findings suggest that novice professional counselors commonly describe their manifestation of burnout as an emotional experience, and as such, this represents a gap in the current conceptualization of counselor burnout.

Two other categories captured in the current study were *physical symptoms* and *cognitive impairment symptoms*. Physical symptoms were coded for 8.9% of the 1,205 units coded, while cognitive symptoms were coded for 6.1% of all coded units. In the existing burnout literature (e.g., Maslach & Jackson, 1981; Shirom & Melamed, 2006), physical symptoms of burnout often paralleled or referenced fatigue or exhaustion. For example, in Shirom and Melamed's (2006) model, physical symptoms were reflective of feeling physically tired. However, in the current study, participants most commonly described their physical symptoms as back pain, illnesses, and headaches. This finding aligns with Kaeding et al. (2017), who found that counseling and clinical psychology trainees attributed their back and neck pain to sitting for long periods of time. We assert that specific physical symptoms may have been inadequately captured by the existing models of burnout.

Relatedly, Shirom and Melamed (2006) suggested that psychological fatigue or psychological manifestations of burnout should be distinguished from those of emotional and physical symptoms, while Kristensen et al. (2005) made no such distinctions. The participants in the current study described numerous cognitive manifestations of burnout, and the most commonly coded subcategories included concentration or focus, rumination, and forgetfulness. These self-reported symptoms closely align with the model of Shirom and Melamed, which describes psychological fatigue as an inability to think clearly and difficulty processing one's own thoughts. Further, Kristensen et al. described one symptom of personal burnout as being at risk of becoming ill. However, no items of cognitive impairment or worsening cognitive abilities are included in the CBI. Informed by our findings, descriptors of cognitive impairment should be considered to understand burnout in novice professional counselors.

Two of the three dimensions of burnout as conceptualized by Maslach and Jackson (1981) were Depersonalization (i.e., cynicism or negative attitudes toward clients) and Decreased Personal Accomplishment (i.e., diminished fulfillment in one's work or feeling ineffective in their work). These two dimensions are similar to Stamm's (2010) conceptualization of burnout for human service professionals, which included the features of perceiving that one's own work is unhelpful and no longer enjoying the work. In the current study, two of the categories that emerged closely aligned with these conceptualizations of burnout: *unfulfilled in counseling work* (11.6% of all coded units) and *self-perceived ineffectiveness as a counselor* (10.5% of all coded units). Collectively, these two categories and related subcategories provide rich descriptors of how novice professional counselors experience their own depersonalization and diminished personal accomplishment (Maslach & Jackson, 1981).

Our findings align with qualitative studies of novice professional counselors' experiences (e.g., Freadling & Foss-Kelly, 2014; Rønnestad & Skovholt, 2013). For example, Freadling and Foss-Kelly (2014) found that novice professional counselors sometimes question if their graduate training adequately prepared them for their current positions. As such, questioning of one's clinical abilities by counselors at this developmental level was also a common experience by participants in our study (Freadling & Foss-Kelly, 2014).

Our findings were consistent with the counselor-specific burnout model in which S. M. Lee et al. (2007) noted the importance of including the unique work environment of counselors and related impact on their personal life. Our findings support the burnout conceptualization with novice professional counselors. For example, participants in the current study described an *unhealthy work*

environment (10.6% of all coded units). The most commonly coded subcategories included unsupportive employer or supervisor, frustrated with system, burdened by documentation, and overburdened by amount of work or multiple roles.

In terms of the impact of counseling work on their personal lives (S. M. Lee et al., 2007), evidence of this dimension was captured in the current study in two categories: *negative impact on personal interest or self-care* and *negative impact on personal relationships*. There is a high degree of interconnectedness between burnout and self-care (Maslach & Leiter, 2016; Warren et al., 2012). Thus, it is unsurprising that participants reported a decrease in their self-care; however, some of the specific self-care behaviors that are affected as a result of novice professional counselors experiencing burnout are less understood. In the current study, the most commonly coded subcategory was difficulty falling asleep or staying asleep, followed by lack of interest in hobbies, poor work/life balance, and general decrease in self-care. As defined in the CBI, lack of time for personal interest and poor work/life balance are both indicators of Deterioration in Personal Life. While sleep onset and maintenance issues are associated with burnout (Yang & Hayes, 2020), counselors' experiences with sleep issues appears to be a novel finding. Another indicator of deterioration in counselors' personal lives as theorized by S. M. Lee et al. was a lack of time to spend with friends, which was also observed in our study. Relatedly, some participants indicated that they isolated from their social support system. Other participants described strained personal relationships (i.e., conflict in personal relationships, poor emotional connection with others), which are unique findings.

Counselor Burnout Versus Counselor Impairment

Although uncommonly reported, some participants in the current study described using *negative coping strategies* (1.8% of all coded units) and *psychological distress* (0.7% of all coded units) as evidence of their self-reported burnout. Examples of negative coping strategies reported by participants included increased substance use (e.g., alcohol, caffeine, nicotine) and overeating or skipping meals, while examples of psychological distress included having received a psychological diagnosis and experiencing increased suicidal ideations, which participants attributed to burnout. These self-reported symptoms of burnout align more closely with the definition of counselor impairment (Lawson et al., 2007) as opposed to the definition of counselor burnout. Our findings are significant for two reasons. First, any study of counselor burnout that utilized one of the commonly used instruments of burnout (e.g., CBI, MBI) would have failed to capture these participants' experiences. Second, these findings suggest that a small number of counselors may be experiencing significant impairment in their personal and professional lives, despite being early in their professional careers. Finally, another infrequently coded category was *questioning of one's career choice* (1.7% of all coded units). Coded units in this category indicated that some counselors were wondering if counseling was a good professional fit for them, while others expressed their intention to seek employment in another profession. It is possible that prolonged disengagement from one's professional work (i.e., cynicism; Maslach & Jackson, 1981) could result in counselors wanting to explore other career options.

Limitations

There are limitations of this study which we must address. The purpose of content analysis is not to generalize findings, so our findings may only reflect the experiences of burnout for the participants in the current study. Their experiences may be influenced by developmental levels, experiences in their specific state, or other reasons that we did not capture.

Another limitation is our response rate of 8.15%. A possible reason for our low response rate is self-selection bias—counselors who were currently experiencing burnout responded to the open-ended items as opposed to those who were not feeling burnout. Future research is needed to see how burnout presents in larger or different populations of counselors. It might also be important to study the career-sustaining behaviors and work environments of those counselors who did not endorse burnout. The final limitation is that this study was descriptive in nature. Future researchers are encouraged to explore the factors that may predict burnout while also considering the novel findings generated from this study.

Implications

Our findings offer implications for counseling researchers, counselors, and supervisors. Although many of the findings from the current study align with prior research, there appears to be some degree of discrepancy between how burnout is conceptualized by scholars and how novice professional counselors describe symptoms of burnout. We implore scholars to further examine the specific descriptors of burnout as reported by participants in this study and to see if the frequency of these self-reported symptoms can be duplicated. Specifically, scholars should focus on the emotional experience of novice professional counselors, fatigue and tiredness, and feeling unfulfilled in their work, which were the most commonly reported symptoms. It also seems critically important to explore the less commonly reported descriptors of burnout, like negative coping strategies, questioning of one's career choice, and psychological distress. Each of these categories could signal counselor impairment and would have been otherwise missed by scholars who relied exclusively on existing Likert-type burnout inventories.

Novice professional counselors sometimes experience self-doubt about their counseling skills or even the profession (Rønnestad & Skovholt, 2013), given the difficult work conditions in which these counselors practice (e.g., low wages, long hours; Freadling & Foss-Kelly, 2014). Novice professional counselors should understand that experiences of burnout appear to be commonly occurring. The illumination of these descriptors may encourage other novice professional counselors to seek guidance from their supervisors on how best to manage these feelings. For those novice professional counselors who are experiencing more serious personal and professional issues associated with burnout (e.g., using negative coping strategies and psychological distress), they should consider whether they are presently able to provide counseling services to clients and seek consultation from a supervisor (ACA, 2014).

Our findings have implications for supervisors. For example, supervisors should be willing to openly discuss burnout with their supervisees. Our results can provide supervisors with descriptors that capture novice professional counselors' experiences of burnout. Supervisors might find it helpful to disclose some of their own experiences of burnout (or mitigating burnout) with their supervisees, which can normalize the supervisees' experiences (Knox et al., 2011). Finally, to the extent that supervisors are able, they should protect novice professional counselors from experiencing an unhealthy work environment or potentially harmful behaviors. For example, in response to supervisees' self-reported symptoms of burnout, supervisors could limit caseloads, allow counselors time to complete documentation, or mandate regular breaks throughout the day (including lunchtime).

Conclusion

There are many novice professional counselors experiencing a wide range of symptoms of burnout. A career in counseling can be rewarding, but prolonged burnout can lead to both personal and professional consequences, as evidenced by the findings from this study. Counselors must attend to their own

symptoms of burnout in order to provide quality care to their clients and lead a fulfilling personal life. Supervisors and educators can support these counselors by discussing the experiences of burnout, and future scholars can better understand the experiences of counselor burnout by studying the phenomenon using definitions and symptoms in the words of counselors as opposed to generic definitions.

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References

- American Counseling Association. (2014). *ACA code of ethics*.
- Bardhoshi, G., Erford, B. T., & Jang, H. (2019). Psychometric synthesis of the Counselor Burnout Inventory. *Journal of Counseling & Development, 97*(2), 195–208. <https://doi.org/10.1002/jcad.12250>
- Cook, R. M., Fye, H. J., & Wind, S. A. (2020). An examination of the Counselor Burnout Inventory using item response theory in early career post-master's counselors. *Measurement and Evaluation in Counseling and Development*. Advance online publication. <https://doi.org/10.1080/07481756.2020.1827439>
- Cook, R. M., & Sackett, C. R. (2018). Exploration of prelicensed counselors' experiences prioritizing information for clinical supervision. *Journal of Counseling & Development, 96*(4), 449–460. <https://doi.org/10.1002/jcad.12226>
- DataUSA. (2018). *Counselors*. <https://datausa.io/profile/soc/counselors#demographics>
- Foreman, T. (2018). Wellness, exposure to trauma, and vicarious traumatization: A pilot study. *Journal of Mental Health Counseling, 40*(2), 142–155. <https://doi.org/10.17744/mehc.40.2.04>
- Freadling, A. H., & Foss-Kelly, L. L. (2014). New counselors' experiences of community health centers. *Counselor Education and Supervision, 53*(3), 219–232. <https://doi.org/10.1002/j.1556-6978.2014.00059.x>
- Freelon, D. (2013). ReCal OIR: Ordinal, interval, and ratio intercoder reliability as a web service. *International Journal of Internet Science, 8*(1), 10–16.
- Fye, H. J., Cook, R. M., Baltrinic, E. R., & Baylin, A. (2020). Examining individual and organizational factors of school counselor burnout. *The Professional Counselor, 10*(2), 235–250. <https://doi.org/10.15241/hjf.10.2.235>
- Gonzalez, E., Sperandio, K. R., Mullen, P. R., & Tuazon, V. E. (2020). Development and initial testing of the Multidimensional Cultural Humility Scale. *Measurement and Evaluation in Counseling and Development, 54*(1), 56–70. <https://doi.org/10.1080/07481756.2020.1745648>
- Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist, 44*(3), 513–524. <https://doi.org/10.1037/0003-066X.44.3.513>
- Kaeding, A., Sougleris, C., Reid, C., van Vreeswijk, M. F., Hayes, C., Dorrian, J., & Simpson, S. (2017). Professional burnout, early maladaptive schemas, and physical health in clinical and counselling psychology trainees. *Journal of Clinical Psychology, 73*(12), 1782–1796. <https://doi.org/10.1002/jclp.22485>
- Knox, S., Edwards, L. M., Hess, S. A., & Hill, C. E. (2011). Supervisor self-disclosure: Supervisees' experiences and perspectives. *Psychotherapy, 48*(4), 336–341. <https://doi.org/10.1037/a0022067>
- Kondracki, N. L., Wellman, N. S., & Amundson, D. R. (2002). Content analysis: Review of methods and their applications in nutrition education. *Journal of Nutrition Education and Behavior, 34*(4), 224–230. [https://doi.org/10.1016/S1499-4046\(06\)60097-3](https://doi.org/10.1016/S1499-4046(06)60097-3)
- Koutsimani, P., Montgomery, A., & Georganta, K. (2019). The relationship between burnout, depression, and anxiety: A systemic review and meta-analysis. *Frontiers in Psychology, 10*(284), 1–19. <https://doi.org/10.3389/fpsyg.2019.00284>
- Krippendorff, K. (2013). *Content analysis: An introduction to its methodology* (3rd ed.). SAGE.

- Kristensen, T. S., Hannerz, H., Høgh, A., & Borg, V. (2005). The Copenhagen Psychosocial Questionnaire: A tool for the assessment and improvement of the psychosocial work environment. *Scandinavian Journal of Work, Environment & Health*, 31(6), 438–449. <https://doi.org/10.5271/sjweh.948>
- Lambert, S. F., & Lawson, G. (2013). Resilience of professional counselors following Hurricanes Katrina and Rita. *Journal of Counseling & Development*, 91(3), 261–268. <https://doi.org/10.1002/j.1556-6676.2013.00094.x>
- Lawson, G., Venart, E., Hazler, R. J., & Kottler, J. A. (2007). Toward a culture of counselor wellness. *Journal of Humanistic Counseling*, 46(1), 5–19. <https://doi.org/10.1002/j.2161-1939.2007.tb00022.x>
- Lee, J., Lim, N., Yang, E., & Lee, S. M. (2011). Antecedents and consequences of three dimensions of burnout in psychotherapists: A meta-analysis. *Professional Psychology: Research and Practice*, 42(3), 252–258. <https://doi.org/10.1037/a0023319>
- Lee, S. M., Baker, C. R., Cho, S. H., Heckathorn, D. E., Holland, M. W., Newgent, R. A., Ogle, N. T., Powell, M. L., Quinn, J. J., Wallace, S. L., & Yu, K. (2007). Development and initial psychometrics of the Counselor Burnout Inventory. *Measurement and Evaluation in Counseling and Development*, 40(3), 142–154. <https://doi.org/10.1080/07481756.2007.11909811>
- Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publication and Communications Board task force report. *American Psychologist*, 73(1), 26–46. <https://doi.org/10.1037/amp0000151>
- Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, 2(2), 99–113. <https://doi.org/10.1002/job.4030020205>
- Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry*, 15(2), 103–111. <https://doi.org/10.1002/wps.20311>
- Rønnestad, M. H., & Skovholt, T. M. (2013). *The developing practitioner: Growth and stagnation of therapists and counselors*. Routledge.
- Shirom, A., & Melamed, S. (2006). A comparison of the construct validity of two burnout measures in two groups of professionals. *International Journal of Stress Management*, 13(2), 176–200. <https://doi.org/10.1037/1072-5245.13.2.176>
- Stamm, B. H. (2010). *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)*. <http://www.proqol.org>.
- Thompson, I., Amatea, E., & Thompson, E. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling*, 36(1), 58–77. <https://doi.org/10.17744/mehc.36.1.p61m73373m4617r3>
- Warren, C. S., Schafer, K. J., Crowley, M. E., & Olivardia, R. (2012). A qualitative analysis of job burnout in eating disorder treatment providers. *Eating Disorders*, 20(3), 175–195. <https://doi.org/10.1080/10640266.2012.668476>
- Westwood, S., Morison, L., Allt, J., & Holmes, N. (2017). Predictors of emotional exhaustion, disengagement and burnout among improving access to psychological therapies (IAPT) practitioners. *Journal of Mental Health*, 26(2), 172–179. <https://doi.org/10.1080/09638237.2016.1276540>
- Yang, Y., & Hayes, J. A. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. *Psychotherapy*, 57(3), 426–463. <https://doi.org/10.1037/pst0000317>

Appendix

Self-Reported Symptoms of Burnout by Novice Professional Counselors (N = 246)

Category and Subcategory	Frequency, <i>n</i> (%) ^a
Negative emotional experience	218 (18.1)
Anger	11 (5.0)
Anxiety	36 (16.5)
Apathy	12 (5.5)
Crying spells	14 (6.4)
Cynical	6 (2.8)
Depression	26 (11.9)
Fear	1 (0.5)
Frustration	9 (4.1)
Guilt	1 (0.5)
Hopeless	7 (3.2)
Impatience	3 (1.4)
Irritability	42 (19.3)
Overwhelmed	21 (9.6)
Stress	27 (12.4)
Withdrawn	2 (0.9)
Fatigue and tiredness	195 (16.2)
Exhaustion	39 (20.0)
Fatigue	57 (29.2)
Low energy	23 (11.8)
Tired	76 (39.0)
Unfulfilled in counseling work	140 (11.6)
Avoid work-related tasks	21 (15.0)
Dread going to work	62 (44.3)
Lack of motivation	28 (20.0)
No longer deriving meaning or joy from work	23 (16.4)
No longer seeking trainings	6 (4.3)
Unhealthy work environment	128 (10.6)
Burdened by documentation	18 (14.1)
Feeling unsafe at work	1 (0.8)
Frustrated with system	24 (18.8)
General negative work environment	6 (4.7)
High caseload	9 (7.0)
Issues with coworkers	2 (1.6)
Long shifts/overworked	8 (6.3)
No breaks throughout the day	4 (3.1)
No time off	3 (2.3)
On-call	2 (1.6)
Overburdened by amount of work or multiple roles	11 (8.6)
Pushed to see more clients	2 (1.6)
Sedentary	2 (1.6)
Underpaid	4 (3.1)
Unsupportive employer or supervisor	32 (25.0)
Physical symptoms	107 (8.9)
Body pain	42 (39.3)
Dizziness	1 (0.9)
General physical description	7 (6.6)
Headaches	16 (15.1)
Illness	16 (15.1)

Low sex drive	1 (0.9)
Stomach issues	10 (9.4)
Teeth grinding	2 (1.9)
Weight changes (i.e., loss or gain)	11 (10.3)
Negative impact on personal interest or self-care	101 (8.4)
Decrease in exercise	5 (5.0)
Difficulty falling asleep or staying asleep	29 (28.7)
General self-care	11 (10.9)
Inability to relax	4 (4.0)
Lack of interest in hobbies	22 (21.8)
Missing social events	11 (10.9)
Poor work/life balance	11 (10.9)
Prefer to zone out	8 (7.9)
Self-perceived ineffectiveness as a counselor	127 (10.5)
Compassion fatigue/secondary traumatic stress	7 (5.5)
Decreased empathy for clients	27 (21.1)
Decreased self-efficacy in one's own clinical skills	40 (31.3)
Desire to rescue clients	1 (0.8)
Difficulty building or maintaining the therapeutic relationship	31 (24.2)
Questioning one's own abilities to facilitate change	22 (17.2)
Cognitive impairment	75 (6.2)
Concentration or focus	27 (36.0)
Confusion	3 (4.1)
Decreased creativity	3 (4.1)
Dissociation	1 (1.4)
Forgetfulness	9 (12.2)
Mental fatigue	5 (6.8)
Rumination	27 (36.5)
Negative impact on personal relationships	63 (5.2)
Conflict in personal relationships	8 (12.7)
Isolating from others	32 (50.8)
Poor emotional connection with others	23 (36.5)
Negative coping strategies	22 (1.8)
Increased alcohol use	7 (31.8)
Increased caffeine use	2 (9.1)
Increased Netflix watching	1 (4.5)
Increased nicotine use	2 (9.1)
Over/under eating	10 (45.5)
Questioning of one's career choice	21 (1.7)
Planning to pursue employment in a non-counseling field	16 (76.2)
Wondering if counseling is a good professional fit	5 (23.8)
Psychological distress	8 (0.7)
Mental health diagnosis	6 (75.0)
Suicidal ideations	2 (25.0)

^aThe percentages for the subcategories reflect the total percentage for each category, and percentages may not total 100% because of rounding.

University Student Well-Being During COVID-19: The Role of Psychological Capital and Coping Strategies



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This study examined the relationships between psychological capital (PsyCap), coping strategies, and well-being among 609 university students using self-report measures. Results revealed that well-being was significantly lower during COVID-19 compared to before the onset of the pandemic. Multiple linear regression analyses indicated that PsyCap predicted well-being, and structural equation modeling demonstrated the mediating role of coping strategies between PsyCap and well-being. Prior to COVID-19, the PsyCap dimensions of optimism and self-efficacy were significant predictors of well-being. During the pandemic, optimism, hope, and resiliency have been significant predictors of well-being. Adaptive coping strategies were also conducive to well-being. Implications and recommendations for psychoeducation and counseling interventions to promote PsyCap and adaptive coping strategies in university students are presented.

Keywords: university students, psychological capital, well-being, coping strategies, COVID-19

In January 2020, the World Health Organization declared the outbreak of a new coronavirus disease, COVID-19, to be a public health emergency of international concern, and the effects continue to be widespread and ongoing. For university students, the pandemic brought about disruptions to life as they knew it. For example, students had to stay home, adapt to online learning, modify internship placements, and/or reconsider graduation plans and jobs. The aim of this study was to understand how the sudden changes and uncertainty resulting from the pandemic affected the well-being of university students during the early period of the pandemic. Specifically, the study addresses coping strategies and psychological capital (PsyCap; F. Luthans et al., 2007) and how they relate to levels of well-being.

University Students and Mental Health

Although mental health distress has been an issue on college campuses prior to the pandemic (Flatt, 2013; Lipson et al., 2019), COVID-19 has and will continue to magnify this phenomenon. Experts are projecting increases in depression, anxiety, post-traumatic stress disorder, and suicide in the United States (Wan, 2020). Johnson (2020) indicated that 35% of students reported increased anxiety associated with a move from face-to-face to online learning in the spring 2020 semester, matching the early phases of the COVID-19 outbreak. Stress associated with adapting to online learning presented particular challenges for students who did not have adequate internet access in their homes (Hoover, 2020).

Researchers have reported that high levels of technology and social media use are associated with depression and anxiety among adolescents and young adults (Huckins et al., 2020; Primack et al., 2017; Twenge, 2017). Given the current realities of physical distancing, there are fewer opportunities

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for traditional-age university students attending primarily residential campuses to maintain social connections, resulting in social fragmentation and isolation. Research has demonstrated that this exacerbates existing mental health concerns among university students (Klussman et al., 2020).

The uncertainties arising from COVID-19 have added to anticipatory anxiety regarding the future (Ray, 2019; Witters & Harter, 2020). From the Great Depression to 9/11 and Hurricane Katrina, victims of these life-shattering events have had to deal with their present circumstances and were also left with worries about how life and society would be inexorably altered in the future. University students are dealing with uncertain current realities and futures and may need to bolster their internal resources to face the challenges ahead. In this context, positive coping strategies and PsyCap may be increasingly valuable assets for university students to address the psychological challenges associated with this pandemic and to maintain or enhance their well-being.

Coping Strategies

Coping is often defined as “efforts to prevent or diminish the threat, harm, and loss, or to reduce associated distress” (Carver & Connor-Smith, 2010, p. 685). There are many ways to categorize coping responses (e.g., engagement coping and disengagement coping, problem-focused coping and emotion-focused coping, accommodative coping and meaning-focused coping, proactive coping). Engagement coping includes problem-focused coping and some forms of emotion-focused coping, such as support seeking, emotion regulation, acceptance, and cognitive restructuring. Disengagement coping includes responses such as avoidance, denial, and wishful thinking, as well as aspects of emotion-focused coping, because it involves an attempt to escape feelings of distress (Carver & Connor-Smith, 2010; de la Fuente et al., 2020). Findings on the effectiveness of problem-focused coping strategies versus emotion-focused coping strategies suggest the effectiveness of the particular strategy is contingent on the context, with controllable issues being better addressed through problem-focused strategies, while emotion-focused strategies are more effective with circumstances that cannot be controlled (Finkelstein-Fox & Park, 2019). In general, problem-focused coping strategies, also known as adaptive coping strategies, include planning, active coping, positive reframing, acceptance, and humor (Carver & Connor-Smith, 2010). Other coping strategies, such as denial, self-blame, distraction, and substance use, are more often associated with negative emotions, such as shame, guilt, lower perception of self-efficacy, and psychological distress, rather than making efforts to remediate them (Billings & Moos, 1984). These strategies can be harmful and unhealthy with regard to effectively coping with stressors. Researchers have recommended coping skills training for university students to modify maladaptive coping strategies and enhance pre-existing adaptive coping styles to optimal levels (Madhyastha et al., 2014).

Flourishing: The PERMA Well-Being Model

Positive psychologists have asserted that studies of wellness and flourishing are important in understanding adaptive behaviors and the potential for growth from challenging circumstances (Joseph & Linley, 2008; Seligman, 2011). *Flourishing* (or *well-being*) is defined as “a dynamic optimal state of psychosocial functioning that arises from functioning well across multiple psychosocial domains” (Butler & Kern, 2016, p. 2). Seligman (2011) proposed a theory of well-being stipulating that well-being was not simply the absence of mental illness (Keyes, 2002), but also the presence of five pillars with the acronym of PERMA (Seligman, 2002, 2011). The first pillar, *positive emotion* (P), is the affective component comprising the feelings of joy, hope, pleasure, rapture, happiness, and contentment. Next are *engagement* (E), the act of being highly interested, absorbed, or focused in daily life activities, and *relationships* (R), the feelings of being cared about by others and authentically and securely connected to others. The final two pillars are *meaning* (M), a sense of purpose in life that is derived from something

greater than oneself, and *accomplishment* (A), a persistent drive that helps one progress toward personal goals and provides one with a sense of achievement in life. Seligman's (2011) PERMA model is one of the most highly regarded models of well-being.

Seligman's multidimensional model integrates both hedonic and eudaimonic views of well-being, and each of the well-being components is seen to have the following three properties: (a) it contributes to well-being, (b) it is pursued for its own sake, and (c) it is defined and measured independently from the other components (Seligman, 2011). Studies show that all five pillars of well-being in the PERMA model are associated with better academic outcomes in students, such as improved college life adjustment, achievement, and overall life satisfaction (Butler & Kern, 2016; DeWitz et al., 2009; Tansey et al., 2018). Additionally, each pillar of PERMA has been shown to be positively associated with physical health, optimal well-being, and life satisfaction and negatively correlated with depression, fatigue, anxiety, perceived stress, loneliness, and negative emotion (Butler & Kern, 2016). At a time of significant stress, promoting the highest human performance and adaptation not only helps with well-being in the midst of the challenge but also can provide a foundation for future potential for optimal well-being (Joseph & Linley, 2008).

Psychological Capital (PsyCap)

PsyCap is a state-like construct that consists of four dimensions: *hope* (H), *self-efficacy* (E), *resilience* (R), and *optimism* (O), often referred to by the acronym HERO (F. Luthans et al., 2007). F. Luthans et al. (2007) developed PsyCap from research in positive organizational behavior and positive psychology. PsyCap is defined as an

individual's positive psychological state of development characterized by (1) having confidence (*self-efficacy*) to take on and put in the necessary effort to succeed at challenging tasks; (2) making a positive attribution (*optimism*) about succeeding now and in the future; (3) persevering toward goals and, when necessary, redirecting paths to goals (*hope*) in order to succeed; and (4) when beset by problems and adversity, sustaining and bouncing back and even beyond (*resilience*) to attain success. (F. Luthans et al., 2015, p. 2)

Over the past decade, PsyCap has been applied to university student development and mental health. There is robust empirical support suggesting that individuals with higher PsyCap have higher levels of performance (job and academic); satisfaction; engagement; attitudinal, behavioral, and relational outcomes; and physical and psychological health and well-being outcomes. Further, they have negative associations with stress, burnout, negative health outcomes, and undesirable behaviors at the individual, team, and organizational levels (Avey, Reichard, et al., 2011; Newman et al., 2014). Researchers have also examined the mediating role of PsyCap in the relationship between positive emotion and academic performance (Carmona-Halty et al., 2019; Hazan Liran & Miller, 2019; B. C. Luthans et al., 2012; K. W. Luthans et al., 2016); relationships and predictions between PsyCap and mental health in university students (Selvaraj & Bhat, 2018); and relationships between PsyCap, well-being, and coping (Rabenu et al., 2017).

Aim of the Study and Research Questions

The aim of the current study was to examine the relationships among well-being in university students before and during the onset of COVID-19 with PsyCap and coping strategies. The following research questions guided our work:

1. Is there a significant difference in the well-being of university students prior to the onset of COVID-19 (reported retrospectively) and after the onset of COVID-19?
2. What is the predictive relationship of PsyCap on well-being prior to the onset of COVID-19 and after the onset of COVID-19?
3. Do coping strategies play a mediating role in the relationship between PsyCap and well-being?

Method

Participants

A total of 806 university students from the United States participated in the study. After cleaning the data, 197 surveys were excluded from the data analyses. Of the final 609 participants, 73.7% ($n = 449$) identified as female, 22% ($n = 139$) identified as male, and 4.3% ($n = 26$) identified as non-binary. The age of participants ranged from 18 to 66 ($M = 27.36$, $SD = 9.9$). Regarding race/ethnicity, most participants identified as Caucasian (83.6%, $n = 509$), while the remaining participants identified as African American (5.3%, $n = 32$), Hispanic or Latina/o (9.5%, $n = 58$), American Indian (0.8%, $n = 5$), Asian (3.6%, $n = 22$), or Other (2.7%, $n = 17$). Fifty-four percent of the participants were undergraduate students ($n = 326$), and the remaining 46% were graduate students ($n = 283$). The majority of the participants were full time students (82%, $n = 498$) compared to part-time students (18%, $n = 111$). Sixty-three percent of the students were employed ($n = 384$) and the remaining 37% were unemployed ($n = 225$).

Data Collection Procedures

After a thorough review of the literature, three standardized measures were identified for use in the study along with a brief survey for demographic information. Instruments utilized in the study measured psychological capital (Psychological Capital Questionnaire [PCQ-12]; Avey, Avolio et al., 2011), coping (Brief COPE; Carver, 1997), and well-being (PERMA-Profil; Butler & Kern, 2016). Data were collected online in May and June 2020 using Qualtrics after obtaining approval from the IRBs of our respective universities. An invitation to participate, which included a link to an informed consent form and the survey, was distributed to all university students at two large U.S. public institutions in the Midwest and the South via campus-wide electronic mailing lists. The survey link was also distributed via a national counselor education listserv, and it was shared on the authors' social media platforms. Participants were asked to complete the well-being assessment twice—first, by responding as they recalled their well-being prior to COVID-19, and second, by responding as they reflected on their well-being during the pandemic.

Instruments

Demographic Questionnaire

A brief questionnaire was used to capture participant information. The questionnaire included items related to age, gender, race/ethnicity, relationship status, education classification, and employment status.

Psychological Capital Questionnaire – Short Version (PCQ-12)

The PCQ-12 (Avey, Avolio et al., 2011), the shortened version of PCQ-24 (F. Luthans et al., 2007), consists of 12 items that measure four HERO dimensions: *hope* (four items), *self-efficacy* (three items), *resilience* (three items), and *optimism* (two items), together forming the construct of psychological capital (PsyCap). The PCQ-12 utilizes a 6-point Likert scale with response options ranging from *strongly disagree* to *strongly agree*. Cronbach's alpha coefficients as a measure of internal consistency of the HERO subscales in the current study were high—*hope* ($\alpha = .86$), *self-efficacy* ($\alpha = .86$), *resilience* ($\alpha = .73$), and *optimism* ($\alpha = .83$)—consistent with the previous studies.

Brief COPE Questionnaire

Coping strategies were evaluated using the Brief COPE questionnaire (Carver, 1997), which is a short form (28 items) of the original COPE inventory (Carver et al., 1989). The Brief COPE is a multidimensional inventory used to assess the different ways in which people generally respond to stressful situations. This instrument is used widely in studies with university students (e.g., Madhyastha et al., 2014; Miyazaki et al., 2008). Fourteen conceptually differentiable coping strategies are measured by the Brief COPE (Carver, 1997): *active coping, planning, using emotional support, using instrumental support, venting, positive reframing, acceptance, denial, self-blame, humor, religion, self-distraction, substance use, and behavioral disengagement*. The 14 subscales may be broadly classified into two types of responses—“adaptive” and “problematic” (Carver, 1997, p. 98). Each subscale is measured by two items and is assessed on a 5-point Likert scale. Thus, in general, internal consistency reliability coefficients tend to be relatively smaller ($\alpha = .5$ to $.9$).

PERMA-Profiler

The PERMA-Profiler (Butler & Kern, 2016) is a 23-item self-report measure that assesses the level of well-being across five well-being domains (i.e., *positive emotion, engagement, relationships, meaning, accomplishment*) and additional subscales that measure *negative emotion, loneliness, and physical health*. Each item is rated on an 11-point scale ranging from *never* (0) to *always* (10), or *not at all* (0) to *completely* (10). The five pillars of well-being are defined and measured separately but are correlated constructs that together are considered to result in flourishing (Seligman, 2011). A single overall flourishing score provides a global indication of well-being, and at the same time, the domain-specific PERMA scores provide meaningful and practical benefits with regard to the possibility of targeted interventions. The measure demonstrates acceptable reliability, cross-time stability, and evidence for convergent and divergent validity (Butler & Kern, 2016). For the present study, reliability scores were high for four pillars—*positive emotion* ($\alpha = .88$), *relationships* ($\alpha = .83$), *meaning* ($\alpha = .89$), *accomplishment* ($\alpha = .82$); high for the subscales of *negative emotion* ($\alpha = .73$) and *physical health* ($\alpha = .85$); and moderate for the pillar of *engagement* ($\alpha = .65$). The overall reliability coefficient of well-being items is very high ($\alpha = .94$).

Data Analysis Procedure

The data were screened and analyzed using Statistical Package for the Social Sciences (SPSS, v25). Changes in PERMA elements were calculated by subtracting PERMA scores reported retrospectively by participants before the pandemic from scores reported at the time of data collection during COVID-19, and a repeated-measures ANOVA was conducted to examine the difference. Point-biserial correlation and Pearson product moment correlation coefficients were calculated to examine the relationships of demographic variables, PsyCap, and coping strategies with change in PERMA scores. Multivariate multiple regression was carried out to understand the predictive role of PsyCap on PERMA at two time points (before and during COVID-19). Structural equation modeling in Analysis of Moment Structures (AMOS, v23) software was used to test the mediating role of coping strategies on the relationship between PsyCap and change in PERMA scores. Mediation models were carried out with bootstrapping procedure with a 95% confidence interval.

Results

Prior to exploring the role of PsyCap and coping strategies on change in well-being due to COVID-19, an initial analysis was conducted to understand the characteristics and relationships of constructs in the study. Correlation analyses (see Table 1) revealed significant and positive correlations between four PsyCap HERO dimensions (i.e., *hope, self-efficacy, resilience, and optimism*; Avey, Avolio et al., 2011) and the six PERMA elements (i.e., *positive emotion, engagement, relationships, meaning, accomplishment, and*

physical health; Butler & Kern, 2016). Further, PsyCap HERO dimensions were negatively correlated to *negative emotion* and *loneliness*. Age was positively correlated with change in PERMA elements, but not gender. Similarly, approach coping strategies such as *active coping*, *positive reframing*, and *acceptance* (Carver, 1997) were resilient strategies to handle pandemic stress whereas *using emotional support* and *planning* showed weaker but significant roles. Similarly, *religion* also tended to be an adaptive coping strategy during the pandemic. *Behavioral disengagement* and *self-blame* (Carver, 1997) were found to be the dominant avoidant coping strategies that were adopted by students, which led to a significant decrease in well-being during the pandemic. Overall, as seen in Table 1, all three variables studied—PsyCap HERO dimensions, eight PERMA elements, and coping strategies—were highly related.

Table 1

Relationship of Demographic Factors, Psychological Capital, and Coping Strategies With Change in PERMA Elements

Variables	Mean	SD	P	E	R	M	A	N	H	L
Age	27.36	9.91	.15**	.11**	.14**	.16**	.14**	.01	.03	-.17**
Course ^Φ	-	-	.19**	.10*	.19**	.16**	.06	-.05	.09*	-.14**
Nature of course ^Φ	-	-	.06	.06	.12**	.13**	.09*	.03	.03	-.10**
Gender ^Φ	-	-	-.01	-.06	.01	-.02	-.02	.02	-.02	.03
Employment ^Φ	-	-	-.17**	-.11**	-.13**	-.19**	-.10*	.04	-.11**	.11**
Self-Efficacy	13.80	3.21	.11**	.13**	.14**	.18**	.16**	-.05	.15**	-.03
Hope	18.68	3.92	.24**	.26**	.20**	.34**	.40**	-.17**	.21**	-.10*
Resilience	13.41	3.08	.23**	.22**	.20**	.32**	.33**	-.16**	.15**	-.13**
Optimism	8.61	2.39	.21**	.27**	.23**	.32**	.30**	-.11**	.16**	-.10*
Self-Distraction	6.32	1.41	-.09*	.01	.03	-.02	.01	.08*	.02	.11**
Active Coping	5.83	2.01	.24**	.28**	.20**	.28**	.32**	-.09*	.23**	-.08*
Denial	2.96	1.42	-.19**	-.14**	-.18**	-.16**	-.16**	.24**	-.16**	.12**
Substance Use	3.60	2.02	-.18**	-.15**	-.15**	-.20**	-.20**	.11**	-.09*	.17**
Using Emotional Support	5.07	1.81	.12**	.11**	.32**	.18**	.11**	.04	.10*	-.02
Using Instrumental Support	4.35	1.70	.01	.04	.20**	.07	.02	.10*	.04	.07
Behavioral Disengagement	3.96	2.11	-.43**	-.37**	-.40**	-.46**	-.44**	.31**	-.26**	.27**
Venting	4.58	1.54	-.24**	-.16**	-.08*	-.17**	-.16**	.29**	-.09*	.16**
Positive Reframing	5.12	1.78	.28**	.27**	.21**	.26**	.25**	-.15**	.18**	-.14**
Planning	5.42	1.75	.07	.12**	.11**	.13**	.11**	.08	.08*	-.04
Humor	4.93	2.00	-.02	-.02	-.02	-.04	-.06	-.02	.02	.05
Acceptance	6.47	1.43	.33**	.27**	.27**	.34**	.31**	-.25**	.21**	-.15**
Religion	3.93	2.03	.21**	.16**	.16**	.22**	.13**	-.08	.15**	-.05
Self-Blame	4.08	1.72	-.33**	-.27**	-.29**	-.36**	-.36**	.29**	-.22**	.20**

Note. P = Positive Emotion, E = Engagement, R = Relationships, M = Meaning, A = Accomplishment, N = Negative Emotion, H = Physical Health, L = Loneliness.

^Φ Point-biserial correlation

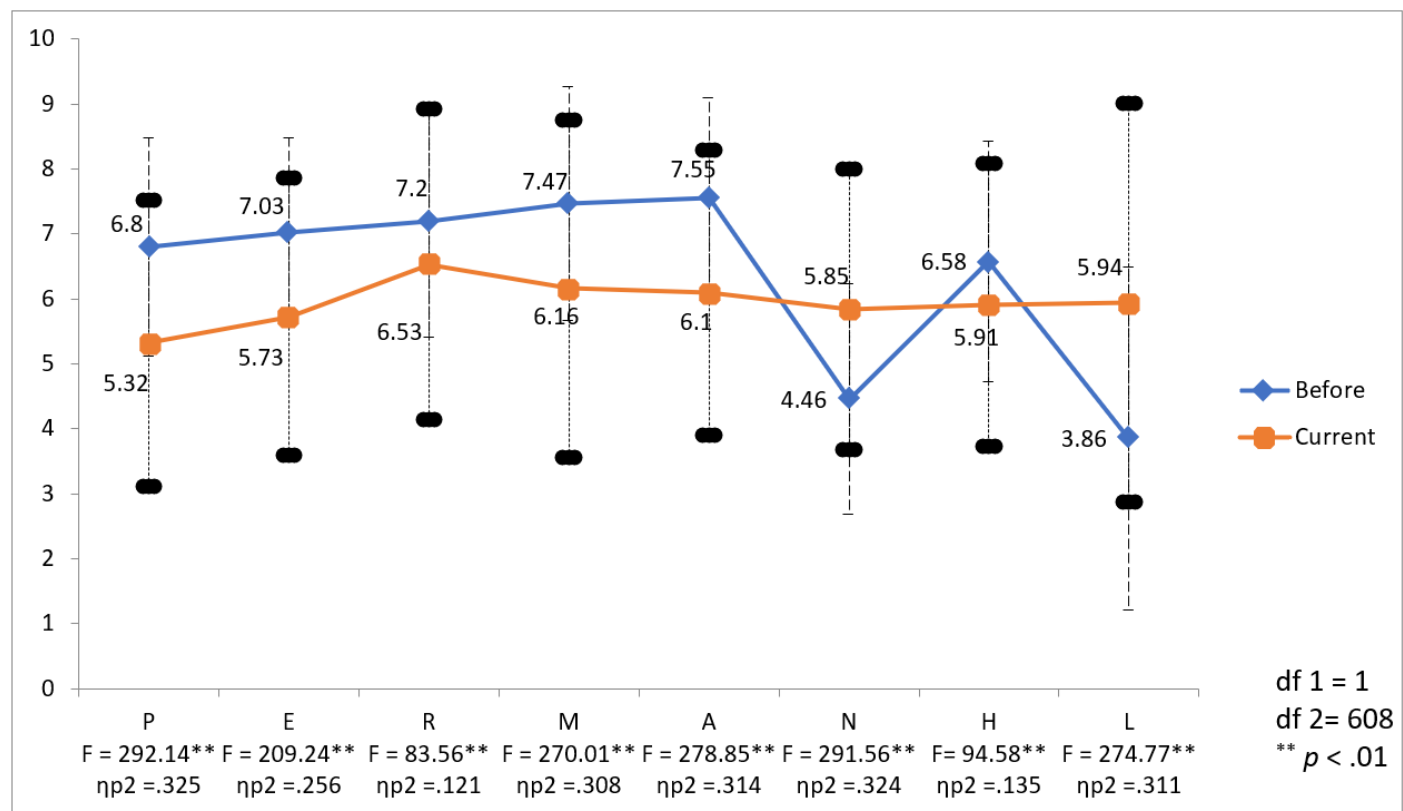
* $p < .05$, ** $p < .01$

Research Question 1

Results of a repeated-measures ANOVA presented in Figure 1 indicate that mean scores of PERMA decreased significantly during COVID-19: $\lambda = .620$; $F(5,604) = 73.99$, $p < .001$. Partial eta squared was reported as the measure of effect size. The effect size of the change in well-being for PERMA elements was 38%, $\eta_p^2 = .380$, a high effect size (Cohen, 1988). As expected, *negative emotion* and *loneliness* significantly increased during the period of COVID-19, impacting overall well-being in an adverse manner. The average scores of *negative emotion* and *loneliness* increased from 4.46 and 3.86 to 5.85 and 5.94, respectively. *Physical health* significantly reduced from 6.58 to 5.91. The effect size of the change in the scores of individual PERMA elements ranged between 12.1% and 32.5%. Among the PERMA elements, *engagement* and *physical health* were least impacted by COVID-19, whereas students' experiences of *positive emotion* and *negative emotion* were the factors that were largely affected.

Figure 1

Changes in the PERMA Prior to the Onset of COVID-19 and After the Onset of COVID-19



Note. P = Positive Emotion, E = Engagement, R = Relationships, M = Meaning, A = Accomplishment, N = Negative Emotion, H = Physical Health, L = Loneliness.

Research Question 2

The predictive role of PsyCap on well-being at two time points (before and after the onset of COVID-19) was analyzed using multivariate multiple regression (see Table 2). Coefficients of determination for models predicting well-being from PsyCap dimensions ranged from 4% to 28%. Before the onset of COVID-19, 23% of the variance in well-being was explained by the PsyCap

dimensions ($R^2 = .23, p < .001$), with *self-efficacy* and *optimism* as the most significant predictors of well-being. However, during the pandemic, the covariance of the PsyCap dimensions with well-being increased to 39% ($R^2 = .39, p < .01$). Interestingly, after the onset of the pandemic, the predictor role of certain PsyCap dimensions shifted. For example, *optimism* became the strongest predictor of overall well-being and *hope* emerged as a predictor of *engagement*, *meaning*, *accomplishment*, and *physical health* during the pandemic. The predictive role of *hope* was negligible before COVID-19. The predictive role of *resilience* on *positive emotion*, *accomplishment*, *negative emotion*, and *loneliness* also became significant during COVID-19. *Self-efficacy* was a consistent predictor of PERMA elements before COVID-19. But during COVID-19, the relevance of *self-efficacy* in predicting PERMA elements was limited to controllable factors—*relationships*, *meaning*, and *physical health*—and the predictive role of *self-efficacy* overall was no longer significant (see Table 2).

Table 2

Predicting PERMA Elements From Psychological Capital Prior to the Onset of COVID-19 and After the Onset of COVID-19

PERMA	Self-Efficacy	Hope	Resilience	Optimism	Adj. R^2	F
Before COVID-19						
Positive Emotion	.10*	-.06	-.01	.44**	.19	37.66**
Engagement	.10*	.06	.01	.11*	.05	8.80**
Relationships	.10*	.07	-.09	.29**	.12	21.33**
Meaning	.21**	.06	-.03	.38**	.28	58.68**
Accomplishment	.24**	.06	.04	.13*	.14	25.62**
Negative Emotion	-.13**	.10	-.05	-.29**	.11	18.97**
Physical Health	.16**	.08	-.04	.12*	.07	12.16**
Loneliness	-.10*	0	-.01	-.19**	.04	7.36**
Well-Being	.19**	.04	-.02	.35**	.23	45.41**
During COVID-19						
Positive Emotion	.04	.09	.10*	.41**	.30	67.05**
Engagement	.02	.21**	.05	.26**	.21	40.86**
Relationships	.09*	.1	-.01	.33**	.19	36.72**
Meaning	.11**	.18**	.09	.38**	.39	99.93**
Accomplishment	.05	.37**	.14**	.17**	.39	96.96**
Negative Emotion	-.03	-.07	-.13*	-.23**	.14	26.80**
Physical Health	.16**	.19**	-.03	.14**	.15	27.25**
Loneliness	-.04	.01	-.11*	-.20**	.08	13.34**
Well-Being	.07	.22**	.08	.37**	.39	97.48**

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

Research Question 3

Structural equation modeling was used to examine whether coping strategies mediate PsyCap's effect on well-being. Coping strategies that predicted change in PERMA were used for mediation analysis. Indirect effects describing pathways from PsyCap factors to PERMA factors through identified coping

strategies were tested for mediating roles. Results indicated that PsyCap affected well-being both directly and indirectly through coping strategies. *Optimism* had a significant indirect effect on change in well-being compared to *hope* and *resilience* (see Table 3). Among adaptive coping strategies, *active coping*, *positive reframing*, and *using emotional support* mediated the relationship between *optimism* and overall well-being. Interestingly, *using emotional support* also showed a similar mediating link between *resilience* and PERMA, but not for the factors of *loneliness* and *negative emotion*. On the other hand, *self-blame* and *behavioral disengagement* were two problematic coping strategies that mediated the relationship between *optimism* and all PERMA elements. Specifically, we found coping through *self-blame* playing a mediating role between PERMA factors and two of the HERO dimensions—*resilience* and *hope*.

Table 3

Indirect Effect of Psychological Capital on PERMA Factors Through Coping Strategies (Mediators)

PsyCap	Standardized Beta (β , Indirect effect)							
	L	H	N	A	M	R	E	P
Active Coping ^Φ								
Optimism	-.016*	.043**	-.017*	.06**	.052**	.037**	.052**	.044**
Resilience	-.005	.014	-.006	.02	.017	.012	.017	.015
Hope	-.007	.018	-.007	.025	.022	.015	.022	.018
Self-Efficacy	-.009	.025	-.01	.034	.03	.021	.03	.025
Positive Reframing ^Φ								
Optimism	-.047**	.06**	-.05**	.085**	.088**	.07**	.094**	.096**
Resilience	-.005	.007	-.006	.01	.01	.008	.011	.011
Hope	.003	-.003	.003	-.005	-.005	-.004	-.005	-.005
Self-Efficacy	-.005	.006	-.005	.009	.009	.007	.01	.01
Using Emotional Support ^Φ								
Optimism	-.007	.02*	.012	.03*	.049**	.086**	.029*	.032**
Resilience	.003	-.012	-.005	-.013*	-.021*	-.037*	-.012*	-.014*
Hope	0	0	0	0	0	0	0	0
Self-Efficacy	-.001	.006	.002	.006	.01	.018	.006	.007
Self-Blame ^Φ								
Optimism	-.038**	.043**	-.056**	.07**	.07**	.056**	.054**	.065**
Resilience	-.03**	.034**	-.044**	.055**	.055**	.044**	.042**	.051**
Hope	-.023*	.025*	-.033*	.042*	.041*	.033*	.032*	.038**
Self-Efficacy	-.005	.006	-.007	.009	.009	.007	.007	.008
Behavioral Disengagement ^Φ								
Optimism	-.07**	.067**	-.081**	.113**	.118**	.104**	.097**	.112**
Resilience	-.02	.02	-.023	.033	.034	.03	.028	.033
Hope	-.032	.03	-.036	.051	.053	.047	.044	.051
Self-Efficacy	-.009	.009	-.011	.015	.016	.014	.013	.015

Note. Coping strategies with insignificant mediating role are not included in the table. P = Positive Emotion, E = Engagement, R = Relationships, M = Meaning, A = Accomplishment, N = Negative Emotion, H = Physical Health, L = Loneliness.

^Φ Mediator coping strategies.

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

Discussion

The current study investigated the PERMA model of well-being (Seligman, 2011) with university students before and during the COVID-19 pandemic, as well as the relationships between PsyCap (F. Luthans et al., 2007), coping strategies, and well-being of university students. We examined whether the COVID-19 context shaped the efficacy of particular strategies to promote well-being. Findings are discussed in three areas: reduction in well-being related to COVID-19, shift in predictive roles of PsyCap HERO dimensions, and coping strategies as a mediator.

Reduction in Well-Being Related to COVID-19

Well-being scores across all PERMA elements, including *physical health*, were lower than those reported retrospectively prior to the pandemic. Such a decline in well-being following a pandemic is consistent with previous occurrences of public health crises or natural disasters (Deaton, 2012). Participants reported higher levels of *negative emotion* and *loneliness* after the onset of COVID-19, and a decrease in *positive emotion*. It is this balance of positive and negative emotions that contributes to life satisfaction (Diener & Larsen, 1993), and our findings support the notion that fostering particular positive psychological states (PsyCap), as well as engaging in related coping strategies, promotes well-being in the context of this large-scale crisis.

Shift in Predictive Roles of PsyCap HERO Dimensions

Consistent with prior research (Avey, Reichard et al., 2011; F. Luthans & Youssef-Morgan, 2017; Youssef-Morgan & Luthans, 2015), we found that PsyCap predicted well-being. PsyCap's positive psychological resources (HERO dimensions) may enable students to have a "positive appraisal of circumstances" (F. Luthans et al., 2007, p. 550) by providing mechanisms for reframing and reinterpreting potentially negative or neutral situations. There was however an interesting shift in the predictive role of PsyCap dimensions before and after the onset of COVID-19. Prior to COVID-19, *self-efficacy* and *optimism* were the two major psychological resources that predicted university student well-being. However, after COVID-19, *self-efficacy* did not present as a predictor of well-being in this study. Although the reason for this result is uncertain, it is conceivable that attending to an uncertain future (i.e., *hope*) and recovering from immediate losses (i.e., *resilience*) became more salient, and one's *self-efficacy* in managing normal, everyday challenges receded in importance. Indeed, *optimism* and *hope* each uniquely predict a major proportion of variance of the change in well-being and may together help students to face an uncertain future (M. W. Gallagher & Lopez, 2009). *Resilience*, the ability to recover from setbacks when pathways are blocked (Masten, 2001), had a predictive role on *positive emotion* and *accomplishment* in this study.

Coping Strategies as a Mediator

While PsyCap directly relates to well-being and coping strategies relate to well-being, our findings indicated that coping strategies also played a significant mediating role in the relationship between PsyCap and well-being. Specifically, adaptive coping strategies played a significant role in enhancing the positive effects of PsyCap on well-being. Adaptive coping strategies—such as *active coping*, *acceptance*, *using emotional support*, and *positive reframing*—were found to better aid in predicting well-being. In this study, accepting the realities, using alternative affirmative explanations, seeking social support for meeting emotional needs, and engaging in active problem-focused coping behaviors seem to be the most helpful ways to counter the negative effects of the pandemic on well-being. Conversely, when individuals employed problematic coping strategies such as *behavioral disengagement* and *self-blame* (Carver, 1997), the negative impacts were much stronger than the positive effect of adaptive coping strategies.

Implications for Counselors

Given findings of the relationship between PsyCap and well-being in the current study, as well as in prior research (F. Luthans et al., 2006; F. Luthans et al., 2015; McGonigal, 2015), counselors may wish to focus on developing PsyCap to help university students flourish both during the pandemic and in a post-pandemic world. Two significant challenges to counseling professionals on college campuses are the lack of resources to adequately respond to mental health concerns among students and the stigma associated with accessing services (R. P. Gallagher, 2014; Michaels et al., 2015). Thus, efficient interventions that are not likely to trigger stigma responses are helpful in this context. Several researchers have found that relatively short training in PsyCap interventions, including web-based platforms (Dello Russo & Stoykova, 2015; Demerouti et al., 2011; Ertosun et al., 2015; B. C. Luthans et al., 2012, 2013) have been effective. Recently, the use of positive psychology smartphone apps such as Happify and resilience-building video games such as SuperBetter have been suggested and tested as motivational tools, especially with younger adults, to foster sustained and continued engagement with PsyCap development (F. Luthans & Youssef-Morgan, 2017; McGonigal, 2015). These are potential areas of practice for college counselors and counselors serving university students.

Interventions that are described as well-being approaches rather than those that highlight pathologies are less stigmatizing (Hunt & Eisenberg, 2010; Umucu et al., 2020) than traditional deficit-based therapeutic approaches. There are a number of research-based approaches offered in the field of positive psychology to guide mental health professionals to facilitate development of PsyCap and other important well-being correlates. These include approaches to building positive emotions (Fredrickson, 2009); coping strategies, which were found in this study to boost well-being (Jardin et al., 2018; Lyubomirsky, 2008); and effective goal pursuits (F. Luthans & Youssef-Morgan, 2017). One of the distinguishing characteristics of PsyCap is its malleability and openness to change and development (Avey, Reichard et al., 2011; F. Luthans et al., 2006). Thus, there is potential for counselors to develop well-being promotion initiatives for students on university campuses targeting PsyCap and its constituting positive psychological HERO resources with the end goal of strengthening well-being (Avey, Avolio et al., 2011; F. Luthans et al., 2015; F. Luthans & Youssef-Morgan, 2017).

Strategies and programming to develop wellness can be delivered in one-on-one sessions with students, as well as in group settings, and may have either a prevention or intervention focus. They could also be adapted to provide services online. A variety of free online assessments are also available for use by counselors, including tools that measure well-being, positive psychological resources, and character strengths of university students in addition to existing assessment batteries. By administering the PERMA-Profiler to university students, counselors could identify and understand what dimension of well-being should be further developed (Umucu et al., 2020). With each PERMA element individually rendering to flourishing mental health, specific targeted positive psychology interventions might be offered as domain-specific interventions.

Counselors could help university students benefit from attending to, appreciating, and attaining life's positives (Sin & Lyubomirsky, 2009) and from enhancing the strength and frequency of employing positive coping strategies through targeted psychoeducational or counseling interventions. Teaching university students active coping strategies, such as positive reframing and how to access emotional support, could help them cope with adverse situations. Sheldon and Lyubomirsky (2006) indicated that practicing gratitude helps people to cope with negative situations because it enables them to view such

situations through a more positive lens. Among university students, healthy coping strategies could buffer them from some of the unique challenges associated with acculturating and adjusting to college experiences (Jardin et al., 2018), especially during a pandemic.

Limitations and Directions for Future Research

The findings of this study should be considered in light of certain limitations. Foremost among these is that data were collected using self-report measures, and in the case of the PERMA-Profilier, data were collected using the retrospective recall of participants as they considered their well-being prior to the onset of COVID-19. Retrospective recall may be inaccurate (Gilbert, 2007) with participants under- or overestimating their well-being. Given the ongoing repercussions of the pandemic, we recommend continued and longitudinal studies on well-being, coping strategies, and PsyCap. Additionally, data collection methods and sample demographics would likely limit generalizability. We utilized a correlational cross-sectional study design; therefore, although PsyCap was predictive of change in well-being before and during COVID-19, neither causation nor directionality can be assumed. In future, researchers may wish to investigate whether PsyCap predicts longitudinal changes in well-being in the COVID-19 context.

A further consideration is that the PERMA model of well-being (Seligman, 2011) may not be associated with similar outcomes for people of other cultures and backgrounds during COVID-19. Future researchers examining well-being in university students in different regions of the country or internationally may wish to further investigate the applicability of the PERMA model as a measure of university students' well-being during the pandemic. Finally, the moderate Cronbach's alpha reliability scores of $< .70$ (Field, 2013) for the subscales of the Brief COPE inventory and the *engagement* subscale of the PERMA-Profilier are of concern, which has also been expressed by prior researchers (Goodman et al., 2018; Iasiello et al., 2017). Future researchers should consider issues of internal consistency as they choose scales and interpret results.

Conclusion

To conclude, the present findings contribute to existing literature on PsyCap and well-being, using the PERMA model of well-being (Seligman, 2011) among university students in the United States in the context of COVID-19. Key findings are that the *optimism*, *hope*, and *resilience* dimensions of PsyCap are significant predictors of well-being, explaining a large amount of variance, with adaptive coping being conducive to flourishing. Further, the present findings highlight the importance of examining the relationships between each element of well-being and with each HERO dimension. Both individual counseling and group-based programming focused on PsyCap and positive coping strategies could support the well-being of university students as they experience ongoing stressors related to the pandemic or as they face other setbacks.

Conflict of Interest and Funding Disclosure

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References

- Avey, J. B., Avolio, B. J., & Luthans, F. (2011). Experimentally analyzing the impact of leader positivity on follower positivity and performance. *The Leadership Quarterly*, 22(2), 282–294. <https://doi.org/10.1016/j.leaqua.2011.02.004>
- Avey, J. B., Reichard, R. J., Luthans, F., & Mhatre, K. H. (2011). Meta-analysis of the impact of positive psychological capital on employee attitudes, behaviors, and performance. *Human Resource Development Quarterly*, 22(2), 127–152. <https://doi.org/10.1002/hrdq.20070>
- Billings, A. G., & Moos, R. H. (1984). Coping, stress, and social resources among adults with unipolar depression. *Journal of Personality and Social Psychology*, 46(4), 877–891. <https://doi.org/10.1037//0022-3514.46.4.877>
- Butler, J., & Kern, M. L. (2016). The PERMA-Profil: A brief multidimensional measure of flourishing. *International Journal of Wellbeing*, 6(3), 1–48. <https://doi.org/10.5502/ijw.v6i3.526>
- Carmona-Halty, M., Schaufeli, W. B., & Salanova, M. (2019). Good relationships, good performance: The mediating role of psychological capital: A three-wave study among students. *Frontiers in Psychology*, 10, 306. <https://doi.org/10.3389/fpsyg.2019.00306>
- Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the Brief COPE. *International Journal of Behavioral Medicine*, 4(1), 92–100. https://doi.org/10.1207/s15327558ijbm0401_6
- Carver, C. S., & Connor-Smith, J. (2010). Personality and coping. *Annual Review of Psychology*, 61, 679–704. <https://doi.org/10.1146/annurev.psych.093008.100352>
- Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, 56(2), 267–283. <https://doi.org/10.1037//0022-3514.56.2.267>
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*. Routledge Academic.
- de la Fuente, J., Lahortiga-Ramos, F., Laspra-Solis, C., Maestro-Martin, C., Alustiza, I., Auba, E., & Martin-Lanas, R. (2020). A structural equation model of achievement emotions, coping strategies and engagement-burnout in undergraduate students: A possible underlying mechanism in facets of perfectionism. *International Journal of Environmental Research and Public Health*, 17(6). <https://doi.org/10.3390/ijerph17062106>
- Deaton, A. (2012). The financial crisis and the well-being of Americans: 2011 OEP Hicks lecture. *Oxford Economic Papers*, 64(1), 1–26. <https://doi.org/10.1093/oep/gpr051>
- Dello Russo, S., & Stoykova, P. (2015). Psychological capital intervention (PCI): A replication and extension. *Human Resource Development Quarterly*, 26(3), 329–347. <https://doi.org/10.1002/hrdq.21212>
- Demerouti, E., van Eeuwijk, E., Snelder, M., & Wild, U. (2011). Assessing the effects of a “personal effectiveness” training on psychological capital, assertiveness and self-awareness using self-other agreement. *The Career Development International*, 16(1), 60–81. <https://doi.org/10.1108/13620431111107810>
- DeWitz, S. J., Woolsey, M. L., & Walsh, W. B. (2009). College student retention: An exploration of the relationship between self-efficacy beliefs and purpose in life among university students. *Journal of College Student Development*, 50(1), 19–34. <https://doi.org/10.1353/csd.0.0049>
- Diener, E., & Larsen, R. J. (1993). The experience of emotional wellbeing. In M. Lewis & J. M. Haviland (Eds.), *Handbook of emotions* (pp. 405–415). Guilford.
- Ertosun, Ö. G., Erdil, O., Deniz, N., & Alpan, L. (2015). Positive psychological capital development: A field study by the Solomon four group design. *International Business Research*, 8(10), 102–111. <https://doi.org/10.5539/ibr.v8n10p102>
- Field, A. (2013). *Discovering statistics using IBM SPSS statistics*. SAGE.
- Finkelstein-Fox, L., & Park, C. L. (2019). Control-coping goodness-of-fit and chronic illness: A systematic review of the literature. *Health Psychology Review*, 13(2), 137–162. <https://doi.org/10.1080/17437199.2018.1560229>
- Flatt, A. K. (2013). A suffering generation: Six factors contributing to the mental health crisis in North American higher education. *College Quarterly*, 16(1).
- Fredrickson, B. L. (2009). *Positivity: Groundbreaking research reveals how to embrace the hidden strength of positive emotions, overcome negativity, and thrive*. Crown.
- Gallagher, M. W., & Lopez, S. J. (2009). Positive expectancies and mental health: Identifying the unique contributions of hope and optimism. *The Journal of Positive Psychology*, 4(6), 548–556. <https://doi.org/10.1080/17439760903157166>

- Gallagher, R. P. (2014). *National Survey of College Counseling Centers 2014*. International Association of Counseling Services, Inc. <http://d-scholarship.pitt.edu/28178>
- Gilbert, D. (2007). *Stumbling on happiness*. Random House.
- Goodman, F. R., Disabato, D. J., Kashdan, T. B., & Kauffman, S. B. (2018). Measuring well-being: A comparison of subjective well-being and PERMA. *The Journal of Positive Psychology, 13*(4), 321–332. <https://doi.org/10.1080/17439760.2017.1388434>
- Hazan Liran, B., & Miller, P. (2019). The role of psychological capital in academic adjustment among university students. *Journal of Happiness Studies: An Interdisciplinary Forum on Subjective Well-Being, 20*(1), 51–65. <https://doi.org/10.1007/s10902-017-9933-3>
- Hoover, E. (2020). Distanced learning. *Chronicle of Higher Education*. <https://www.chronicle.com/article/distanced-learning>
- Huckins, J. F., DaSilva, A. W., Wang, W., Hedlund, E., Rogers, C., Nepal, S. K., Wu, J., Obuchi, M., Murphy, E. I., Meyer, M. L., Wagner, D. D., Holtzheimer, P. E., & Campbell, A. T. (2020). Mental health and behavior of college students during the early phases of the COVID-19 pandemic: Longitudinal smartphone and ecological momentary assessment study. *Journal of Medical Internet Research, 22*(6), e20185. <https://doi.org/10.2196/20185>
- Hunt, J., & Eisenberg, D. (2010). Mental health problems and help-seeking behavior among college students. *Journal of Adolescent Health, 46*(1), 3–10. <https://doi.org/10.1016/j.jadohealth.2009.08.008>
- Iasiello, M., Bartholomaeus, J., Jarden, A., & Kelly, G. (2017). Measuring PERMA+ in South Australia, the State of Wellbeing: A comparison with national and international norms. *Journal of Positive Psychology and Wellbeing, 1*(2), 53–72.
- Jardin, C., Mayorga, N. A., Bakhshaie, J., Garey, L., Viana, A. G., Sharp, C., Cardoso, J. B., & Zvolensky, M. J. (2018). Clarifying the relation of acculturative stress and anxiety/depressive symptoms: The role of anxiety sensitivity among Hispanic college students. *Cultural Diversity and Ethnic Minority Psychology, 24*(2), 221–230. <https://doi.org/10.1037/cdp0000175>
- Johnson, R. (2020). *Students stressed out due to coronavirus, new survey finds*. *Best Colleges* (April 20, 2020). <https://www.bestcolleges.com/blog/coronavirus-survey>
- Joseph, S., & Linley, P. A. (Eds.). (2008). *Trauma, recovery, and growth: Positive psychological perspectives on posttraumatic stress*. Wiley.
- Keyes, C. L. M. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of Health and Social Behavior, 43*(2), 207–222. <https://doi.org/10.2307/3090197>
- Klussman, K., Nichols, A. L., Langer, J., & Curtin, N. (2020). Connection and disconnection as predictors of mental health and wellbeing. *International Journal of Wellbeing, 10*(2). <https://doi.org/10.5502/ijw.v10i2.855>
- Lipson, S. K., Lattie, E. G., & Eisenberg, D. (2019). Increased rates of mental health service utilization by U.S. college students: 10-year population-level trends (2007–2017). *Psychiatric Services, 70*(1), 60–63. <https://doi.org/10.1176/appi.ps.201800332>
- Luthans, B. C., Luthans, K. W., & Avey, J. B. (2013). Building the leaders of tomorrow: The development of academic psychological capital. *Journal of Leadership & Organizational Studies, 21*(2), 191–199. <https://doi.org/10.1177/1548051813517003>
- Luthans, B. C., Luthans, K. W., & Jensen, S. M. (2012). The impact of business school students' psychological capital on academic performance. *The Journal of Education for Business, 87*(5), 253–259. <https://doi.org/10.1080/08832323.2011.609844>
- Luthans, F., Avey, J. B., Avolio, B. J., Norman, S. M., & Combs, G. M. (2006). Psychological capital development: Toward a micro-intervention. *Journal of Organizational Behavior, 27*(3), 387–393. <https://doi.org/10.1002/job.373>
- Luthans, F., Avolio, B. J., Avey, J. B., & Norman, S. M. (2007). Positive psychological capital: Measurement and relationship with performance and satisfaction. *Personnel Psychology, 60*(3), 541–572. <https://doi.org/10.1111/j.1744-6570.2007.00083.x>
- Luthans, F., & Youssef-Morgan, C. M. (2017). Psychological capital: An evidence-based positive approach. *Annual Review of Organizational Psychology and Organizational Behavior, 4*, 339–366.
- Luthans, F., Youssef-Morgan, C. M., & Avolio, B. J. (2015). *Psychological capital and beyond*. Oxford University Press.

- Luthans, K. W., Luthans, B. C., & Palmer, N. F. (2016). A positive approach to management education: The relationship between academic PsyCap and student engagement. *Journal of Management Development*, 35(9), 1098–1118. <https://doi.org/10.1108/JMD-06-2015-0091>
- Lyubomirsky, S. (2008). *The how of happiness: A scientific approach to getting the life you want*. Penguin.
- Madhyastha, S., Latha, K. S., & Kamath, A. (2014). Stress, coping and gender differences in third year medical students. *Journal of Health Management*, 16(2), 315–326. <https://doi.org/10.1177/0972063414526124>
- Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, 56(3), 227–238. <https://doi.org/10.1037//0003-066x.56.3.227>
- McGonigal, J. (2015). *SuperBetter: A revolutionary approach to getting stronger, happier, braver and more resilient*. Penguin Press.
- Michaels, P. J., Corrigan, P. W., Kanodia, N., Buchholz, B., & Abelson, S. (2015). Mental health priorities: Stigma elimination and community advocacy in college settings. *Journal of College Student Development*, 56(8), 872–875. <https://doi.org/10.1353/csd.2015.0088>
- Miyazaki, Y., Bodenhorn, N., Zalaquett, C., & Ng, K.-M. (2008). Factorial structure of Brief COPE for international students attending U.S. colleges. *College Student Journal*, 42(3), 795–806.
- Newman, A., Ucbasaran, D., Zhu, F., & Hirst, G. (2014). Psychological capital: A review and synthesis. *Journal of Organizational Behavior*, 35(S1), S120–S138. <https://doi.org/10.1002/job.1916>
- Primack, B. A., Shensa, A., Escobar-Viera, C. G., Barrett, E. L., Sidani, J. E., Colditz, J. B., & Everette James, A. (2017). Use of multiple social media platforms and symptoms of depression and anxiety: A nationally-representative study among U.S. young adults. *Computer Human Behavior*, 69, 1–9. <https://doi.org/10.1016/j.chb.2016.11.013>
- Rabenu, E., Yaniv, E., & Elizur, D. (2017). The relationship between psychological capital, coping with stress, well-being, and performance. *Current Psychology*, 36(4), 875–887. <https://doi.org/10.1007/s12144-016-9477-4>
- Ray, J. (2019). *Americans' stress, worry and anger intensified in 2018*. Gallup. <https://news.gallup.com/poll/249098/americans-stress-worry-anger-intensified-2018.aspx>
- Seligman, M. E. P. (2002). *Authentic happiness: Using the new positive psychology to realize your potential for lasting fulfillment*. Simon & Schuster.
- Seligman, M. E. P. (2011). *Flourish: A visionary new understanding of happiness and well-being*. Simon & Schuster.
- Selvaraj, P. R., & Bhat, C. S. (2018). Predicting the mental health of college students with psychological capital. *Journal of Mental Health*, 27(3), 279–287. <https://doi.org/10.1080/09638237.2018.1469738>
- Sheldon, K. M., & Lyubomirsky, S. (2006). How to increase and sustain positive emotion: The effects of expressing gratitude and visualizing best possible selves. *The Journal of Positive Psychology*, 1(2), 73–82. <https://doi.org/10.1080/17439760500510676>
- Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal of Clinical Psychology*, 65(5), 467–487. <https://doi.org/10.1002/jclp.20593>
- Tansey, T. N., Smedema, S., Umucu, E., Iwanaga, K., Wu, J.-R., Cardoso, E. D. S., & Strauser, D. (2018). Assessing college life adjustment of students with disabilities: Application of the PERMA framework. *Rehabilitation Counseling Bulletin*, 61(3), 131–142. <https://doi.org/10.1177/0034355217702136>
- Twenge, J. M. (2017). *iGen: Why today's super-connected kids are growing up less rebellious, more tolerant, less happy — and completely unprepared for adulthood — and what that means for the rest of us*. Atria Books.
- Umucu, E., Wu, J.-R., Sanchez, J., Brooks, J. M., Chiu, C.-Y., Tu, W.-M., & Chan, F. (2020). Psychometric validation of the PERMA-profiler as a well-being measure for student veterans. *Journal of American College Health*, 68(3), 271–277. <https://doi.org/10.1080/07448481.2018.1546182>
- Wan, W. (2020). The coronavirus pandemic is pushing America into a mental health crisis. *Washington Post*. <https://www.washingtonpost.com/health/2020/05/04/mental-health-coronavirus>
- Witters, D., & Harter, J. (2020). Worry and stress fuel record drop in U.S. life satisfaction. *Gallup*. <https://news.gallup.com/poll/310250/worry-stress-fuel-record-drop-life-satisfaction.aspx>
- Youssef-Morgan, C. M., & Luthans, F. (2015). Psychological capital and well-being. *Stress Health*, 31(3), 180–188. <https://doi.org/10.1002/smi.2623>

***The Professional Counselor*: Author and Article Characteristics From 2011 to 2019**



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This meta-study evaluates publication patterns and trends occurring in the first 9 years of *The Professional Counselor* (TPC). Both author (e.g., gender, domicile, employment setting, top individual and university contributors) and article characteristics (e.g., topic, research design, participant type, sample size, statistics) are identified, with a particular focus on research articles. Almost 64% of lead authors and all authors were women, 92.1% of lead authors were affiliated with universities, and 3.4% of lead authors were internationally domiciled. From 2011–2019, the University of Central Florida featured the greatest number of lead authors, and the top author overall was Dr. Kathleen Brown-Rice. About 58% of published works were research articles, and of those, 69% used quantitative design methodology. Nearly all coded research variables were stable over time, except for participant types, as the proportion of adult participant samples increased while undergraduate participant samples decreased over time.

Keywords: meta-study, author characteristics, article characteristics, publication patterns, quantitative design

The Professional Counselor (TPC) is an electronic journal published by the National Board for Certified Counselors (NBCC; *The Professional Counselor*, n.d.). Beginning publication in 2011, this peer-reviewed and open-access journal publishes research and practice-based articles related to school counseling, marriage and family counseling, counseling supervision, theory development, counseling ethics, mental and behavioral health counseling, and multicultural and international counseling. The primary goal of this quarterly journal is to provide relevant and interesting resources and information for individuals all across the counseling profession, including counselors, counselor educators, mental health practitioners, graduate students, and supervisors. Thus, TPC is meant to address the professional development and informational needs of all counselors, regardless of specialty, work setting, or discipline. Each issue of TPC is released alongside a digital reader's digest, a collection of summaries of the articles that are included within the issue.

Myriad characteristics within the counseling profession have evolved over the last decade, and along with this evolution, counseling research also has changed. Just as it is important to periodically review changes to the counseling profession, it also is vital to review journal characteristics to observe and analyze how journals evolve in relation to societal and cultural changes (Erford et al., 2010). Such an analysis informs the editorial board, authors, and readership about who and what is published in a journal, characteristics of methodological considerations, and the trajectories of those characteristics. As TPC began publication in 2011, this is the first multi-year review of the journal's characteristics, providing an opportunity to examine trends within this journal that have yet to be studied. Historical reviews such as this allow for longitudinal monitoring of the advancement of, and challenges occurring within, the counseling profession.

Erford et al. (2010) identified several viable processes for analyzing and recording journal publication patterns. These methods include content analysis of published special issues and sections, qualitative synthesis, and quantitative meta-studies. From 2011–2019, five special issues were published in

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TPC—Counseling the Military and Their Families (Volume 4, Issue 2); Counseling and the DSM-5 (4.3); School Counseling (4.5); Counseling Children With Special Needs and Circumstances (5.2); and School Counselors and a Multi-Tiered System of Supports: Cultivating Systemic Change and Equitable Outcomes (6.3)—along with one special section (Counselor Education and Supervision [5.1]). To date, no qualitative syntheses of *TPC* content have been published in *TPC*. Qualitative syntheses are usually conducted by a scholar with expertise in qualitative analysis and provide an in-depth scholarly treatise of the content published by a journal.

This current article is the first meta-study of *TPC* content. A meta-study involves conducting a quantitative review and trend analysis of patterns found within the published literature. Quantitative meta-studies typically include an analysis of the author and article characteristics, as well as the use of descriptive and univariate statistical procedures in order to identify trends over time within the characteristics analyzed. These studies can be as narrowly focused as a single journal or topic or can span across multiple journals focusing on specific concepts. Quantitative meta-studies have the advantage of allowing objective, numerical, statistical analysis of changing trends across a large variety of variables using hypothesis testing to determine statistical significance and effect sizes. This quantitative meta-study focused on the scholarly content of *TPC* from the first nine volumes (2011–2019) and attempted to answer two basic questions: (a) What is published within *The Professional Counselor* (article characteristics), particularly with regard to research? and (b) Who publishes in *The Professional Counselor* (author characteristics)? These questions are also analyzed for trends to determine changes occurring in journal characteristics over time.

Method

Mirroring the methods of Saks et al. (2020), all articles published from 2011 through 2019 in *TPC* were examined, analyzed, and coded to describe article and author characteristics in order to answer the primary research questions of who and what is published in *TPC* and how those characteristics have changed over time. This systematic approach also allowed comparisons of these variable displays across journals. Scholarly contributions were accepted into the analysis while less scholarly works were rejected and not included in the analysis (e.g., editorials, introductions to special issues, biographies, profiles). Identified author characteristics included the number of authors, name, gender, and employment setting of all authors, and university and domicile (national or international) of the lead author. Identified article characteristics included type of article (i.e., expository/other and research), topical content (e.g., professional issues, symptoms/disorders, technique/theory, multicultural issues), and focus (i.e., research or not research). Additional characteristics were identified specifically in research articles. These research characteristics included: intervention or nonintervention; research paradigm (i.e., quantitative or qualitative); type of research design (i.e., qualitative, true or quasi-experimental, test development, descriptive/survey, comparative, correlational, meta-analysis/other); use of random or nonrandom sampling/assignment procedures; types of participants (i.e., adults, counselors/providers, youth, undergraduate students, graduate students or counselor trainees, nonhuman); sample size; sample size category (i.e., small, medium, large, or very large); sophistication of statistical applications (basic, intermediate, or advanced); primary statistical analyses used (i.e., descriptive, correlation, regression analysis, *t*-test/ANOVA/ANCOVA, nonparametric, MANOVA/MANCOVA, factor analysis); and inclusion of sample effect size estimate, reliability, and validity as indicators of quantitative reporting standards. Qualitative designs (e.g., grounded theory, phenomenological, case study) were further disaggregated and analyzed.

Our first two authors, Dorrie Williams and Marcella Melanson, independently coded each article for these characteristics into separate Microsoft Excel spreadsheets, sequenced by article release date. The data were then assessed for discrepancies and resolved by consensus. Analysis included descriptive statistics and one-way ANOVA using weighted proportions to analyze trends over time. Post hoc tests of significant results were conducted using Scheffe tests and significance for Type I error was set at $\alpha < .05$. The interpretive guidelines of .01 = small effect, .09 = medium effect, and .25 = large effect were used to report ANOVA effect sizes (η^2). These effect size estimates help demonstrate the power or relevance of the observed effects; larger effect sizes indicate more important or relevant changes being observed.

Results

From 2011–2019, 272 articles were published in *TPC*. Of these, 265 articles were accepted into this analysis, with only seven articles rejected because they were less scholarly submissions (e.g., editorials, introductions to special issues, biographies, profiles). Results were analyzed for trends over time using ANOVA with weighted proportions after being aggregated into two time windows (2011–2014 and 2015–2019). The following results were segmented by author and article characteristics.

Author Characteristics

Author demographic variables, such as the gender of the lead author and all authors and employment setting and domicile of lead author, were used to assess *TPC* author characteristics. We also identified the most prolific author contributors and sponsoring institutions and monitored collaboration trends by computing the average number of authors per article. A consistent, solid majority of lead and all authors from 2011–2019 self-identified as women. Women lead authors formed a proportion of 64.2%— $F(1, 263) = 0.543, p = .462, \eta^2 = .002$ —with a similar result for all authors (63.8% women): $F(1, 703) = 1.134, p = .287, \eta^2 = .002$. Reflecting a slight collaboration trend, the average number of authors per article has risen slightly over time. In 2011–2014, *TPC* reflected an average of 2.43 authors per article, while in 2015–2019, the average increased slightly to 2.83 authors per article.

TPC lead author employment affiliation in university and non-university settings was very stable over time: $F(1, 263) = 0.953, p = .330, \eta^2 = .004$. A consistent proportion of 92.1% of all lead authors were employed or primarily affiliated within a university work setting. During 2011–2019, only 3.4% ($n = 9$) internationally domiciled lead authors published in *TPC*: $F(1, 263) = 2.80, p = .133, \eta^2 = .009$.

The most frequently contributing individual authors (weighted as the lead author receives 3 points, second author receives 2 points, and subsequent authors receive 1 point each) from 2011–2019 included the following, listed from highest rank to lowest: Kathleen Brown-Rice, with 17 points; Jeffrey M. Warren, with 15 points; Robert C. Reardon, with 12 points; Patrick R. Mullen, with 11 points; Sejal M. Barden, Ashley J. Blount, and Emily Goodman-Scott, with 10 points each; M. Ann Shillingford-Butler, with nine points; Randall M. Moate, with eight points; and Simone Lambert, James P. Sampson, Jr., Richard A. Wantz, and Laura E. Welfare, with seven points each. Using a weighted point system allows more credit to be allotted to primary article contributors over time, whereas a unit weighting system (one point of credit per article authored) benefits contributors who served in secondary or tertiary capacities. From 2011–2019, the following universities supported the highest number of *TPC* lead authors, listed from highest to lowest: the University of Central Florida, with 12 articles; the University of South Dakota, with 10 articles; Virginia Tech, with six articles; East Carolina University, Florida State University, University of North Carolina – Charlotte, and University of North Carolina – Pembroke, each with five articles; and Wake Forest University and Walden University, with four articles each.

These universities align well with productive contributing authors in the list above or clusters of contributing authors, representing counseling faculty and counselor education programs with high degrees of dedication to enhancing the counseling literature in *TPC*.

Article Characteristics

Table 1 shows that topical content appearing in *TPC* publications from 2011–2019 was consistent and diverse: $F(1, 530) = 0.666, p = .415, \eta^2 = .001$. The topics of counselor education and training, school counseling, and multicultural issues each occurred in more than 10% of *TPC* articles, each benefitting as foci in special issues/sections over the years. When inspecting article typology from the perspective of the tables of contents, it is noted that *TPC* only designates two major categories of articles: research and expository, the latter of which we combined with an “other” category, as specialized, non-research articles do appear in *TPC* from time to time. This *TPC* table of contents bi-factor typology was consistent from 2011–2019: $F(1, 263) = 2.033, p = .155, \eta^2 = .008$. Given this result, it is then not surprising that *TPC* also displayed a consistent proportion of published research articles (58.1% from 2011–2019): $F(1, 263) = 2.357, p = .126, \eta^2 = .009$. The remainder of this Results section reviews various characteristics of the 154 research articles published in *TPC* between 2011 and 2019.

Table 1

Issue Categories in TPC Articles From 2011–2019

Content Topic	2011–2014	2015–2019	Total
Counselor Education/Training	35 (16.9%)	52 (16.0%)	87 (16.4%)
Multicultural Issues	26 (12.6%)	29 (8.9%)	55 (10.3%)
School Counseling	19 (9.2%)	36 (11.1%)	55 (10.3%)
Health/Wellness	15 (7.2%)	30 (9.2%)	45 (8.4%)
Treatment/Intervention	11 (5.3%)	32 (9.8%)	43 (8.1%)
Counseling Process	7 (3.4%)	33 (10.2%)	40 (7.5%)
Symptoms/Disorders	21 (10.1%)	15 (4.6%)	36 (6.8%)
Professional Issues	16 (7.7%)	16 (4.9%)	32 (6.0%)
Ethical/Legal Issues	10 (4.8%)	19 (5.8%)	29 (5.4%)
Academic/Career	7 (3.4%)	18 (5.5%)	25 (4.7%)
Career Development	12 (5.8%)	13 (4.0%)	25 (4.7%)
Assessment/Evaluation	11 (5.3%)	13 (4.0%)	24 (4.5%)
Supervision	10 (4.8%)	9 (2.8%)	19 (3.6%)
Identity Development	7 (3.4%)	10 (3.1%)	17 (3.2%)
Totals	207	325	532

Note. Many articles were coded to reflect multiple content issues. Thus, totals exceed the number of accepted articles.

The proportions of quantitative and qualitative research studies appearing in *TPC* have changed significantly over time— $F(1, 176) = 9.025, p = .003, \eta^2 = .049$ —constituting the highest effect size of any analysis in this study, albeit still a small effect. Quantitative designs shifted from a slight minority (46.9%) of research designs in 2011–2014 to a substantial proportional majority (69.3%) in 2015–2019, while the qualitative studies displayed converse proportions. We noted that about one-third of the qualitative studies did not specify an approach or methodological tradition. When qualitative approaches/methodologies were specified: 15.4% used a generic “content analysis”, 30.7% were phenomenological, 9.6% used grounded theory, 7.7% used case study, 5.8% used consensual qualitative research, 5.8% used narrative, 3.8% used constant comparative, and 1.9% simply specified an ethnographic approach.

Intervention studies maintained a stable presence among *TPC* research articles at 12.3%: $F(1, 152) = 0.020, p = .889, \eta^2 = .000$. Likewise, the types of research designs appearing in *TPC* research articles (see Table 2) have been relatively stable over time: $F(1, 156) = 1.232, p = .269, \eta^2 = .008$. Non-experimental designs dominated *TPC* research articles and were heavily weighted toward descriptive/survey (42.4%), qualitative (18.4%), and correlational designs (18.4%). The most rigorous experimental designs (true/quasi-experimental designs) comprised only 4.4% of *TPC* research studies.

Table 2

Proportion of Research Designs Used in TPC Research Studies

Time	2011–2014	2015–2019	Total
Descriptive/Survey	22 (35.5%)	45 (46.9%)	67 (42.4%)
Qualitative	16 (25.8%)	13 (13.5%)	29 (18.4%)
Correlation	17 (27.4%)	12 (12.5%)	29 (18.4%)
SSRD	1 (1.6%)	7 (7.3%)	8 (5.1%)
Comparative	2 (3.2%)	5 (5.2%)	7 (4.4%)
True/Quasi-Experiment	3 (4.8%)	4 (4.2%)	7 (4.4%)
Meta-Analysis/Other	0 (0.0%)	6 (6.2%)	6 (3.8%)
Test Development	1 (1.6%)	4 (4.2%)	5 (3.2%)
Totals	62	96	158

Note. SSRD = Single-subject research design

Proportions of types of participants have shifted significantly across *TPC* research studies— $F(1, 224) = 5.573, p = .019, \eta^2 = .024$ —the second highest effect size of this meta-study. From the 2011–2014 to 2015–2019 time windows, adult participant samples increased from 28.0% to 41.7%, while undergraduate samples dropped from 17.3% to 6.0% (see Table 3). *TPC* research article sample sizes by category were consistent over time: $F(1, 153) = 0.901, p = .344, \eta^2 = .006$. Small samples (< 30 participants) composed 33.5% of all studies, medium samples (30–99 participants) 20.0%, large samples (100–499 participants) 36.1%, and very large samples (500+ participants) only 10.3% of research studies. At the same time, the median sample size increased from 65 participants in 2011–

2014 to 107 participants in 2015–2019, commensurate with the slight decrease in qualitative studies. Finally, the proportions of use of randomization in assignment procedures was also consistent— $F(1, 152) = 1.172, p = .281, \eta^2 = .008$ —holding steady at 11.7% of studies.

Table 3

Types of Participants Used in TPC Research Articles

Time	2011–2014	2015–2019	Total
Adults	21 (28.0%)	63 (41.7%)	84 (37.2%)
Counselors/Providers	14 (18.7%)	39 (25.8%)	53 (23.5%)
Graduate Students/Trainees	15 (20.0%)	19 (12.6%)	34 (15.0%)
Undergraduates	13 (17.3%)	9 (6.0%)	22 (9.7%)
Youth	9 (12.0%)	15 (9.9%)	24 (10.6%)
Nonhumans	3 (4.0%)	6 (4.0%)	9 (4.0%)
Totals	75	151	226

Categorization of statistical procedures into basic, intermediate, or advanced designations was used as an indicator of statistical sophistication, which remained stable over time: $F(1, 152) = 0.141, p = .707, \eta^2 = .001$. Articles were specifically categorized as research and non-research articles, and all types of statistical procedures from Table 4 were aggregated into the collapsed categories of basic, intermediate, and advanced statistics. Based on this categorization, over the 9 years, 59.1% of TPC research studies used basic statistical procedures (e.g., descriptive, correlation, *t*-test, chi-square), 31.8% used intermediate statistical procedures (e.g., ANOVA, regression analysis, other nonparametric), and only 9.1% used advanced procedures (e.g., MANOVA, factor analysis). Likewise, when specific statistical procedures used were analyzed, no significant shifts over time occurred (see Table 4): $F(1, 290) = 0.055, p = .814, \eta^2 = .000$. Descriptive statistics were used in 29.8%, ANOVA/*t* in 13.4%, and content analysis or thematic coding in 21.2% of TPC research studies.

Table 4

Proportion of Various Statistical Procedures Used in TPC Research Studies

Time	2011–2014	2015–2019	Total
Descriptive	29 (27.4%)	58 (31.2%)	87 (29.8%)
Content Analysis	25 (23.6%)	37 (19.9%)	62 (21.2%)
Correlation	14 (13.2%)	29 (15.6%)	43 (14.7%)
ANOVA/ <i>t</i>	18 (17.0%)	21 (11.3%)	39 (13.4%)
Regression	10 (9.4%)	19 (10.2%)	29 (9.9%)
Factor Analysis	3 (2.8%)	13 (7.0%)	16 (5.5%)
MANOVA	3 (2.8%)	7 (3.8%)	10 (3.4%)
Nonparametric	4 (3.8%)	2 (1.1%)	6 (2.1%)
Totals	106	186	292

TPC consistently reported study effect sizes at a rate of 23.5% of all research articles published from 2011–2019: $F(1, 152) = 1.172$; $p = .281$; $\eta^2 = .008$. Sample reliability and validity reports were also stable over time with reports of sample reliability at a steady rate of 39.2%— $F(1, 151) = 1.961$; $p = .161$; $\eta^2 = .012$ —and sample score validity at a consistent proportion of 36.6% from 2011–2019: $F(1, 151) = 0.299$; $p = .585$; $\eta^2 = .002$.

Discussion

TPC published an average of about 30 articles per year from 2011–2019, 57.7% of which have been research articles. *TPC* mirrors the evolution of the counseling profession and through research and expository articles helps to address new professional issues, topics, and challenges that contribute to the advancement and growth of the counseling profession (*TPC*, 2020). The online publishing format makes this information freely available to professional counselors and the public; no print edition exists. This section discusses *TPC* author and article characteristics from the journal's inception in 2011 to 2019. Interestingly, only two variables displayed trends between the two time windows, demonstrating an admirable focus and stability of decision making among *TPC* editorial board members for a new counseling journal. That is, in just 9 years, *TPC* already appears to have attracted and published broadly consistent types of articles from authors with similar characteristics.

Author Characteristics: Who Publishes in *TPC*?

In the first 9 years of publication, only nine (3.4%) *TPC* lead authors were domiciled outside the United States. Other counseling journals have also historically displayed international publishing rates of less than 5%, including the *Journal of Addictions & Offender Counseling* (MacInerney et al., 2020), *The Journal of Humanistic Counseling* (Sylvester et al., in press), the *Journal of College Counseling* (Milowsky et al., in press), and the *Journal of LGBT Issues in Counseling* (Gayowsky et al., in press). Still, *TPC* has an opportunity to reach out to the international counseling community and invite more diverse expository and research contributions, thereby expanding into the international counseling domain. Perhaps a call for articles from international authors could form a special issue of *TPC*, contributing multicultural insights, evaluating cross-cultural perspectives, or helping to establish a focus for global connectivity. This is particularly important given NBCC's historic leadership in developing international counseling initiatives through its International Capacity Building department (NBCC, n.d.). International outreach is consistent with the mission of NBCC's international collaborations with organizations such as the African Union – Southern Africa Regional Office (AU-SARO) and around the world, and *TPC* is positioned to aid in that international scope of activities. As such, *TPC* could become a leader in international focus among counseling journals. Currently, two counseling journals do exceptional jobs attracting international scholars. The *Journal of Employment Counseling* (Siegler et al., in press) featured a 53% internationally domiciled lead author proportion from 2010–2019, and *Measurement and Evaluation in Counseling and Development* published 28% of its articles from international lead authors over the same period (Saks et al., 2020).

A consistent majority of women composed the lead authors (64.2%) and all authors (63.8%) of published *TPC* articles from 2011–2019. A near 2-to-1 proportion is acknowledgement of the importance and majority standing of women counselor educator scholars in the United States (U.S. Census Bureau, 2016). A nearly two-thirds majority is consistent with many other counseling journals and indicates the rise to prominence of women scholars in counselor education (Johnson et al., 2021; MacInerney et al., 2020; Menzies et al., 2020; Milowski et al., in press; Saks et al., 2020; Sylvester et al., in press).

At the same time the vast majority of lead authors (92.1%) listed primary affiliations in university work settings. Although a non-university-affiliated participation rate of only 7.9% seems low overall, compared to other counseling journals, it actually is comparable with counseling journal leaders in this category like the *Journal of Mental Health Counseling* (Menzies et al., 2020) and *Counseling Outcome Research and Evaluation* (Johnson et al., 2021), and higher than most other counseling journals (MacInerney et al., 2020; Milowsky et al., in press; Saks et al., 2020; Sylvester et al., in press). This low level of participation from non-university-affiliated authors across counseling journals is curious given the powerful and necessary voices practitioners can lend to real-world counseling issues and interventions.

But there are certainly barriers and constraints on practitioner motivations to engage in scholarship. First, practitioners are rarely compensated for research, nor are employee evaluations substantively impacted by scholarly contributions. If more incentives like compensation and evaluation were tied to practitioner scholarship efforts, we could expect practitioners to have a larger presence in counseling scholarship and collaborations. Practitioners are also incredibly busy providing counseling services to clients and students, and research and program evaluation becomes a lower priority as time constraints tighten. In contrast, employee scholarship production often is rewarded by universities through salary increases, promotions, and tenure. Likewise, professors are expected to, and often rewarded for, scholarship, including collaboration with graduate students and colleagues in research projects. Graduate students often engage in research to enhance their levels of qualification for doctoral study and future opportunities to join the professoriate. It is also possible that authors who are practitioner-students or scholar-practitioners simply default to a university affiliation for some reason—perhaps believing that university affiliations are more prestigious or may be given greater consideration in a positive disposition. In any case, journal editorial boards should encourage authors to list multiple affiliations to better gauge the prevalence of practitioners among contributing authors.

Counselor scholars should continue to search for opportunities to collaborate with practitioners, both to access rich sources of field-based data and to amplify the valuable voices of experienced clinicians. In just the first 9 years, *TPC* experienced increased author collaboration, from 2.43 authors per article in 2011–2014 up to 2.83 in 2015–2019. This trend toward more collaboration was seen in all other counseling journals, with many in the same vicinity of average author contributions as *TPC*, including *AdultSpan* (Rippeto et al., in press), the *Journal of Employment Counseling* (Siegler et al., in press), *The Journal of Humanistic Counseling* (Sylvester et al., in press), and others far higher, exceeding 3.10 authors per article, such as *Measurement and Evaluation in Counseling and Development* (Saks et al., 2020) and the *Journal of College Counseling* (Milowsky et al., in press).

Collaboration is essential to the future of counseling research as the profession and our domain of knowledge become larger and at the same time more specialized. This trend toward increased collaboration is very positive, perhaps reflecting a greater focus on mentorship and partnership. It will not be a surprise to note that simultaneous with this rise in collaboration was a proportional rise in publishing research articles. Research ventures are great opportunities for collaboration and building research partnerships with colleagues, graduate students, and practitioners. In particular, partnering with practitioners promotes meaningful field-based studies that enrich practice and document promising evidence-based interventions. Finally, as counselor educator-scholars, we must recommit to training practitioners who can collect, conduct, and collaborate in the publication of field-based research. Field-based studies are critical in counseling research because that is where the overwhelming majority of clients and students are counseled and treated. Conducting studies in

research labs must generalize to implementation in the field; studies conducted in the field already have bridged that gap. Melding field-based innovations, counseling research, and practitioner voices will help the counseling profession evolve into a more evidence-based practice accountable to, and valued by, clients and other stakeholders.

Article Characteristics: What Is Published in *TPC*?

Over the first 9 years of *TPC* publications, articles were quite well balanced over a broad range of topical content (see Table 1). When combined, over one-third of the articles focused primarily on three topics: counselor education/training (16.4%), multicultural issues (10.3%), and school counseling (10.3%). However, an appropriate and even spread of topic coverage was observed in the other areas, ranging from a low of 3.2% for identity development to 8.4% for health/wellness. Thus, the *TPC* editorial board is approving a broad swath of important and meaningful topical content for the readership of *TPC*. It will be important to maintain this balance in the decade ahead as *TPC* fulfills its goal as a journal of value to all professional counselors, regardless of work setting and counseling sub-discipline.

Research articles are critical components of professional journals. Research articles form the scientific foundation of a profession, and the more we know about the clients we serve, the better prepared we are to serve them. At 58.1%, the proportion of research studies published in *TPC* is typical when compared with other counseling journals, most of which are in the range of 50%–68%, including *Counseling and Values: Spirituality, Ethics, and Religion in Counseling* (Alder et al., in press); the *Journal of LGBT Issues in Counseling* (Gayowsky et al., in press); the *Journal of Mental Health Counseling* (Menzies et al., 2020); and *Adultspan* (Rippeto et al., in press). The proportion of research studies in *TPC* is albeit far lower than the more research-focused counseling journals like *Measurement and Evaluation in Counseling and Development* (80.7%; Saks et al, 2020), *Counseling Outcome Research and Evaluation* (75.6%; Johnson et al., 2021), the *Journal of Employment Counseling* (86.4%; Siegler et al., in press), and *Counselor Education & Supervision* (90.4%; Johnsen et al., in press) produced during the 2015–2019 time window. Still, *TPC* has made great inroads in the proportion of research articles published in its first decade, and it will be interesting to see where this trajectory will lead in the next decade.

The research designs used in *TPC* research studies are heavily weighted toward non-experimental designs, including descriptive or survey (42.4%), qualitative (18.4%), and correlational (18.4%) designs (see Table 2). Descriptive/survey research simply seeks to describe the characteristics of participants and their interactions or performance on variables. True- and quasi-experimental designs appeared in only 4.4% of all *TPC* research articles, which is a low rate among the family of counseling journals. At the same time, the 12.3% proportion of intervention-focused articles is quite good when compared to other counselor journals (Menzies et al., 2020), as Ray et al. (2011) reported that only about 6% of all research articles published in counseling journals focus on the efficacy of interventions. Intervention research studies tend to be among the most valuable studies published in the counseling profession because intervention studies inform the reader on what efficacy counselors can expect when implementing the intervention with clients or students. Thus, intervention studies help inform us about what we know that works in counseling. In summary, *TPC* should strive to increase the proportion of intervention articles, as well as true- and quasi-experimental designs, as these approaches help counselors understand what works in counseling related to the effectiveness of counseling practice. True- and quasi-experimental designs also enhance generalizability of sample results to the population, which gives counselors confidence that the more robust experimental results from these studies are more applicable to the broader populations of clients served by counselors.

During its first 4 years of publication, *TPC* produced one of the highest proportions of qualitative tradition articles seen in the family of counseling journals (53.1%), before declining significantly in 2015–2019 (30.7%). Qualitative research has consistently accounted for 30–45% of research publications in some counseling journals over the last 20 years (Alder et al., in press; Gayowsky et al., in press; MacInerney et al., 2020), but is much lower in other journals like *Measurement and Evaluation in Counseling and Development* (Saks et al., 2020) and *Counseling Outcome Research and Evaluation* (Johnson et al., 2021), which produce more quantitative, generalizable research. It will be interesting to see if the significant decline in qualitative articles continues over the next decade or stabilizes in the 30% range.

The significant increases in adults and counselors or other mental health service providers as participants in *TPC* research studies was interesting, as these two groups comprised more than two-thirds (67.5%) of participant types in the 2015–2019 time window (see Table 3). This was accompanied by a significant decline in the use of undergraduate and graduate students. The use of adult participants in counseling research is a welcome occurrence, as adults comprise the majority of clients seen in counseling agencies and private practice. And the focus on counseling practitioners is very appropriate for a journal whose mission it is to meet the professional needs of all counselors across diverse work settings and disciplines.

Although the median sample sizes did increase from 65 to 107 participants across the two time windows, that observation is expected given the increase in the proportion of quantitative compared to qualitative studies, as quantitative studies generally have higher sample sizes. Still, the overall consistency in the proportions of small, medium, large, and very large sample sizes is a sign of maturation in such a young journal.

Statistical procedures appearing in *TPC* articles were very well balanced across categories and across the two time windows. Not surprisingly, basic approaches like descriptive analyses and thematic coding comprised about half of all procedures. Descriptive statistics are the most basic type of statistics and are often used to convey results in surveys and nonexperimental studies. MANOVA, ANOVA, and *t*-tests combined for a very respectable total proportion of 16.8%. *TPC* should strive to increase the prominence of these more sophisticated statistical tests. Among counseling journals, *Counseling Outcome Research and Evaluation* (Johnson et al., 2021) leads the way in use of these tests of difference statistics at more than 20%, but *TPC* is not far behind.

Finally, *TPC* editors have a great deal of progress to make in improving the proportions of reporting standards. In the first 9 years of publication, *TPC* authors reported effect size estimates in only 23.5% of articles, sample reliability estimates in only 39.2%, and sample validity estimates in 36.6% of research articles published. Reports of effect size, score reliability, and score validity are indications of study rigor and meaningfulness. For example, authors should always report on the reliability of scores of standardized dependent variables used in a study so readers know how much error variance in measurement occurred. Likewise, statistical significance is important in hypothesis testing, but effect sizes give readers an indication of how important and meaningful the results are in a grander context. These effect size and reliability reports are among the lowest rates of any counseling family journal (MacInerney et al., 2020; Milowsky et al., in press; Rippetto et al., in press; Saks et al., 2020; Siegler, in press; Sylvester et al., in press), so the *TPC* editorial board is encouraged to add these reporting standard aspects to review protocols and author requirements to insure inclusion in future articles.

Limitations and Conclusion

This synthesis and analysis of the first 9 years of *TPC* publications has several limitations that should be explicated. First, no causal inference may be derived from these results. This means that one cannot determine the cause of any of the analyses indicated because the design of the study was not experimental; we were able to describe the variables, not determine what caused the results. This meta-study used descriptive and comparative statistical analyses to summarize proportions aggregated across time windows to discern trends occurring over time. However, no inference is offered as to why the proportions and trends were observed.

Second, despite the use of independent coders and robust, standardized coding procedures, the potential for coding errors always exists. Thus, some categorization or classification errors may have occurred. This is a particular risk within categories that are more subjective or when the descriptions provided by *TPC* authors lacked clarity or essential information. Third, we chose to segment the 9 years of *TPC* publications into two periods to bolster analytic power, although others might prefer smaller time windows when engaging in trend analysis.

Fourth, while this meta-study combined the quantitative and qualitative designs into a larger analysis and then took a closer look at just the quantitative designs, there is value in conducting a parallel analysis of the methodological rigor of both the quantitative and qualitative studies published in *TPC* to date. This will help address or at least acknowledge the possible limits of a positivist epistemological lens.

Finally, we were not able to code important author demographics such as race, ethnicity, age, or other attributes. We instead focused on readily available information like lead author domicile and author institutional affiliations and gender. For future analyses, it would be helpful if authors would self-identify a wider variety of demographic descriptors (e.g., self-identified gender, race, nationality) or at least designate all university and non-university affiliations. This would help clarify the degree to which practitioners and authors of diverse backgrounds are represented within author configurations.

In summary, *TPC* has made great progress across many dimensions over its first 9 years of publication. Also, it appears that *TPC* is well on its way to fulfilling its mission to provide valuable research and practice information to all professional counselors regardless of work setting or sub-discipline. We look forward to seeing the continued progress of this new counseling journal in the decades ahead and hope this meta-study is of use to the *TPC* editorial board, authors, and readership as a description of who and what is published in *TPC*.

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References

- Alder, C., Yu, C., & Erford, B. T. (in press). A meta-study of the *Counseling and Values: Spirituality, Ethics, and Religion in Counseling (CVJ)*: An analysis of publication characteristics, 2000-2019. *Counseling and Values: Spirituality, Ethics, and Religion in Counseling*.
- Erford, B. T., Miller, E. M., Duncan, K., & Erford, B. M. (2010). Submission patterns: *Measurement and Evaluation in Counseling and Development* author and article characteristics from 1990 to 2009. *Measurement and Evaluation in Counseling and Development*, 42(4), 296–307. <https://doi.org/10.1177/0748175609354619>
- Gayowsky, J., Choi, J., & Erford, B. T. (in press). Meta-study of *Journal of LGBT Issues in Counseling* publication patterns from 2006-2019. *Journal of LGBT Issues in Counseling*.
- Johnsen, S., Watson, K., Erford, B. T., Crockett, S., & Byrd, R. (in press). *Counselor Education and Supervision (CES)*: An analysis of publication characteristics from 2000-2019. *Counselor Education and Supervision*.
- Johnson, A., West, C., & Erford, B. T. (2021). A meta-study of *Counseling Outcome Research and Evaluation (CORE)*: An analysis of publication characteristics from 2010-2019. *Counseling Outcome Research and Evaluation*.
- MacInerney, E. K., Johnsen, S. T., Cobb, N., Smith, H., & Erford, B. T. (2020). *Journal of Addictions & Offender Counseling* publication patterns from 1998 to 2017: Author and article characteristics. *Journal of Addictions & Offender Counseling*, 41(2), 82–96. <https://doi.org/10.1002/jaoc.12082>
- Menzies, A., Kepley, L., Crockett, S. A., Erford, B. T., Byrd, R., & Aier, B. (2020). A meta-study of the *Journal of Mental Health Counseling*: An analysis of publication characteristics 2000-2019. *Journal of Mental Health Counseling*, 42(3), 206–219. <https://doi.org/10.17744/mehc.42.3.02>
- Milowsky, A. I., Haffner, A. M., Bardhoshi, G., Erford, B. T., Byrd, R., & Crockett, S. A. (in press). A meta-study of *Journal of College Counseling (JCC)*: An analysis of publication characteristics from 2000-2019. *Journal of College Counseling*.
- National Board for Certified Counselors. (n.d.). NBCC Foundation: International capacity building. <https://www.nbccf.org/programs/international>
- The Professional Counselor*. (n.d.). *The Professional Counselor*. <https://tpcjournal.nbcc.org>
- Ray, D. C., Hull, D. M., Thacker, A. J., Pace, L. S., Swan, K. L., Carlson, S. E., & Sullivan, J. M. (2011). Research in counseling: A 10-year review to inform practice. *Journal of Counseling & Development*, 89(3), 349–359. <https://doi.org/10.1002/j.1556-6678.2011.tb00099.x>
- Rippeto, M., Stewart, E., & Erford, B. T. (in press). A meta-study of *Adultspan* publication characteristics from 1999-2019. *Adultspan*.
- Saks, J., Fuller, A., Erford, B. T., & Bardhoshi, G. (2020). Meta-study of *Measurement and Evaluation in Counseling and Development (MECD)* publication patterns from 2000–2019. *Measurement and Evaluation in Counseling and Development*, 53(4), 279–288. <https://doi.org/10.1080/07481756.2020.1735222>
- Siegler, E., Stafford, C., Crockett, S., Zhou, Y., & Erford, B. T. (in press). A meta-study of *Journal of Employment Counseling (JEC)*: An analysis of publication patterns from 2010-2019. *Journal of Employment Counseling*.
- Sylvester, A.-M., Wary, S., Erford, B. T., & MacInerney, E. (in press). A meta-study of *The Journal of Humanistic Counseling (JHC)*: An analysis of publication characteristics, 2000-2019. *Journal of Humanistic Counseling*.
- U.S. Census Bureau. (2016). ACS public use microdata sample. [Data file]. <https://www.census.gov/programs-surveys/acs/data/pums.html>

Mental Health Equity of Filipino Communities in COVID-19: A Framework for Practice and Advocacy



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The emergence and global spread of COVID-19 precipitated a massive public health crisis combined with multiple incidents of racial discrimination and violence toward Asian American and Pacific Islander (AAPI) communities. Although East Asian communities are more frequently targeted for instances of pandemic-related racial discrimination, multiple disparities converge upon Filipino communities that affect their access to mental health care in light of COVID-19. This article empowers professional counselors to support the Filipino community by addressing three main areas: (a) describing how COVID-19 contributes to racial microaggressions and institutional racism toward Filipino communities; (b) underscoring how COVID-19 exacerbates exposure to stressors and disparities that influence help-seeking behaviors and utilization of counseling among Filipinos; and (c) outlining how professional counselors can promote racial socialization, outreach, and mental health equity with Filipino communities to mitigate the effects of COVID-19.

Keywords: Asian American, Filipino, mental health equity, COVID-19, discrimination

Asian Americans represent the fastest-growing ethnic group in the United States (Budiman et al., 2019). Following the global outbreak of COVID-19, many Asian Americans and Pacific Islanders (AAPIs) have experienced a substantial increase in race-based hate incidents. These incidents of racial discrimination have included verbal harassment, physical attacks, and discrimination against Asian-owned businesses (Jeung & Nham, 2020), which multiply the harmful effects on psychological well-being and life satisfaction among AAPIs (Litam & Oh, 2020). According to Pew Research Center trends (Ruiz et al., 2020), about three in 10 Asian adults reported they experienced racial discrimination since the outbreak began. Proliferation of anti-Chinese and xenophobic hate speech from political leaders, news outlets, and social media, which touted COVID-19 as the “Chinese virus,” further exacerbate instances of race-based discrimination (U.S. Department of Justice, 2020) and echo the Yellow Peril discourse from the late 19th century (Litam, 2020; Poon, 2020).

Although the community is often aggregated, Asian Americans are not a monolithic entity (Choi et al., 2017; Jones-Smith, 2019; Sue et al., 2019). The term *Asian American* encompasses over 40 distinct subgroups, each with distinct languages, cultures, beliefs, and migration histories (Pew Research Center, 2013; Sue et al., 2019). It is no surprise, therefore, that specific ethnic subgroups would be more affected by the pandemic than others. For example, instances of COVID-19–related racial discrimination disproportionately affect East Asian communities, specifically Chinese migrants and Chinese Americans. An analysis of nearly 1,500 reports of anti-Asian hate incidents indicated approximately 40% of Chinese individuals reported experiences of discrimination as compared to 16% of Korean individuals and 5.5% of Filipinos (Jeung & Nham, 2020). Although Chinese individuals disproportionately experience overt forms of COVID-19–related discrimination, Filipino migrants and Filipino Americans are not immune to the deleterious effects of the pandemic.

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With over 4 million people of Filipino descent residing in the United States (Asian Journal Press, 2018), it is of paramount importance for professional counselors to recognize how the Filipino American experience may compound with additional COVID-19 exposure and related stressors in unique ways that distinctively impact their experiences of stress and mental health. The current article identifies how the racialized climate of COVID-19 influences Filipino-specific microaggressions and the presence of systemic and institutional racism toward Filipino communities. The ways in which COVID-19 exacerbates existing racial disparities across social determinants of health, help-seeking behaviors, and utilization of counseling services are described. Finally, the implications for counseling practice and advocacy are presented in ways that can embolden professional counselors to promote racial socialization, outreach, and health equity with Filipino communities to mitigate the effects of COVID-19.

Health Disparities Among Filipino Americans

The unprecedented emergence of COVID-19 has affected the global community. As of January 5, 2021, a total of 21,382,296 cases were confirmed and 362,972 deaths had been reported in the United States (Worldometer, n.d.). Although information about how racial and ethnic groups are affected by the pandemic is forthcoming, emerging data suggests that specific groups are disproportionately affected. Professional counselors must be prepared to support communities that may be more vulnerable to pandemic-related stress and face challenges related to medical and mental health care access because of intersecting marginalized identities, such as age, race, ethnicity, gender identity, sexual identity, social class, and migration history (Chan & Henesy, 2018; Chan et al., 2019; Litam & Hipolito-Delgado, 2021). For example, the AAPI population may be especially in need of mental health support because of ongoing xenophobic sentiments from political leaders that combine with intergenerational trauma, racial discrimination, and racial trauma (Litam, 2020).

Underutilization of Mental Health Services

Compared to other Asian American subgroups, Filipinos are the least likely to seek professional mental health services. In a study of 2,230 Filipinos, approximately 73% had never used any type of mental health service and only 17% sought help from friends, community members, peers, and religious or spiritual leaders (Gong et al., 2003). Since the Gong et al. (2003) study, a multitude of researchers have documented the persistent disparity of mental health usage and unfavorable attitudes toward professional help-seeking among Filipinos (David & Nadal, 2013; David et al., 2019; Nadal, 2021; Tuazon et al., 2019), despite high rates of psychological distress (Martinez et al., 2020).

The experiences of Filipino communities uniquely influence aspects of mental health and wellness. Compared to other subgroups of Asian Americans, Filipino Americans with post-traumatic stress experiences tend to exhibit poorer health (Kim et al., 2012; Klest et al., 2013), and report higher rates of racial discrimination (Li, 2014). As a subgroup, Filipino Americans present to mental health counseling settings with high rates of depression, suicide, HIV, unintended pregnancy, eating disorders, and drug use (David et al., 2017; Klest et al., 2013; Nadal, 2000, 2021). Compared to other Asian subgroups, Filipinos may experience lower social class and employment statuses, which may increase the prevalence of mental health issues (Araneta, 1993). Among Filipinos, intergenerational cultural conflicts and experiences of racial discrimination were identified as significant contributors to depression and suicidal ideation (Choi et al., 2020). The underutilization of professional mental health services and help-seeking among Filipino communities is unusual because of their familiarity with Western notions, systems, and institutions, which surface as traits that are typically associated with mental health help-seeking within the broader AAPI community (Abe-Kim et al., 2002, 2004; Shea & Yeh, 2008).

Distinct Experiences of Oppression

Aspects of Filipino history are characterized by colonization, oppression, and intergenerational racial trauma (David & Nadal, 2013) and have been rewritten by White voices in ways that communicate how America *saved* the Philippines from Spanish rule through colonization (Ocampo, 2016). These sentiments remain deeply entrenched within the mindset of many Filipinos in the form of colonial mentality (David & Nadal, 2013; Tuazon et al., 2019). *Colonial mentality* refers to the socialized and oppressive mindset characterized by beliefs about the superiority of American values and denigration of Filipino culture and self (David & Okazaki, 2006a, 2006b). Colonial mentality is the insidious aftermath galvanized through years of intergenerational trauma, U.S. occupation, and socialization under White supremacy (David et al., 2017). Professional counselors must recognize the interplay between colonial mentality and the mental health and well-being of Filipino clients to best support this unique population.

The internalized experiences of oppression perpetuate the denigration of Filipinos *by* Filipinos as a result of the internalized anti-Black sentiments and notions of White supremacy that remain at the forefront of American history (Ocampo, 2016). The Filipino experience is one that is characterized by forms of discrimination by individuals who reside both within and outside of the Filipino community (Nadal, 2021). For example, Filipinos who espouse a colonial mentality disparage those with Indigenous Filipino traits (i.e., dark skin and textured hair) as unattractive, undesirable, and worthy of shame (Angan, 2013; David, 2020; Mendoza, 2014). Filipinos also experience a sense of otherness within the AAPI community and from other communities of color because their history, culture, and phenotype combine in ways that “break the rules of race” (Ocampo, 2016, p. 13). Although Filipinos are sometimes confused with individuals from Chinese communities, they are not typically perceived as Asian or East Asian (Lee, 2020) and are often mistaken for Black or Latinx (Ocampo, 2016; Sanchez & Gaw, 2007). These pervasive experiences render the Filipino identity invisible (Nadal, 2021). Ultimately, Filipinos remain among the most mislabeled and culturally marginalized of Asian Americans (Sanchez & Gaw, 2007). Professional counselors who work with Filipino clients must obtain a deeper understanding of how these unique experiences of invisibility and colonial mentality continue to affect the minds and the worldviews of Filipinos and Filipino Americans.

Risk Factors for COVID-19 Exposure

The burgeoning rate of COVID-19 cases has devastated hospitals and medical settings. The overwhelming strain faced by medical communities uniquely affects Filipino migrants and Filipino Americans who are overrepresented in health care and disproportionately at risk of COVID-19 exposure (National Nurses United, 2020). The overrepresentation of Filipinos in health care, particularly within the nursing profession, is directly tied to the history of U.S. colonization. Following the U.S. occupation of the Philippines from 1899 to 1946, the Filipino zeitgeist became imbued with profound cultural notions of American superiority and affinity for Westernized attitudes, behaviors, and values (David et al., 2017). For example, the introduction of the American nursing curricula by U.S. Army personnel during the Spanish-American war (McFarling, 2020) instilled pervasive cultural influences that positioned the nursing profession as a viable strategy to escape political and economic instability in pursuit of a better life in the United States (Choy, 2003). These cultural notions have culminated to make the Philippines the leading exporter of nurses in the world (Choy, 2003; Espiritu, 2016). Of the immigrant health care workers across the United States, an estimated 28% of registered nurses, 4% of physicians and surgeons, and 12% of home health aides are Filipinos (Batalova, 2020). About 150,000 registered nurses in the United States are Filipino, equating to about 4% of the overall nursing population (McFarling, 2020; National Nurses United, 2020). According to the National Nurses United (2020) report, 31.5% of deaths among registered nurses and 54% of deaths among registered nurses of color were Filipinos. Based on these statistics, Filipinos face disproportionate exposure to pandemic-related stressors and death that may increase the risk for mental health issues.

Individuals of Filipino descent may also face significant COVID-19–related challenges, as they are predisposed to several health conditions that have been linked with poorer treatment prognosis and outcomes (Ghimire et al., 2018; Maxwell et al., 2012). Compared to other racial and ethnic subgroups, Filipinos residing in California had higher rates of type II diabetes, asthma, and cardiovascular disease (Adia et al., 2020). High rates of hypertension, cholesterol, and diabetes were also noted in studies of Filipino Americans residing in the greater Philadelphia region (Bhimla et al., 2017) and in Las Vegas, Nevada (Ghimire et al., 2018). One study of Filipinos residing in the New York metropolitan area indicated rates of obesity significantly increased the longer Filipino immigrants resided in the United States (Afable et al., 2016). The Centers for Disease Control and Prevention (2021) associated each of these underlying medical conditions with a greater likelihood for hospitalization, intensive care, use of a ventilator, and increased mortality. Filipino Americans also tend to report lower social class and employment statuses as compared to other Asian Americans, which may contribute to higher rates of mental health issues and create barriers to health care access (Adia et al., 2020; Sue et al., 2019).

Cultural Barriers to Professional Mental Health Services

Filipinos face culturally rooted barriers to seeking professional mental health services that may include fears related to reputation, endorsement of fatalistic attitudes, religiousness, communication barriers, and lack of culturally competent services (Gong et al., 2003; Nadal, 2021; Pacquiao, 2004). The presence of mental illness stigma is also deeply entrenched within Filipino communities (Appel et al., 2011; Augsberger et al., 2015; Tuazon et al., 2019). In many traditional Filipino families, mental illness is mitigated by addressing personal and emotional problems with family and close friends, and through faith in God (David & Nadal, 2013). Rejection of mental illness is based on the belief that individuals who receive counseling or therapy are crazy, dangerous, and unpredictable (de Torres, 2002; Nadal, 2021).

Connection and Kinship

Given the central prominence of family, it is no surprise that Filipino individuals' mental health begins to suffer when their connection to community and kinship is compromised. Although relatively few studies on Filipino mental health exist, Filipinos and Filipino Americans consistently report family-related issues as among the most stressful. In one study of Filipino and Korean families in the Midwest ($N = 1,574$), the presence of intergenerational family conflict significantly contributed to an increase in depressive symptoms and suicidal ideation (Choi et al., 2020). In another study of Filipino Americans, quality time with family, friends, and community was identified as an important factor in mitigating the effects of depression (Edman & Johnson, 1999). The centralized role of Filipino families uniquely combines with a group mentality in ways that may additionally hinder rates of professional help-seeking.

Hiya and Amor Propio

Notions of *hiya* and *amor propio* each represent culturally specific barriers to seeking mental health care. According to Gong and colleagues (2003), *hiya* and *amor propio* are related to the East Asian notions of saving face. While *hiya* emphasizes the more extensive experience of shame that arises from fear of losing face, *amor propio* is associated with concepts of self-esteem linked to the desire to maintain social acceptance. A loss of *amor propio* would result in a loss of face and may compromise the cherished position of community acceptance (Gong et al., 2003). Filipino Americans may thus avoid seeking professional mental health services because of combined feelings of shame (*hiya*) linked to beliefs that one has failed or is unable to overcome their problems independently, and fears of losing social positioning within one's community (*amor propio*). To experience *amor propio* would put a Filipino—or worse, their family—at risk for *tsismis*, or gossip. Indeed, avoiding behaviors that may lead others within the Filipino community to engage in *tsismis* about the client or their family is a significant factor

that guides choices and behaviors. Engaging in behaviors that result in one's family becoming the focus of *tsismis* is considered highly shameful and reprehensible among Filipino communities.

Bahala Na

The Tagalog term *bahala na* refers to the sense of optimistic fatalism that characterizes the shared experiences of many Filipinos and Filipino Americans. *Bahala na* can be evidenced through Filipino cultural expectations to endure emotional problems and avoid discussion of personal issues. This core attitude may have deleterious effects on mental health and help-seeking, as many Filipinos are socialized to deny or minimize stressful experiences or to simply endure emotional problems (Araneta, 1993; Sanchez & Gaw, 2007). A qualitative analysis of 33 interviews and 18 focus groups of Filipino Americans indicated *bahala na* may combine with religious beliefs to create additional barriers to addressing mental health problems (Javier et al., 2014). For example, virtuous and religious Filipinos and Filipino Americans may endorse *bahala na* attitudes by believing their higher power has instilled purposeful challenges that can be overcome by sufficient faith and endurance (Javier et al., 2014).

Hindi Ibang Tao

Moreover, many Filipinos and Filipino Americans demonstrate hesitance to trust individuals who are considered outsiders. When interactions with those considered *other* cannot be avoided, traditional Filipinos tend to be reticent, conceal their real emotions, and avoid disclosure of personal thoughts, needs, and beliefs (Pasco et al., 2004). Filipino community members place a large value on in-group versus out-group members and largely prefer to seek support from helping professionals within the Filipino community, rather than from others outside of the group (Gong et al., 2003). Individuals who are *hindi ibang tao* (in Tagalog, "one of us") are differentiated from those who are *ibang tao* (in Tagalog, "not one of us"), which influences interactions and amount of trust given to health care providers (Sanchez & Gaw, 2007). White counselors may be able to bridge the cultural gap with Filipino clients to become *hindi ibang tao* by exhibiting respect, approachability, and a willingness to consider the specific influences of Filipino history and the importance of family (Sanchez & Gaw, 2007). Professional counselors who overlook, minimize, or disregard these cultural values risk higher rates of early termination and may experience their Filipino clients as exhibiting little emotion (Nadal, 2021). Filipino clients who are not yet comfortable with professional counselors may interact in a polite, yet superficial manner because culturally responsive relationships and trust have not been developed (Gong et al., 2003; Pasco et al., 2004; Tuazon et al., 2019).

Pakikisama and Kapwa

Another Filipino cultural barrier is *pakikisama*, or the notion that when one belongs to a group, one should be wholly dedicated to pleasing the group (Bautista, 1999; Nadal, 2021). Filipino core values extend beyond the general notion of collectivism and include *kapwa*, an Indigenous worldview in which the self is not distinguished from others (David et al., 2017; Enriquez, 2010). Thus, Filipinos do not solely act in ways that benefit the group; they are also expected to make decisions that please other group members, even at the expense of their own desires, needs, or mental health (Nadal, 2021). The cultural notions of *pakikisama* and *kapwa* interplay with *amor propio* in ways that have detrimental effects on Filipinos in dire need of mental health support. For example, a second-generation Filipino American may recognize that their suicidal thoughts and experiences of depression may be worthy of mental health support, but recognition of cultural mistrust toward those deemed *other* may risk their family's social acceptance (*amor propio*). Risking the family's social acceptance could ultimately violate group wishes (*pakikisama*) and may subject their family to stigma and gossip (*tsismis*).

Implications for Practice and Advocacy in Professional Counseling

The COVID-19 pandemic and increased visibility to discrimination against Asian Americans illuminates the importance of addressing the presence of mental health barriers among Filipino communities. Filipino communities face complex barriers rooted in colonialism, racism, and colorism that negatively affect their overall mental health (David & Nadal, 2013; Tuazon et al., 2019; Woo et al., 2020). The combination of educational, health, and welfare disparities culminate in poorer health outcomes for Filipino American communities compared to other ethnic Asian groups (Adia et al., 2020). Many of these identifiable barriers and forces of oppression increase the racial trauma narratives incurred among Filipino communities (David et al., 2017; Klest et al., 2013); deny the impact of microaggressions and discrimination (Nadal et al., 2014); divest resources that support economic, educational, and social well-being (Nadal, 2021; Smith & Weinstock, 2019); and discourage the utilization of needed counseling spaces (Tuazon et al., 2019).

Cultivating cultural sensitivity in health care providers can buffer the psychological toll and emotional consequences of negative health care encounters for historically marginalized communities (Flynn et al., 2020), including Filipinos. Findings associated with health equity and help-seeking behaviors (e.g., Flynn et al., 2020; Ghimire et al., 2018) have significant ramifications for Filipino communities that face a litany of barriers to counseling services (Gong et al., 2003; Tuazon et al., 2019). In light of COVID-19, professional counselors are encouraged to employ culturally responsive interpersonal and systemic interventions that promote the sustainable mental health equity of Filipino communities.

Promoting Racial Socialization and Critical Consciousness

Reducing barriers for mental health access is connected to protective factors, actions, and cultural capital instilled across generations of Filipino communities (David et al., 2017). Filipino communities draw from several generations of colonization, which continues to affect second-generation Filipinos living in the United States (David & Okazaki, 2006a, 2006b). Experiences of historical colonization, forced assimilation into other cultures, and the erasure of Filipino cultural values have resulted in a range of Eurocentrically biased and historically oppressive experiences (Choi et al., 2020; David & Nadal, 2013). These experiences have prepared Filipino communities, intergenerationally and collectively, to respond to experiences of discrimination in ways that preserve their cultural values (David et al., 2017). The preservation of Filipino cultural values across generations has bolstered a type of protective factor through racial socialization, where parents and families teach future generations of children about race and racism (Juang et al., 2017). Ultimately, preparing future generations of Filipinos to respond to racial oppression can protect cultural assets (David et al., 2017). In fact, a study by Woo and colleagues (2020) indicated Filipino parents who prepared their children to respond to racial discrimination prepared them for bias and strengthened their ethnic identity.

One strategy that professional counselors can use to infuse social justice in their work is to help Filipino clients raise their critical consciousness. *Critical consciousness* is an approach that helps clients to recognize the systemic factors contributing to their barriers with mental health utilization and mental health stressors (David et al., 2019; Diemer et al., 2016; Ratts & Greenleaf, 2018; Seider et al., 2020) and to feel empowered to take part in action (Ratts et al., 2016; Watts & Hipolito-Delgado, 2015). Professional counselors can raise Filipino clients' critical consciousness by engaging in conversations about how the history of colonization, endorsement of colonial mentality, and systemic factors continue to marginalize Filipinos (David et al., 2019). Connecting critical consciousness to COVID-19, professional counselors can highlight how public anti-Asian discourse echoes centuries of oppression and leads to cultural mistrust

of health care providers, particularly professional counselors (Litam, 2020; Ratts & Greenleaf, 2018; Tuazon et al., 2019). Similarly, professional counselors can raise the critical consciousness of Filipino clients by discussing the effects of race-based trauma and racial violence as a result of COVID-19 (Litam, 2020; Nadal, 2021). Including these topics during counseling can be instrumental for detecting the effects of race-based trauma, such as somatic symptoms, while grasping the manifestation of pandemic stress (Taylor et al., 2020). As health care providers focus predominantly on wellness, professional counselors play a significant part in deconstructing the connections and nuances among race-based traumatic stress and pandemic stress (Ratts & Greenleaf, 2018).

Additionally, professional counselors can raise the critical consciousness of Filipino clients by examining the intersection of underlying health disparities, Filipino core values, and overrepresentation of Filipinos working in health care positions during COVID-19 through a trauma-informed lens. Aligned with this perspective, professional counselors can identify and discuss how intergenerational trauma narratives may have persisted across generations of Filipino communities (David & Okazaki, 2006b; David et al., 2019; Nadal, 2021; Tuazon et al., 2019) in ways that have adverse effects on mental health. For example, professional counselors may support Filipino clients to critically reflect on how socialized messages from parents and elders with intergenerational trauma may have contributed to the internalization of colonial mentality. Professional counselors may also broach these cultural factors by promoting discussions within clients' families and communities about the cultural preservation of Filipino identities (Choi et al., 2017, 2020; David et al., 2017).

Culturally Congruent Coping Responses Among Filipino Clients

Professional counselors can help Filipino clients who seek counseling during COVID-19 by empowering them to engage in coping responses that cultivate their cultural assets and strengthen their ethnic identity (David et al., 2017, 2019; Woo et al., 2020). Before implementing these culturally sensitive strategies, professional counselors must reflect on whether they hold individualistic notions and Western attitudes about which coping responses are deemed helpful or unhelpful to mitigate the effects of racial discrimination (Oh et al., in press; Sue et al., 2019). Following experiences of racial discrimination and stress, Filipinos tend to use disengagement coping responses (Centeno & Fernandez, 2020; Tuason et al., 2007). Following an assessment of coping responses, professional counselors can support Filipino clients by reinforcing culturally responsive disengagement coping strategies, such as *tiyaga* (Tagalog for "patience and endurance") and *lakas ng loob* (Tagalog for "inner strength and hardiness"), to promote resilience and demonstrate flexibility.

Given these central cultural values, professional counselors must be cautioned from solely using emotion-centered counseling strategies that center experiences of stress, racial trauma, or COVID-19-related discrimination (Litam, 2020). Instead, Filipino clients may benefit from interventions that draw from their cultural values of endurance (*tiyaga*) and inner strength (*lakas ng loob*) to refocus energy toward cultivating meaningful relationships and roles (David & Nadal, 2013; David et al., 2017). For example, Filipino clients who are concerned about the wellness of their community may experience a heightened sense of purpose and inner strength by reflecting on how their actions have already benefitted their families rather than focusing on their fears. Indeed, when stressful experiences occur, Filipinos have a long history of demonstrating resilience. Empowering Filipino clients to reflect on the historical ways that the Filipino community has evidenced resilience and inner strength may cultivate a strong sense of Filipino pride and strengthen ethnic identity as protective factors to mental health distress (Choi et al., 2020; David et al., 2019; Tuazon et al., 2019).

Filipinos may also benefit from engagement coping strategies, such as prayer, employing religious and spiritual resources, and responding with humor, to promote health and wellness (Nadal, 2021; Sanchez & Gaw, 2007). Counselors can help Filipino clients leverage engagement coping strategies by reflecting on existing responses to stress. Counselors may ask, “How have you intentionally responded to stressful events in the past?” and “How did these ways of coping impact your levels of stress?” Counselors can also demonstrate culturally sensitive strategies and lines of questioning that move from general, shared Filipino values to specific client experiences. For example, counselors can state: “Many Filipinos find peace of mind through prayer, religious practices, and humor. I’m wondering if this is true for you?” Because of the community orientation and collectivism embedded within Filipino culture, it may be helpful for counselors to elaborate on cultural contexts and relationships that inform coping strategies: “I am wondering how you may have seen some of these coping strategies in your home, family, or community. How might you have experienced a coping strategy like humor within your own community?” This statement communicates a familiarity with Filipino cultural values and creates an invitation for clients to explore their coping resources.

Creating Outreach Initiatives and Partnerships

For counselors placed in school and community settings, challenging the systemic effects of COVID-19 among Filipino communities necessitates community partnerships and integrated care settings to achieve health equity (Adia et al., 2019). Health equity initiatives call for two types of overarching efforts to sustain long-term benefits and changes. One aspect of health equity relates to developing community partnerships as a method to intentionally increase health literacy within the community (Guo et al., 2018). Increasing mental health literacy, including education about counseling services and a comprehensive approach to wellness, operates as a direct intervention to cultural and linguistic barriers that precede negative health care experiences (Flynn et al., 2020). Increasing mental health literacy in Filipino communities may also normalize the process of professional mental health services, challenge the cultural notion that those who seek mental health care are *crazy*, and offer strength-based language related to counseling services (Ghimire et al., 2018; Maxwell et al., 2012; Nadal, 2021). Expanding on recommendations by Tuazon and colleagues (2019), professional counselors can challenge the systemic effects of COVID-19 in Filipino communities by helping community stakeholders understand culturally responsive practices for seeking professional mental health services. Professional counselors employed in community settings can leverage opportunities to liaise with Filipino community organizations and leaders to increase the utilization of counseling services as a preventive method (Graham et al., 2018; Maxwell et al., 2012), especially in response to the increased mental health issues in Filipinos following COVID-19. Professional counselors employed in community settings are therefore uniquely positioned to broach cultural factors of colonialism and systemic racism while addressing the urgency of mental health services for Filipino communities during COVID-19 (Day-Vines et al., 2018, 2020).

Increasing Visibility of Filipino Counselors

The second aspect of health equity initiatives focuses on increasing representation in the pipeline of providers. Although Flynn and colleagues (2020) documented the importance of culturally responsive practices to buffer negative health care experiences, public health scholars have generally identified that the representation of professional counselors is crucial for encouraging historically marginalized communities to seek services (Campbell, 2019; Graham et al., 2018; Griffith, 2018). According to Campbell (2019), historically marginalized clients are more likely to pursue services and demonstrate an openness to speak with professional counselors who are representative of their communities. In addition to increasing Filipino counselors and counselor educators in the pipeline (Tuazon et al., 2019), professional counselors can enact community-based initiatives that position Filipino leaders

to support the larger Filipino community (Guo et al., 2018; Maxwell et al., 2012; Nadal, 2021). For example, professional counselors can train Filipino leaders and community members to share information about coping responses (e.g., mindfulness, yoga, and diaphragmatic breathing) that mitigate the deleterious effects of racism, colonialism, and COVID-19–related stress. Professional counselors can also work with community members to establish Filipino-led wellness groups that frame discussions about stress within the broader context of health and wellness. Assessing for previous assumptions about mental health literacy may be helpful to normalize group discussions about stress and mental health. As outreach initiatives and community partnerships are established within the context of COVID-19, professional counselors must consider how they develop marketing materials for counseling services that appropriately reflect the cultural and linguistic diversity of Filipinos and invite input from Filipino community leaders (Campbell, 2019; Graham et al., 2018).

Conclusion

The cumulative effects of colonialism and racism continue to influence the mental health and visibility of Filipino communities within the global crisis of COVID-19. Unlike other AAPI subgroups, experiences of pandemic-related distress in Filipinos are additionally compounded by their distinct history of colonization, cultural values, and low levels of help-seeking behaviors. Specific interventions for culturally responsive counseling and outreach for Filipino communities are critical (Choi et al., 2017; David & Nadal, 2013; David et al., 2017; Tuazon et al., 2019) and were outlined in this article. Professional counselors, especially those in community settings, have numerous opportunities to enact a systematic plan of action that integrates culture, health, and policy (Chan & Henesy, 2018; Nadal, 2021). These interventions illuminate a longstanding and never more urgent call to action for extending efforts and initiatives to increase the visibility of Filipino communities and support individuals of Filipino descent in counseling.

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References

- Abe-Kim, J., Gong, F., & Takeuchi, D. (2004). Religiosity, spirituality, and help-seeking among Filipino Americans: Religious clergy or mental health professionals? *Journal of Community Psychology*, 32(6), 675–689. <https://doi.org/10.1002/jcop.20026>
- Abe-Kim, J., Takeuchi, D. T., & Hwang, W.-C. (2002). Predictors of help seeking for emotional distress among Chinese Americans: Family matters. *Journal of Consulting and Clinical Psychology*, 70(5), 1186–1190. <https://doi.org/10.1037/0022-006X.70.5.1186>
- Adia, A. C., Nazareno, J., Operario, D., & Ponce, N. A. (2020). Health conditions, outcomes, and service access among Filipino, Vietnamese, Chinese, Japanese, and Korean adults in California, 2011–2017. *American Journal of Public Health*, 110(4), 520–526. <https://doi.org/10.2105/AJPH.2019.305523>
- Adia, A. C., Ng, M. J., Quilantang, M. I., Restar, A. J., Hernandez, L. I., Imperial, R. H., Nazareno, J., & Operario, D. (2019). Collective coping strategies for HIV-related challenges among men who have sex with men in Manila, Philippines. *AIDS Education and Prevention*, 31(5), 479–490. <https://doi.org/10.1521/aeap.2019.31.5.479>

- Afable, A., Ursua, R., Wyatt, L. C., Aguilar, D., Kwon, S. C., Islam, N. S., & Trinh-Shevrin, C. (2016). Duration of US residence is associated with overweight risk in Filipino immigrants living in New York metro area. *Family and Community Health*, 39(1), 13–23. <https://doi.org/10.1097/FCH.0000000000000086>
- Angan, J. (2013). *Beyond the beach: The untold story of Boracay's Ati tribe*. GMA News Online. <https://www.gmanet.com/news/lifestyle/artandculture/313920/beyond-the-beach-the-untold-story-of-boracay-s-ati-tribe/story>
- Appel, H. B., Huang, B., Ai, A. L., & Lin, C. J. (2011). Physical, behavioral, and mental health issues in Asian American women: Results from the National Latino Asian American Study. *Journal of Women's Health*, 20(11), 1703–1711. <https://doi.org/10.1089/jwh.2010.2726>
- Araneta, E. G. (1993). Psychiatric care of Filipino Americans. In A. C. Gaw (Ed.), *Culture, Ethnicity, and Mental Illness* (pp. 377–411). American Psychiatric Association.
- Asian Journal Press. (2018). *New census data shows more than four million Filipinos in the US*. <https://www.asianjournal.com/usa/deline-usa/new-census-data-shows-more-than-four-million-filipinos-in-the-us>
- Augsberger, A., Yeung, A., Dougher, M., & Hahn, H. C. (2015). Factors influencing the underutilization of mental health services among Asian American women with a history of depression and suicide. *BMC Health Services Research*, 15(1), 1–11. <https://doi.org/10.1186/s12913-015-1191-7>
- Batalova, J. (2020). *Immigrant health-care workers in the United States*. Migration Policy Institute. <https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states-2018>
- Bautista, V. (1999). *The Filipino Americans: From 1763 to the present: Their history, culture, and traditions*. Bookhaus.
- Bhimla, A., Yap, L., Lee, M., Seals, B., Aczon, H., & Ma, G. X. (2017). Addressing the health needs of high-risk Filipino Americans in the greater Philadelphia region. *Journal of Community Health*, 42(2), 269–277. <https://doi.org/10.1007/s10900-016-0252-0>
- Budiman, A., Cilluffo, A., & Ruiz, N. G. (2019). *Key facts about Asian origin groups in the U.S*. Pew Research Center. <https://www.pewresearch.org/fact-tank/2019/05/22/key-facts-about-asian-origin-groups-in-the-u-s>
- Campbell, K. M. (2019). Race, gender, and health equity. *Journal of Best Practices in Health Professions Diversity*, 11(2), 155–157.
- Centeno, R. P. R., & Fernandez, K. T. G. (2020). Effect of mindfulness on empathy and self-compassion: An adapted MBCT program on Filipino college students. *Behavioral Sciences*, 10(3), 1–15. <https://doi.org/10.3390/bs10030061>
- Centers for Disease Control and Prevention. (2021). *People with certain medical conditions*. Retrieved March 14, 2021, from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fgroups-at-higher-risk.html
- Chan, C. D., & Henesy, R. K. (2018). Navigating intersectional approaches, methods, and interdisciplinarity to health equity in LGBTQ+ communities. *Journal of LGBT Issues in Counseling*, 12(4), 230–247. <https://doi.org/10.1080/15538605.2018.1526157>
- Chan, C. D., Henesy, R. K., & Erby, A. N. (2019). Toward praxis, promise, and futures of intersectionality in multimethod counseling research. *Counseling Outcome Research and Evaluation*, 10(1), 12–18. <https://doi.org/10.1080/21501378.2018.1562845>
- Choi, Y., Park, M., Lee, J. P., Kim, T. Y., & Tan, K. (2017). Culture and family process: Examination of culture-specific family process via development of new parenting measures among Filipino and Korean American families with adolescents. In Y. Choi & H. C. Hahm (Eds.), *Asian American parenting: Family process and intervention* (pp. 37–68). Springer. https://doi.org/10.1007/978-3-319-63136-3_3
- Choi, Y., Park, M., Noh, S., Lee, J. P., & Takeuchi, D. (2020). Asian American mental health: Longitudinal trend and explanatory factors among young Filipino- and Korean Americans. *SSM - Population Health*, 10, 1–10. <https://doi.org/10.1016/j.ssmph.2020.100542>
- Choy, C. C. (2003). *Empire of care: Nursing and migration in Filipino American history*. Duke University Press.
- David, E. J. R. (2020). Addressing anti-Black microaggressions in Filipino families. *Psychology Today*. <https://www.psychologytoday.com/us/blog/unseen-and-unheard/202006/addressing-anti-black-microaggressions-in-filipino-families-0>
- David, E. J. R., & Nadal, K. L. (2013). The colonial context of Filipino American immigrants' psychological experiences. *Cultural Diversity and Ethnic Minority Psychology*, 19(3), 298–309. <https://doi.org/10.1037/a0032903>

- David, E. J. R., & Okazaki, S. (2006a). Colonial mentality: A review and recommendation for Filipino American psychology. *Cultural Diversity and Ethnic Minority Psychology, 12*(1), 1–16. <https://doi.org/10.1037/1099-9809.12.1.1>
- David, E. J. R., & Okazaki, S. (2006b). The Colonial Mentality Scale (CMS) for Filipino Americans: Scale construction and psychological implications. *Journal of Counseling Psychology, 53*(2), 241–252. <https://doi.org/10.1037/0022-0167.53.2.241>
- David, E. J. R., Sharma, D. K. B., & Petalio, J. (2017). Losing kapwa: Colonial legacies and the Filipino American family. *Asian American Journal of Psychology, 8*(1), 43–55. <https://doi.org/10.1037/aap0000068>
- David, E. J. R., Schroeder, T. M., & Fernandez, J. (2019). Internalized racism: A systematic review of the psychological literature on racism's most insidious consequence. *Journal of Social Issues, 75*(4), 1057–1086. <https://doi.org/10.1111/josi.12350>
- Day-Vines, N. L., Booker Ammah, B., Steen, S., & Arnold, K. M. (2018). Getting comfortable with discomfort: Preparing counselor trainees to broach racial, ethnic, and cultural factors with clients during counseling. *International Journal for the Advancement of Counselling, 40*(2), 89–104. <https://doi.org/10.1007/s10447-017-9308-9>
- Day-Vines, N. L., Cluxton-Keller, F., Agorsor, C., Gubara, S., & Otobil, N. A. A. (2020). The multidimensional model of broaching behavior. *Journal of Counseling & Development, 98*(1), 107–118. <https://doi.org/10.1002/jcad.12304>
- de Torres, S. (2002). *Understanding persons of Philippine origin: A primer for rehabilitation service providers*. Center for Institutional Rehabilitation Research Information and Exchange. <http://cirrie-sphhp.webapps.buffalo.edu/culture/monographs/philippines.php>
- Diemer, M. A., Rapa, L. J., Voight, A. M., & McWhirter, E. H. (2016). Critical consciousness: A developmental approach to addressing marginalization and oppression. *Child Development Perspectives, 10*(4), 216–221. <https://doi.org/10.1111/cdep.12193>
- Edman, J. L., & Johnson, R. C. (1999). Filipino American and Caucasian American beliefs about the causes and treatment of mental problems. *Cultural Diversity and Ethnic Minority Psychology, 5*(4), 380–386. <https://doi.org/10.1037/1099-9809.5.4.380>
- Enriquez, V. G. (2010). *From colonial to liberation psychology: The Philippine experience* (2nd ed.). University of the Philippines Press.
- Espiritu, Y. L. (2016). Gender, migration, and work: Filipina health care professionals to the United States. In M. Zhou & A. C. Ocampo (Eds.), *Contemporary Asian America: A multidisciplinary reader* (3rd ed., pp. 236–256). New York University Press.
- Flynn, P. M., Betancourt, H., Emerson, N. D., Nunez, E. I., & Nance, C. M. (2020). Health professional cultural competence reduces the psychological and behavioral impact of negative healthcare encounters. *Cultural Diversity and Ethnic Minority Psychology, 26*(3), 271–279. <https://doi.org/10.1037/cdp0000295>
- Ghimire, S., Cheong, P., Sagadraca, L., Chien, L.-C., & Sy, F. S. (2018). A health needs assessment of the Filipino American community in the greater Las Vegas area. *Health Equity, 2*(1), 334–348. <https://doi.org/10.1089/heq.2018.0042>
- Gong, F., Gage, S.-J. L., & Tacata, L. A., Jr. (2003). Helpseeking behavior among Filipino Americans: A cultural analysis of face and language. *Journal of Community Psychology, 31*(5), 469–488. <https://doi.org/10.1002/jcop.10063>
- Graham, L. F., Scott, L., Lopeyok, E., Douglas, H., Gubrium, A., & Buchanan, D. (2018). Outreach strategies to recruit low-income African American men to participate in health promotion programs and research: Lessons from the Men of Color Health Awareness (MOCHA) project. *American Journal of Men's Health, 12*(5), 1307–1316. <https://doi.org/10.1177/1557988318768602>
- Griffith, D. M. (2018). "Centering the margins": Moving equity to the center of men's health research. *American Journal of Men's Health, 12*(5), 1317–1327. <https://doi.org/10.1177/1557988318773973>
- Guo, M., Quensell, M., Chang, A., Miyamura, J., & Sentell, T. (2018). Understanding of key obstetric quality terminology by Asian and Pacific Islander subgroups: Implications for patient engagement and health equity. *Maternal and Child Health Journal, 22*(11), 1543–1549. <https://doi.org/10.1007/s10995-018-2597-8>
- Javier, J. R., Supan, J., Lansang, A., Beyer, W., Kubicek, K., & Palinkas, L. A. (2014). Preventing Filipino mental health disparities: Perspectives from adolescents, caregivers, providers, and advocates. *Asian American Journal of Psychology, 5*(4), 316–324. <https://doi.org/10.1037/a0036479>

- Jeung, R., & Nham, K. (2020). *Incidents of Coronavirus-related discrimination*. Asian Pacific Policy & Planning Council. http://www.asianpacificpolicyandplanningcouncil.org/wp-content/uploads/STOP_AAPIOHATE_MONTHLY_REPORT_4_23_20.pdf
- Jones-Smith, E. (2019). *Culturally diverse counseling: Theory and practice*. SAGE.
- Juang, L. P., Yoo, H. C., & Atkin, A. (2017). A critical race perspective on an empirical review of Asian American parental racial-ethnic socialization. In Y. Choi & H. C. Hahm (Eds.), *Asian American parenting: Family process and intervention* (pp. 11–35). Springer. https://doi.org/10.1007/978-3-319-63136-3_2
- Kim, G., Chiriboga, D. A., Bryant, A., Huang, C.-H., Crowther, M., & Ma, G. X. (2012). Self-rated mental health among Asian American adults: Association with psychiatric disorders. *Asian American Journal of Psychology*, 3(1), 44–52. <https://doi.org/10.1037/a0024318BB>
- Klest, B., Freyd, J. J., Hampson, S. E., & Dubanoski, J. P. (2013). Trauma, socioeconomic resources, and self-rated health in an ethnically diverse adult cohort. *Ethnicity & Health*, 18(1), 97–113. <https://doi.org/10.1080/13557858.2012.700916>
- Li, M. (2014). Discrimination and psychiatric disorder among Asian American immigrants: A national analysis by subgroups. *Journal of Immigrant and Minority Health*, 16, 1157–1166. <https://doi.org/10.1007/s10903-013-9920-7>
- Litam, S. D. A. (2020). “Take your Kung-Flu back to Wuhan”: Counseling Asians, Asian Americans, and Pacific Islanders with race-based trauma related to COVID-19. *The Professional Counselor*, 10(2), 144–156. <https://doi.org/10.15241/sdal.10.2.144>
- Litam, S. D. A., & Hipolito-Delgado, C. P. (2021). When being “essential” illuminates disparities: Counseling clients affected by COVID-19. *Journal of Counseling & Development*, 99(1), 3–10. <https://doi.org/10.1002/jcad.12349>
- Litam, S. D. A., & Oh, S. (2020). Ethnic identity and coping strategies as moderators of COVID-19 racial discrimination experiences among Chinese Americans. *Counseling Outcome Research and Evaluation*. Online publication. <https://doi.org/10.1080/21501378.2020.1814138>
- Martinez, A. B., Co, M., Lau, J., & Brown, J. S. L. (2020). Filipino help-seeking for mental health problems and associated barriers and facilitators: A systematic review. *Social Psychiatry and Psychiatric Epidemiology*, 55, 1397–1413. <https://doi.org/10.1007/s00127-020-01937-2>
- Maxwell, A. E., Danao, L. L., Cayetano, R. T., Crespi, C. M., & Bastani, R. (2012). Evaluating the training of Filipino American community health advisors to disseminate colorectal cancer screening. *Journal of Community Health*, 37(6), 1218–1225. <https://doi.org/10.1007/s10900-012-9557-9>
- McFarling, U. L. (2020). Nursing ranks are filled with Filipino Americans. *The pandemic is taking an outsized toll on them*. Stat. <https://www.statnews.com/2020/04/28/coronavirus-taking-outsized-toll-on-filipino-american-nurses>
- Mendoza, R. L. (2014). The skin whitening industry in the Philippines. *Journal of Public Health Policy*, 35(2), 219–238. <https://doi.org/10.1057/jphp.2013.50>
- Nadal, K. L. (2000). F/Filipino American substance abuse: Sociocultural factors and methods of treatment. *Journal of Alcohol and Drug Education*, 46(2), 26–36.
- Nadal, K. L. (2021). *Filipino American psychology: A handbook of theory, research, and clinical practice* (2nd ed.). Wiley. <https://doi.org/10.1002/9781119677109>
- Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: Counseling implications for clients of color. *Journal of Counseling & Development*, 92(1), 57–66. <https://doi.org/10.1002/j.1556-6676.2014.00130.x>
- National Nurses United. (2020). *Sins of omission: How government failures to track COVID-19 data have led to more than 1,700 health care worker deaths and jeopardize public health*. https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/0920_Covid19_SinsOfOmission_Data_Report.pdf
- Ocampo, A. C. (2016). *The Latinos of Asia: How Filipino Americans break the rules of race*. Stanford University Press.
- Oh, S., Litam, S. D. A., & Chang, C. (in press). COVID-19 fueled subtle and blatant racism and stress-related growth among international Asians in the United States: The roles of ethnic identity, resiliency, and coping. *Asian American Journal of Psychology*.
- Pacquiao, D. (2004). Overcoming stigma and mental illness among Filipinos. Presentation at the National Conference of the New York Coalition for Asian Mental Health. New York Academic of Medicine, New York.

- Pasco, A. C. Y., Morse, J. M., & Olson, J. K. (2004). Cross-cultural relationships between nurses and Filipino Canadian patients. *Journal of Nursing Scholarship*, 36(3), 239–246. <https://doi.org/10.1111/j.1547-5069.2004.04044.x>
- Pew Research Center. (2013). *The rise of Asian Americans*. <https://www.pewsocialtrends.org/2012/06/19/the-rise-of-asian-americans>
- Poon, L. (2020, April 7). *What bigotry looks like during social distancing*. Citylab. <https://www.citylab.com/equity/2020/04/coronavirus-racism-hate-crimes-asian-americans-xenophobia/609517>
- Ratts, M. J., & Greenleaf, A. T. (2018). Counselor–advocate–scholar model: Changing the dominant discourse in counseling. *Journal of Multicultural Counseling and Development*, 46(2), 78–96. <https://doi.org/10.1002/jmcd.12094>
- Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, 44(1), 28–48. <https://doi.org/10.1002/jmcd.12035>
- Ruiz, N. G., Horowitz, J. M., & Tamir, C. (2020). *Many Black and Asian Americans say they have experienced discrimination amid the COVID-19 outbreak*. Pew Research Center. <https://www.pewsocialtrends.org/2020/07/01/many-black-and-asian-americans-say-they-have-experienced-discrimination-amid-the-covid-19-outbreak>
- Sanchez, F., & Gaw, A. (2007). Mental health care of Filipino Americans. *Psychiatric Services*, 58(6), 810–815. <https://doi.org/10.1176/ps.2007.58.6.810>
- Seider, S., Clark, S., & Graves, D. (2020). The development of critical consciousness and its relation to academic achievement in adolescents of color. *Child Development*, 91(2), e451–e474. <https://doi.org/10.1111/cdev.13262>
- Shea, M., & Yeh, C. (2008). Asian American students' cultural values, stigma, and relational self-construal: Correlates of attitudes toward professional help-seeking. *Journal of Mental Health Counseling*, 30(2), 157–172. <https://doi.org/10.17744/mehc.30.2.g662g5l2r1352198>
- Smith, M. J., & Weinstock, D. (2019). Reducing health inequities through intersectoral action: Balancing equity in health with equity for other social goods. *International Journal of Health Policy and Management*, 8(1), 1–3. <https://doi.org/10.15171/IJHPM.2018.103>
- Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counseling the culturally diverse: Theory and practice* (8th ed.). Wiley.
- Taylor, S., Landry, C. A., Paluszek, M. M., Fergus, T. A., McKay, D., & Asmundson, G. J. G. (2020). Development and initial validation of the COVID Stress Scales. *Journal of Anxiety Disorders*, 72(2020), 1–7. <https://doi.org/10.1016/j.janxdis.2020.102232>
- Tuason, M. T. G., Taylor, A. R., Rollings, L., Harris, T., & Martin, C. (2007). On both sides of the hyphen: Exploring the Filipino-American identity. *Journal of Counseling Psychology*, 54(4), 362–372. <https://doi.org/10.1037/0022-0167.54.4.362>
- Tuazon, V. E., Gonzalez, E., Gutierrez, D., & Nelson, L. (2019). Colonial mentality and mental health help-seeking of Filipino Americans. *Journal of Counseling & Development*, 97(4), 352–363. <https://doi.org/10.1002/jcad.12284>
- U.S. Department of Justice. (2020). *Coronavirus is no excuse for hate: Remembering Vincent Chin*. Department of Justice, U.S. Attorneys' Office, District of Idaho. <https://www.justice.gov/usao-id/pr/coronavirus-no-excuse-hate>
- Watts, R. J., & Hipolito-Delgado, C. P. (2015). Thinking ourselves to liberation? Advancing sociopolitical action in critical consciousness. *The Urban Review*, 47(5), 847–867. <https://doi.org/10.1007/s11256-015-0341-x>
- Woo, B., Maglalang, D. D., Ko, S., Park, M., Choi, Y., & Takeuchi, D. T. (2020). Racial discrimination, ethnic-racial socialization, and cultural identities among Asian American youths. *Cultural Diversity & Ethnic Minority Psychology*, 26(4), 447–459. <https://doi.org/10.1037/cdp0000327>
- Worldometer. (n.d.). *Covid-19 coronavirus pandemic*. <https://www.worldometers.info/coronavirus/#countries>

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Researchers have frequently described rural women as invisible, yet at 28 million, they represent over half of the rural population in the United States. We conducted a transcendental phenomenological study using semi-structured interviews and artifacts to explore 12 Midwestern rural-based mental health counselors' experiences counseling rural women through a feminist lens. Overall, we found eight themes organized under two main categories: (a) *perceptions of work with rural women* (e.g., counselors' sense of purpose, a rural heritage, a lack of training for work with rural women, and the need for additional research); and (b) *perceptions of rural women and mental health* (e.g., challenges, resiliency, protective factors, and barriers to mental health services for rural women). We offer specific implications for counselors to address the unique mental health needs of rural women, including hearing their stories through their personal lenses and offering them opportunities for empowerment at their own pace.

Keywords: rural women, mental health counselors, feminist, perceptions, phenomenological

More than 28 million women, ages 18 and older, live in rural America and represent over half of the rural population in the United States (Bennett et al., 2013; U.S. Census Bureau, 2010). Researchers have discussed women's issues as a distinct category within counseling for over 50 years, yet few counseling programs offer training specific to counseling women (American Psychological Association [APA], 2018; Broverman et al., 1970; Enns, 2017). Rural women have garnered even less attention within counseling literature and training over time (Bennett et al., 2013; Fifield & Oliver, 2016). In addition, rural mental health researchers have focused on rural populations in general, encapsulating women under the entire family unit (U.S. Department of Agriculture, 2015). However, in all environments, women experience mental health needs in unique ways (Mulder & Lambert, 2006; Wong, 2017). Although government agencies have increased efforts to alleviate mental health disparities in rural areas, there is limited research available on rural women's mental health to guide these efforts (Carlton & Simmons, 2011; Hill et al., 2016). Thus, more studies focused on rural women can assist in comprehensive data-based decision-making efforts of federal, state, and local policymakers (Van Montfoort & Glasser, 2020). Mental health counselors who work with rural women have a unique perspective in understanding the needs of rural women and the disparities they face.

The Invisibility of Rural Women's Mental Health

Researchers have described rural women as invisible within the mental health literature. Specifically, they have used words such as "unnoticed," "lack of recognition," "overlooked," and "no voice and no choice," which may illuminate why rural women have less access to appropriate mental health services and may underlie the noticeable absence of rural women as participants within research (Mulder & Lambert, 2006; Weeks et al., 2016). Members of rural communities have traditionally seen women as an extension of their nuclear and extended families and as responsible for involvement in community and

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church activities (Mulder & Lambert, 2006). Rural women, as a population with unique mental health needs, may need help (i.e., representation in research) getting their voices heard on a more macro level to promote systemic changes (Van Montfoort & Glasser, 2020). A research approach based in feminist theory may amplify the voices of rural women (Schwarz, 2017).

Feminism is a theoretical approach that evolved following the women's movement in the 1960s, and grew to effect change in social, political, and cultural beliefs about women's roles (Evans et al., 2005). Many of the early feminist writers spoke of women as "oppressed" and "having no voice" (Evans et al., 2005). Those words have been similarly found throughout the literature on rural women (Weeks et al., 2016). Feminist theory has traditionally challenged the status quo of the patriarchy by working to reduce the invisibility of women's experiences (Evans et al., 2005; Schwarz, 2017). Further, feminist theory has evolved to amplify voices of all oppressed and marginalized individuals and to promote recognition of the intersectionality of identity. The feminist perspective can facilitate insight into the context of rural women's experiences (Wong, 2017).

Challenges Faced by Rural Women

The definition of rural areas has historically been based on population size (U.S. Census Bureau, 2010). Some consider *rurality* a more accurate term than rural, as it may include population density, economic concerns, travel distances to providers, religion, agricultural heritage, behavioral norms, a shared history, and geographical location (Smalley & Warren, 2014). Rural women face unique needs related to the intersection of gender with race, ethnicity, age, and sexual orientation (Barefoot et al., 2015). Rural women have less access to educational opportunities, are often the head of household, and are more likely to live in poverty than urban women (Watson, 2019). Lesbian and bisexual rural women face challenges of bias, lack of support, and increased victimization (Barefoot et al., 2015). Although urban women also experience mental health issues related to motherhood, rural women often must travel long distances to services and have limited access to postpartum care (Radunovich et al., 2017). Residents in many rural communities experience food insecurity and related disordered eating with less proximity to grocery stores and limited food choices (Doudna et al., 2015). Isolation also creates a greater risk for partner abuse that is complicated by long distances to shelters, lack of anonymity, and a widely held view of traditional gender roles (Weeks et al., 2016). The lack of research regarding rural women and mental health compromises the efforts of rural counselors to provide care that is culturally responsive and efficacious (Imig, 2014). In addition, the recognized barriers of accessibility, availability, and acceptability of mental health services in rural areas disproportionately affect rural women (Radunovich et al., 2017).

Barriers to Mental Health Services

A lack of professionals, limited training for work in rural areas, high rates of turnover of mental health professionals, and limited research about rural demographics can negatively impact the quality of services (Smalley & Warren, 2014). In addition, rural residents may experience barriers such as long distances to services, adverse weather conditions, affordability of services, and a lack of insurance coverage (Smalley & Warren, 2014). Rural women may also feel reluctant to seek out mental health services for fear of loss of anonymity and the stigma attached to seeking mental health services in rural areas (Snell-Rood et al., 2019). Approximately 40% of rural residents with mental health issues opt to seek treatment from primary care physicians (PCPs), as these professionals may represent the only health care provider in the area (Snell-Rood et al., 2017). However, these professionals often have limited expertise in diagnosing and treating mental health issues (Hill et al., 2016).

Currently, the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015) does not specify rurality or other cultural identities when referencing cultural competence within required curriculum. This omission may contribute to minimal specialized training, in addition to the limited research for mental health counselors to use as a guide for understanding the unique needs of rural women (Watson, 2019). Additionally, agencies have difficulty recruiting mental health counselors because of isolation from colleagues and supervisors, lower salaries, limited social and cultural opportunities, and few training opportunities specific to rural mental health (Fifield & Oliver, 2016).

Addressing Mental Health Needs of Rural Women

Given the limited research about rural women and their unique mental health needs, rural counselors are left with few evidence-based practices to utilize when working with this population (Imig, 2014). Historically, counseling researchers have equated “mentally healthy adults” with “mentally healthy adult males,” resulting in literature that is focused on best practices more appropriate for men (Broverman et al., 1970), and potentially upholding sex-role stereotypes within the fields of psychology, social work, medicine, and mental health counseling (APA, 2018; Schwarz, 2017). More recent researchers have demonstrated the efficacy of gender-specific counseling approaches (Enns, 2017). However, the approaches often do not consider the additional barriers to services that rural women may face, such as long distances to services, limited availability of mental health professionals, and the stigma of seeking services in a rural area (Hill et al., 2016).

In this transcendental phenomenological study, we sought to explore the lived experiences of licensed professional counselors (LPCs) who work with rural women in terms of their perceptions of rural Midwestern women’s mental health, and the academic training they received to prepare them for working with rural women. The study sought to answer the following research questions: (a) What are the lived experiences of LPCs who work with rural women?; (b) What are the challenges and benefits of working with rural women?; (c) How are mental health services perceived by those working with rural women?; and (d) What training, if any, did the participants receive that was specific to work with rural women?

Method

Qualitative research, by its very nature, validates individuals who may be disempowered (Morrow, 2007; Ponterotto, 2010). Phenomenology is a qualitative method that helps researchers describe the common meaning of participants’ lived experiences specific to a particular phenomenon (Creswell & Poth, 2018). In this study, the phenomenon was the lived experiences of LPCs who worked with rural women. Transcendental phenomenology (Moustakas, 1994) provided a framework for the study that began with *epoché*, a process of bracketing the researchers’ experiences and biases, and the collection of participant stories (Creswell & Poth, 2018). For this study, postpositivist elements of transcendental phenomenology (e.g., bracketing and data analysis) were utilized to reduce researcher biases (Moustakas, 1994). Specifically, we viewed bracketing as essential because participants might not share the feminist viewpoint of the researchers. The infusion of feminism into the study came from a constructivist/interpretivist standpoint as I (i.e., first author and lead researcher) believed—based on literature—the stories of rural women were not being heard and, thus, designed the study to help illuminate the experiences, mental health needs, and resiliency of rural women (Morrow, 2007).

Participants

For this study, participants were recruited using criterion and snowball sampling. Criterion sampling involved selecting individuals on the basis of their shared experiences and their abilities to articulate

those experiences (Heppner et al., 2016). Snowball sampling allowed for selecting participants who previously had a demonstrated interest in this area of research based on their connection to other participants. Criteria for participation included a degree from a CACREP-accredited counseling program, licensure within their jurisdiction, current practice, and clinical work that included rural women. To recruit participants, we collected names and emails from a Midwestern state counseling association; however, this method produced only two responses. So, we utilized snowball sampling by asking participants to refer us to others who met our eligibility criteria (Creswell & Poth, 2018). We determined the number of LPCs needed to describe the phenomena by achieving saturation of the data collected (Heppner et al., 2016). This saturation was reflected by eventual redundancy in participant responses.

Following approval from the appropriate IRB, an invitation to participate was emailed to potential participants and included a link to a demographic form and informed consent for those who met the criteria and wished to participate. Rural areas were defined as those geographic areas containing counties with populations of less than 50,000, a definition that did not include population density but was appropriate for the Midwestern areas included in the study (Smalley & Warren, 2014). Twelve mental health counselors met the eligibility criteria for participation and enrolled in the study.

All participants had graduated from a CACREP-accredited counseling program, were licensed to practice within their jurisdiction, were currently practicing privately or in an agency, and had a clinical caseload that included rural women. The designation of LPC was used throughout the study and included all levels of licensure within the various jurisdictions. All of the LPCs reported working with a wide variety of mental health issues; three of the LPCs had addiction counseling credentials. Eleven participants self-identified as female and one self-identified as non-binary. Eleven participants self-identified as Caucasian, and one self-identified as Native American. Years of experience working as a mental health professional ranged from 4 years to 27 years, with an average of approximately 12 years. All participants reported working with both urban and rural clients, and one participant listed a reservation as the primary location for her work. LPCs' clients included adult rural women from the upper Midwest. The rural women were single or married with children, working or unemployed, Caucasian or Native American. In addition, all the participants expressed a connection to rural areas, either through personal experience of growing up in a rural area or through connections with extended family. Each participant chose a pseudonym that is referred to throughout the manuscript.

Data Collection

We collected data through individual semi-structured interviews and participant artifacts. The semi-structured interview format allowed for more collaboration and interaction between interviewer and interviewee (Creswell & Poth, 2018). In this way, the interview format aligned with a feminist research approach and helped eliminate a power differential between researcher and participant (Heppner et al., 2016). There were 12 interview questions aimed at exploring participants' work with rural women, participants' perceptions of the unique mental health needs of rural women, the influence of participants' rural heritage on their work with rural women, challenges and benefits of participants' work with rural women, and participants' training specific to work with rural women (see Appendix for all 12 interview questions). As lead researcher, I conducted all 12 interviews in order to maximize consistency in employing the interview protocol while allowing participants to elaborate on responses. Interviews ranged from 30–45 minutes. All research documents, such as informed consents, demographic questionnaires, and transcriptions, were securely stored on a password-protected device.

Participants were invited to share artifacts that represented their work with rural women. Artifacts could include personal letters, poems, artwork, and photos (Heppner et al., 2016). The artifacts in

this study provided an opportunity for broader expression of the counselors' experiences as well as understanding their connection to rural life. Seven artifacts were pictures of objects or individuals that inspired participants' work with rural women, two were stories about experiences of rural women, and one was an original poem entitled "Rural Woman."

Data Analysis

Brown and Gilligan's (1992) research of young women and relationships utilized a Listener's Guide for analyzing data. This guide is feminist and relational and allows researchers to pay attention to unheard voices. The Listening Guide is considered a psychological method that reflects the "social and cultural frameworks that affect what can and cannot be spoken or heard" (Gilligan & Eddy, 2017, p. 76). The method included three successive "listens" — one for plot, one for "I" statements, and one for the individual in relationship to others (Brown & Gilligan, 1992). Throughout the listening process, I looked for and highlighted significant statements the participants made during the interview process that reflected the experiences of the phenomenon. I organized information via a phenomenological template under the heading "Essence of the Phenomenon" and included personal bracketing (*epoché*), significant statements, meaning units, and textural and structural descriptions (Creswell & Poth, 2018). Although a transcription service was utilized to transcribe the interviews, I read through the transcripts several times and coded data into categories or themes, which emerged organically from the transcripts. An independent peer reviewer then examined the transcriptions and helped to develop the codes and themes. We developed clusters of meaning from the significant statements into themes, followed by a textural and structural description that encompassed the significant statements and related themes. The rich and thick descriptions became the essence of the phenomenon enhanced by continual review of the interview tapes, journal notes, artifacts, and other data collected (Morrow, 2005).

Epoché

The *epoché* section was written from my perspective as the primary researcher and first author. I was responsible for designing the study, collecting and analyzing data, and writing the manuscript. My co-authors served as consultants in designing the study and helped to write and edit the manuscript. As the primary researcher, I sought to see the lived experiences of participants from a perspective that was free from my assumptions (Creswell & Poth, 2018). I grew up in a Midwestern rural area, steeped in traditional gender roles, while witnessing significant change for all women in expectations and opportunities. During the process of the study, it became apparent that my perceptions of rural women as stay-at-home farmwives have changed to reflect a population more diverse in ethnicity, family structure, and socioeconomic status; however, the traditional patriarchal expectations have not changed. My work as a mental health professional shaped my desire to explore the perceptions of other LPCs' experiences of their work with rural women. Prior to the data analysis, I bracketed my personal and professional rural experiences about power differentials within rural areas.

Trustworthiness

To promote trustworthiness, I utilized self-reflective journaling, member checks, the achievement of data saturation, independent peer review, and an external audit. I kept a journal and made notes throughout the data collection process to facilitate an awareness of biases and/or assumptions that emerged during the process (Heppner et al., 2016; Morrow, 2005). I also conducted member checks, asking all participants to review and provide feedback via email on descriptions or themes (Creswell & Poth, 2018; Morrow, 2005). Frequently, participants would elaborate on themes by adding clarification to their responses to the interview questions. The "prolonged interaction" (Ponterotto, 2010, p. 583) with participants was significant for developing an egalitarian and unbiased relationship between researcher and participant. This strategy was congruent with feminist theory because it acknowledged

the subjectivity of the researcher within the study and facilitated a collaborative relationship between researcher and participant (Morrow, 2007).

Coding the data into categories or themes helped arrange the large amount of data that was collected. The process was made easier by taking notes, or “memoing,” when reading through the information. The peer reviewer evaluated potential researcher bias by checking the coding against all transcripts, serving as a “mirror” that reflected my responses to the research process (Morrow, 2005, p. 254). Next, we discussed possible themes that emerged from the data (Heppner et al., 2016). I also utilized an external auditor to aid in establishing confirmability of the results rather than objectivity (Morrow, 2005). The auditor examined the entire process and determined whether the data supported my interpretations (Creswell & Poth, 2018). Both individuals had participated in phenomenological research and were not authors of this article.

Results

Analysis of the interview transcripts, the artifacts, and the journal reflections resulted in eight themes, organized into two categories. I further categorized each theme as: 1) textural, a subjective experience of the LPC’s experience with rural women; or 2) structural, the context of the experience. According to Moustakas (1994), the textural themes represent phenomenological reduction, a way of understanding that includes an external and internal experience; the structural themes represent imaginative variation, the context of the experience. One of the themes, *counselor experience*, fit the description of both textural and structural. The categories represented two distinct dimensions of the phenomenon: (a) LPCs’ perceptions of their work with rural women, and (b) LPCs’ perceptions of rural women and issues related to mental health.

Dimension 1: LPCs’ Perceptions of Their Work With Rural Women

Five textural themes emerged from the coding process; I took the names of three of these verbatim from the interviews. The textural themes included 20 codes that represented the subjective experiences of LPCs’ work with rural women. The participants’ pseudonyms were inserted into the direct quotes included in theme descriptions. Artifacts offered by participants were also included.

Bootstraps

Rooted in the familiar saying of “pull yourself up by your bootstraps,” this theme included codes of resilient, stoic, self-sufficient, and independent. According to LPCs’ perceptions of rural women, *bootstraps* described an acceptance of the current conditions of rural life and a reliance on past experiences for guidance. Many of the LPCs believed that rural women came to counseling with a skill set that, as Nancy said, “can teach us and others about how to be resilient.” Fave commented that working with rural women also required patience:

It’s this sense of “I can do this.” There are more demands with farming, and rural women still believe they should be able to do it all. When they come into counseling it can be difficult because they have worked hard to sort of protect this thing and keep it close to them because they’re pretty sure they can figure it out themselves.

Courtney shared a story about a ranch woman who was grieving the loss of her husband and was struggling with family issues. She remarked in one session, “Today I decided it was time to put on my red cowboy boots.” For Courtney, this represented her client’s resiliency and stoicism — “I’ve got this, and I’ve got my red boots on to prove it.”

Trailblazer

Trailblazer included pioneer, open-minded, resourceful, educated, and empowered; these words described LPCs' perceptions of rural women's abilities to move past accepting the realities of rural living and work toward change for improving themselves, their families, and their communities. According to the LPCs, this theme is distinct from *bootstraps* in that it is future-oriented rather than past-oriented. Elsie first referred to *trailblazer* when she told a story about a client who began recycling in the early 1980s: "She had bins and bins of recycling because she said, 'I'm gonna leave this planet in a different shape than I found it.' Rural women very much can be trailblazers." The LPCs' perceptions represented a new perspective that reflected resourceful change-makers, educated and empowered to challenge the status quo.

As one of her artifacts, Courtney offered a story about one woman's determination to make Christmas special even though there were no resources for gifts and decorations. The woman found a large tumbleweed, covered it with lights and decorations, and declared it beautiful. Courtney said, "She was not just making do, but making things better."

Challenges of Rural Women

LPCs observed multiple challenges for rural women including isolation, poverty/financial insecurity, role overload, grief, and generational trauma. Layla talked about the complex grief that was experienced by Native American women. She commented that "the death of a family member can mean losing someone from three or four generations. There is grief from loss of jobs, moving from the reservation, and loss of culture." LPCs cited role overload as one of the most common experiences among rural women. Many rural women worked full-time jobs in addition to caring for family members while contributing to the farm/ranch operation. Jean observed that rural women "are responsible for everyone's emotions in the family, sometimes leaving them isolated within the family." LPCs believed that the isolation contributed to vulnerability. Rural women faced domestic violence, anxiety, depression, and addictions, exacerbated by having no one to talk with and long distances to services. Jean noted that resistance to change was perpetuated by the fear and control inherent in domestic abuse for many of her clients and led to complacency in reporting. The challenges of rural women described by participants defined the issues that LPCs faced when working in rural areas and increased their awareness of the critical needs of rural women.

Protective Factors

Protective factors included a sense of identity and the strong support systems of families and community that gave rural women "a lot of people that you can draw upon to help you through hard times," according to Nancy. Her clients valued the easy access to nature and the opportunity to "immerse yourself in something bigger than yourself. It's a way to build resilience and find meaning and joy spending time outside." Layla found a strong sense of identity evident in rural Native women as central to the ability to teach their children cultural beliefs—a protective factor for future generations.

Nancy shared a picture of a family moving their 100-year-old home to a new location as her artifact. Her description of the house and rural heritage symbolized part of what she believed was important for rural women—the connection to family and heritage along with a sense of purpose in maintaining family culture. She said, "It's a good way to pass down the family stories and even the family culture."

Counselor Experience

Counselor experience (textural) included the reasons why participants chose to become LPCs. These included the motivations that sustained their work and advice for new counselors. Assumptions about diversity, a sense of purpose, listening, and connections to resources encapsulated this theme.

Layla became a counselor because she wanted “to give back to my Native people.” Nancy believed that the work with rural women helped her build a rural counselor identity. Woods’ early experience with rural women felt profound because of the chaos she observed in the lives of her clients, many of them impoverished single mothers struggling to survive. She was given a sense of purpose in her work saying, “These women are burned into my head.”

When asked about advice for new counselors who anticipate working with rural women, participants offered the following brief statements:

- “Don’t make assumptions.” (Courtney)
- “Ask to be taught.” (Marie)
- “Hear their story without filtering through your own personal lens.” (Nancy)
- “There is a difference in working in rural areas—a conservative mind-set, practicality—and you need to meet people where they are.” (Kay)
- “Listen more than you talk.” (Suzie)
- “Have respect for their culture.” (Layla)

LPCs’ Perceptions of Rural Women and Issues Related to Mental Health

Three structural themes represented what Moustakas (1994) termed *imaginative variation*, the acknowledgment of the context of multiple perspectives. The themes were derived from nine codes that provided a vital aspect of further describing the phenomenon. The theme descriptions included participants’ quotes and artifacts.

Perceptions of Rural Heritage

This theme represented LPCs’ view of rural life, including traditional values, heritage, and expectations/perfectionism. According to participants, many of the rural women embraced the traditional values of their rural heritage, and the roles of rural life; this theme honors that perspective. Fave talked about the expectations that rural women often have of themselves: “It’s a perfectionist perspective, meaning they can do it all.” Even in light of the increased demands on rural women’s time and energy, Marie found that rural women were often hesitant to seek outside professional mental health counseling, choosing instead to rely on family and community.

Barriers to Mental Health Services

The barriers included codes of lack of resources, stigma, and invisibility. All LPCs felt concerned about the lack of resources for rural women. Suzie talked about the dearth of women’s shelters on the reservation and resources for women who are victims of domestic violence. Suzie said, “They often stay because there are no resources for them to leave, and they can’t afford it.” Woods noted the lack of daycare providers and the fact that many rural women cannot afford these services and depend on family members for childcare. According to several LPCs, rural women do not prioritize their mental health needs, possibly because of the many demands on them.

Kay and Marie practiced in an urban area but saw many rural women who chose to travel long distances for mental health services because it gave them a sense of anonymity. Kay said, “They know if their car is parked at the counselor’s office, it won’t be recognized by everyone in town.” Rural women also feared exposing family secrets if they disclosed something to a counselor who lived in the same area.

Poignantly, LPCs acknowledged the invisibility and minimization of rural women’s mental health needs. The following comments by participants exemplified the rural woman’s experiences of being unnoticed or dismissed. Elsie stated, “Even if rural women are speaking, they don’t have the platform like urban women do, and they feel like nobody gets this life.” Kay stated, “Everything is fine, everything’s great and we’re not going to talk about the fact that Grandma is crying all the time and wearing sunglasses.”

The statements of the participants provided powerful examples of the ramifications of the silencing imposed on rural women through traditional or cultural norms. The stigma of accessing mental health services created a loss of connection between the rural women who needed the services and their community. In addition, rural women often felt selfish in seeking services just for themselves. The consensus among LPCs was that rural women suffer to a greater extent than other rural populations because their needs are minimized or not recognized. Elsie remarked that rural women do not often see their stories in mainstream media, leading them to believe “I’m living this experience that nobody else lives.”

The description of the artifact contributed for this theme may further elucidate the invisibility of rural women. Woods’ artifact was a picture of two locally designed sculptures of women. Woods said, “They are so rooted and earthy.” One sculpture had no arms or legs and, for Woods, that “speaks to the limited access to needed supports and the lack of voice.”

Counselor Experience

Counselor experience (structural) described how LPCs provide mental health services to rural women and included connection to rural life, distances and dual relationships, and lack of academic training/postgraduate training. Although not all the participants grew up in rural areas, many had rural ties through extended family. Marie’s upbringing on a ranch influenced her understanding of rural women: “There is a more intense work ethic; women are very strong and independent and hardworking.”

The LPCs seemed to feel a strong sense of purpose in their work; some of them chose to become counselors and returned to their home communities to work. They discovered that the connections of shared experiences fostered trust in the counseling relationship and process. Most felt that they were helping to make positive change. Although all participants believed the connection to a rural heritage was critical in their work with rural women, some LPCs did not live and work in the same location, saying it helped to reduce the possibility of multiple relationships. Nancy commuted almost an hour to her work “because you really want to have the counseling relationship be through your therapeutic lens and not through the community lens.”

None of the participants recalled receiving academic training specific to rural areas; however, all participants agreed on the need for academic training focused on rural areas and rural women. Elsie believed that textbooks should “include women’s voices and rural voices.” Jean expressed her concern that “We don’t necessarily address rural women or what they need from the communities around them or even what their typical experience is. I think that’s a disservice to our counseling students.”

Two artifacts aligned with this theme: Marie's picture of a young girl, dressed in overalls, pitching hay, and Mae's great-grandmother's writing desk (see Figure 1). Marie's artifact exemplified the family's connection to rural life and the physical strength of rural women that she observed in her work. Mae now uses the writing desk in her practice and feels it gives her a strong connection to her rural heritage.

Figure 1

Mae's Great-Grandmother's Writing Desk



Note. Mae presented this picture of her great-grandma's writing desk when asked to provide an artifact that demonstrated her work with rural women.

Discussion

LPCs described rural women as strong, independent, resourceful, and resilient. However, this image of rural women was not corroborated within the research literature. An APA report on the behavioral health care needs of rural women (Mulder et al., 2000) did not mention resiliency as a coping strategy; however, in 2006, the report's lead author recognized the need for additional research about resiliency in rural women, saying it would offer "significant potential benefit to rural women" (Mulder & Lambert, 2006, p. 15). In the present study, LPCs' perceptions of rural women as resilient called attention to the innate strengths of rural women that developed out of necessity, cultivated by connections with family, community, and earth.

Rural heritage represented a dichotomy of rural tradition. From a positive perspective, participants believed the traditional roles of rural women provided a sense of identity and belonging. From a negative perspective, the traditional patriarchy evident in many rural areas dictated social and cultural norms, leaving rural women with the expectation that they should be able to “do it all.” Both perspectives defined a critical aspect of LPCs’ understanding of rural women. Even though many of the rural women participants described worked full-time to contribute to household income and health insurance (in addition to caretaker responsibilities), they faced gender inequities in income, employment, and educational opportunities (Watson, 2019). In addition, rural women have had little political power to effect needed policy changes for better access to care (Van Montfoort & Glasser, 2020).

LPCs highlighted multiple challenges that rural women experience: isolation, poverty, grief, role overload, and generational trauma. Barriers to obtaining services included stigma of mental health issues, loss of anonymity, a lack of resources, invisibility, and minimization of mental health issues. The general population also faces barriers of accessibility, acceptability, and availability of counseling services (Smalley & Warren, 2014); however, there were fewer references to the mental health barriers and challenges specific to rural women (Van Montfoort & Glasser, 2020). This is surprising given that the population of rural women exceeds that of any other population group in rural areas (Bennett et al., 2013). Rural women experience higher risks of depression, domestic violence, and poverty (Snell-Rood et al., 2019). The mental health services available in rural areas, often described as “loosely organized, of uneven quality, and low in resources” (Snell-Rood et al., 2019, p. 63), compound the challenges for rural women.

As evident in the themes of assumptions and diversity, rural women represent a unique population who deserve mental health services that reflect their specific needs. Rural communities and rural women are more diverse than once believed. LPCs’ observations are corroborated by research that acknowledged differences among rural women in socioeconomic status, family structure, age, sexual identity, ethnicity, education, and geographical location (Barefoot et al., 2015). In addition, there remains a misconception that the mental health needs of urban and rural women are the same; in fact, much of the literature about women and mental health is based on an urban context (Weaver & Gjesfjeld, 2014). The findings of the current study support the lack of recognition of the context of rural women’s issues and their status as an invisible population (Bender, 2016). Two LPCs’ observations of the isolation felt by rural women reinforced previous research of the invisibility of rural women. Elsie said, “Rural women don’t see their story a lot,” and Fave shared that “a lot of the women I work with don’t feel like they’re heard.”

None of the participants recalled academic training or postgraduate opportunities specific to work in rural areas or with rural women. Even though rural areas represent the largest population subgroup in the United States (Smalley & Warren, 2014), this study suggests that new counselors may not feel prepared to meet the needs of this underserved population. The shortage of mental health professionals working in rural areas and the lack of counselors who have training specific to rural mental health care suggest a need for rural-based training that might include an elective course in rural mental health and rural internships (Fifield & Oliver, 2016).

Implications

The recognition of the challenges and benefits of working with rural women may validate rural LPCs’ experiences, promote their professional identity as rural counselors, and potentially decrease the isolation felt when working in rural areas. Protective factors, including connections to family,

community, and nature, may be critical for building resiliency in both rural women *and* rural LPCs. The increasing diversity of rural women is often contrary to the traditional stereotype of a stay-at-home farmwife (Carpenter-Song & Snell-Rood, 2017); diverse rural women may face unique barriers to accessing culturally relevant mental health services. In addition, many rural women experience role overload from working full-time and caring for families while contributing to the farm/ranch operation. Counselors should avoid interacting with rural women clients in ways that limit their identities based on stereotypes and work to make their services accessible for all women.

The study results also have implications for counselor educators. Rural-based counselors in this study did not report being taught how to work with rural women. A review of the 2016 CACREP programs found few gender-based counseling courses and none that addressed rural mental health. Programs could offer electives on counseling in rural areas, incorporate the context of gender and rural mental health into current curricula, and encourage rural internships. Collaborating with other rural health professionals may provide more informed approaches to working in rural areas. Rural residents may see their PCPs for mental health-related treatment, as PCPs may be the only health care provider in rural areas (Snell-Rood et al., 2017). Lloyd-Hazlett et al. (2020) suggested creating additional training for LPCs who choose to work in settings offering integrated care. Incorporating LPCs who have the appropriate training and skills into rural medical settings may offer mental health services in a familiar clinical context and one that does not broadcast engagement in mental health care. The collaboration may also provide more awareness of the mental health needs of rural women.

Limitations

The study has several limitations. Although I took measures to reduce any personal bias as a non-traditional rural woman, I do not believe it is possible to eliminate all biases. Many of the participants talked about empowering rural women and working toward making their clients' voices heard, both tenets of feminist theory (Evans et al., 2005); however, participants rarely used the language of feminism. Several of the participants related personal stories of their connections with rurality and, often, their stories of rural women were from decades ago. Their stories may not have represented the current generation of rural women. Another limitation relates to the demographics of LPCs because a majority of participants self-identified as Caucasian and female and represented rural areas in the Midwest. LPCs working in other areas of the United States may encounter different demographics of rural women, mental health challenges specific to region, and unique intersections of their clients' identities. Finally, the experiences of rural women were heard through LPCs and not from rural women clients themselves.

Directions for Future Research

This study included a sample of rural LPCs who were primarily Caucasian females from the Midwestern United States; future researchers may seek professional perspectives from participants who represent a blend of race, ethnicities, gender identities, and geographical locations. Research with rural women as participants themselves is also an important opportunity. Based on findings from this study, future researchers might also explore training needs related to work with rural women and rural populations. Studying counselor educators who teach in counseling programs based in rural areas could also offer unique insights. This may reveal information about ways educators currently infuse rural culture and work with rural women into the curriculum. Future researchers may study counselors, health care providers, and rural women in finding ways to integrate health care services

in rural areas to provide better access to services and reduce the stigma often associated with mental health. Finally, additional studies about working with rural PCPs may highlight issues (e.g., intimate partner violence) that could benefit from early screening of symptoms.

Conclusion

Gilligan offers these words: “To have something to say is to be a person. But speaking depends on listening and being heard; it is an intensely relational act” (1982/1993, p. xvi). As indicated in our findings, rural women are too often invisible and unheard. This study represents a first step in amplifying the voices of rural women regarding their specific mental health needs. The experiences of the LPCs in this study have illuminated ways to connect with rural women, listen to their stories, and validate unique aspects of their cultural identities that seem to be well illustrated in one participant’s poem:

*Rural Women
Resilient; stubborn; motivated
frightened; broken; courageous
Struggling; down-trodden; strong
Relentless in self-expectation
Armed with determination.
A common thread unites us
The heart gently calls, and the
soul asks only—please—listen to me.*

Conflict of Interest and Funding Disclosure

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References

- American Psychological Association. (2018). *APA guidelines for psychological practice with girls and women*. <http://www.apa.org/about/policy/psychological-practice-girls-women.pdf>
- Barefoot, K. N., Rickard, A., Smalley, K. B., & Warren, J. C. (2015). Rural lesbians: Unique challenges and implications for mental health providers. *Journal of Rural Mental Health, 39*(1), 22–33. <https://doi.org/10.1037/rmh0000014>
- Bender, A. K. (2016). Health care experiences of rural women experiencing intimate partner violence and substance abuse. *Journal of Social Work Practice in the Addictions, 16*(1–2), 202–221. <https://doi.org/10.1080/1533256X.2015.1124783>
- Bennett, K. J., Lopes, J. E., Jr., Spencer, K., & van Hecke, S. (2013). Rural women’s health. *National Rural Health Association Policy Brief*. [https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/RuralWomensHealth-\(1\).pdf.aspx](https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/RuralWomensHealth-(1).pdf.aspx)
- Broverman, I. K., Broverman, D. M., Clarkson, F. E., Rosencrantz, P. S., & Vogel, S. R. (1970). Sex-role stereotypes and clinical judgments of mental health. *Journal of Counseling and Clinical Psychology, 34*(1), 1–7. <https://doi.org/10.1037/h0028797>
- Brown, L. M., & Gilligan, C. (1992). *Meeting at the crossroads: Women’s psychology and girls’ development*. Harvard University Press.

- Carlton, E., & Simmons, L. (2011). Health decision-making among rural women: Physician access and prescription adherence. *Journal of Rural and Remote Health Research, Education, Practice and Policy*, 11, 1–10.
- Carpenter-Song, E., & Snell-Rood, C. (2017). The changing context of rural America: A call to examine the impact of social change on mental health and mental health care. *Psychiatric Services*, 68(5), 503–506. <https://doi.org/10.1176/appi.ps.201600024>
- Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP standards*. <http://www.cacrep.org/for-programs/2016-cacrep-standards>
- Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). SAGE.
- Doudna, K. D., Reina, A. S., & Greder, K. A. (2015). Longitudinal associations among food insecurity, depressive symptoms, and parenting. *Journal of Rural Mental Health*, 39(3–4), 178–187. <https://doi.org/10.1037/rmh0000036>
- Enns, C. Z. (2017). Contemporary adaptations of traditional approaches to counseling women. In M. Kopala & M. Keitel (Eds.), *Handbook of counseling women* (2nd ed., pp. 51–62). SAGE.
- Evans, K. M., Kincade, E. A., Marbley, A. F., & Seem, S. R. (2005). Feminism and feminist therapy: Lessons from the past and hopes for the future. *Journal of Counseling & Development*, 83(3), 269–277. <https://doi.org/10.1002/j.1556-6678.2005.tb00342.x>
- Fifield, A. O., & Oliver, K. J. (2016). Enhancing the perceived competence and training of rural mental health practitioners. *Journal of Rural Mental Health*, 40(1), 77–83. <https://doi.org/10.1037/rmh0000040>
- Gilligan, C. (1993). *In a different voice: Psychological theory and women's development*. Harvard University Press. (Original work published 1982)
- Gilligan, C., & Eddy, J. (2017). Listening as a path to psychological discovery: An introduction to the Listening Guide. *Perspectives on Medical Education*, 6, 76–81. <https://doi.org/10.1007/s40037-017-0335-3>
- Heppner, P. P., Wampold, B. E., Owen, J., Thompson, M. N., & Wang, K. T. (2016). *Research design in counseling* (4th ed.). Cengage.
- Hill, S. K., Cantrell, P., Edwards, J., & Dalton, W. (2016). Factors influencing mental health screening and treatment among women in a rural south central Appalachian primary care clinic. *Journal of Rural Health*, 32(1), 82–91. <https://doi.org/10.1111/jrh.12134>
- Imig, A. (2014). Small but mighty: Perspectives of rural mental health counselors. *The Professional Counselor*, 4(4), 404–412. <https://doi.org/10.15241/aii.4.4.404>
- Lloyd-Hazlett, J., Knight, C., Ogbeide, S., Trepal, H., & Blessing, N. (2020). Strengthening the behavioral health workforce: Spotlight on PITCH. *The Professional Counselor*, 10(3), 306–317. <https://doi.org/10.15241/jlh.10.3.306>
- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, 52(2), 250–260. <https://doi.org/10.1037/0022-0167.52.2.250>
- Morrow, S. L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist*, 35(2), 209–235. <https://doi.org/10.1177/0011000006286990>
- Moustakas, C. (1994). *Phenomenological research methods*. SAGE.
- Mulder, P. L., & Lambert, W. (2006). Behavioral health of rural women: Challenges and stressors. In R. T. Coward, L. A. Davis, C. H. Gold, H. Smiciklas-Wright, L. E. Thorndyke, & F. W. Vondracek (Eds.), *Rural women's health: Mental, behavioral, and physical issues* (pp. 15–30). Springer.
- Mulder, P. L., Shellenberger, S., Streiegel, R., Jumper-Thurman, P., Danda, C. E., Kenkel, M. B., Constantine, M. G., Sears, S. F., Kalodner, M., & Hager, A. (2000). *The behavioral healthcare needs of rural women*. <http://www.apa.org/practice/programs/rural/rural-women.pdf>
- Ponterotto, J. G. (2010). Qualitative research in multicultural psychology: Philosophical underpinnings, popular approaches, and ethical considerations. *Cultural Diversity and Ethnic Minority Psychology*, 16(4), 581–589. <https://doi.org/10.1037/a0012051>
- Radunovich, H. L., Smith, S. R., Ontai, L., Hunter, C., & Cannella, R. (2017). The role of partner support in the physical and mental health of poor, rural mothers. *Journal of Rural Mental Health*, 41(4), 237–247. <https://doi.org/10.1037/rmh0000077>
- Schwarz, J. (2017). Counseling women and girls: Introduction to empowerment feminist therapy. In J. E. Schwarz (Ed.), *Counseling women across the life span: Empowerment, advocacy, and intervention* (pp. 1–20). Springer.

- Smalley, K. B., & Warren, J. C. (2014). Mental health in rural areas. In J. C. Warren & K. B. Smalley (Eds.), *Rural public health: Best practices and preventive models* (pp. 85–93). Springer.
- Snell-Rood, C., Feltner, F., & Schoenberg, N. (2019). What role can community health workers play in connecting rural women with depression to the “de facto” mental health care system? *Community Mental Health Journal*, 55, 63–73. <https://doi.org/10.1007/s10597-017-0221-9>
- Snell-Rood, C., Hauenstein, E., Leukefeld, C., Feltner, F., Marcum, A., & Schoenberg, N. (2017). Mental health treatment seeking patterns and preferences of Appalachian women with depression. *American Journal of Orthopsychiatry*, 87(3), 233–241. <https://doi.org/10.1037/ort0000193>
- U.S. Census Bureau. (2010). 2010 census urban and rural classification and urban area criteria. <http://census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural/2010-urban-rural.html>
- U.S. Department of Agriculture. (2015). *Rural America at a glance*. https://www.ers.usda.gov/webdocs/publications/44015/55581_eib145.pdf?v=751.6
- Van Montfoort, A., & Glasser, M. (2020). Rural women’s mental health: Status and need for services. *Journal of Depression and Anxiety*, 9(3), 1–7.
- Watson, D. M. (2019). Counselor knows best: A grounded theory approach to understanding how working class, rural women experience the mental health counseling process. *Journal of Rural Mental Health*, 43(4), 150–163. <https://doi.org/10.1037/rmh0000120>
- Weaver, A., & Gjesfjeld, C. (2014). Barriers to preventive services use for rural women in the southeastern United States. *Social Work Research*, 38(4), 225–234. <https://doi.org/10.1093/swr/svu023>
- Weeks, L. E., Macquarrie, C., Begley, L., Gill, C., & Leblanc, K. D. (2016). Strengthening resources for midlife and older rural women who experience intimate partner violence. *Journal of Women & Aging*, 28(1), 46–57. <https://doi.org/10.1080/08952841.2014.950500>
- Wong, A. (2017). Intersectionality: Understanding power, privilege, and the intersecting identities of women. In J. E. Schwarz (Ed.), *Counseling women across the life span: Empowerment, advocacy, and intervention* (pp. 39–56). Springer.

Appendix

Twelve Interview Questions

1. Tell me about what comes to mind when you think about working with rural women.
2. Tell me about where you grew up and how that has influenced your work with rural women.
3. Tell me about how you began your work with rural women.
4. What have you learned about rural women through your work with them?
5. What are the unique mental health needs of rural women that you have seen in your work?
6. Tell me about some of the benefits and rewards, if any, you have experienced working with rural women.
7. Tell me about some of the challenges, if any, you have experienced working with rural women.
8. How have your experiences working with rural women changed you as a mental health counselor?
9. Tell me about any academic/classroom experiences in your graduate program that involved the mental health issues of rural women (e.g., class discussions, special projects, conversations with colleagues, internship experiences).
10. Tell me about any training experience post-graduation that have involved the mental health issues of rural women (e.g., workshops, conference presentations, webinars, conversations with colleagues).
11. What would you like other counselors to know about working with rural women?
12. Please describe how the artifact that you have chosen relates to your work with rural women.



Mental Health Epigenetics: A Primer With Implications for Counselors



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Epigenetics is the study of modifications to gene expression without an alteration to the DNA sequence. Currently there is limited translation of epigenetics to the counseling profession. The purpose of this article is to inform counseling practitioners and counselor educators about the potential role epigenetics plays in mental health. Current mental health epigenetic research supports that adverse psychosocial experiences are associated with mental health disorders such as schizophrenia, anxiety, depression, and addiction. There are also positive epigenetic associations with counseling interventions, including cognitive behavioral therapy, mindfulness, diet, and exercise. These mental health epigenetic findings have implications for the counseling profession such as engaging in early life span health prevention and wellness, attending to micro and macro environmental influences during assessment and treatment, collaborating with other health professionals in epigenetic research, and incorporating epigenetic findings into counselor education curricula that meet the standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP).

Keywords: epigenetics, mental health, counseling, prevention and wellness, counselor education

Epigenetics, defined as the study of chemical changes at the cellular level that alter gene expression but do not alter the genetic code (T.-Y. Zhang & Meaney, 2010), has emerging significance for the profession of counseling. Historically, people who studied abnormal behavior focused on determining whether the cause of poor mental health outcomes was either “nature or nurture” (i.e., either genetics or environmental factors). What we now understand is that both nature *and* nurture, or the interaction between the individual and their environment (e.g., neglect, trauma, substance abuse, diet, social support, exercise), can modify gene expression positively or negatively (Cohen et al., 2017; Suderman et al., 2014).

In the concept of nature and nurture, there is evidence that psychosocial experiences can change the landscape of epigenetic chemical tags across the genome. This change in landscape influences mental health concerns, such as addiction, anxiety, and depression, that are addressed by counseling practitioners (Lester et al., 2016; Provençal & Binder, 2015; Szyf et al., 2016). Because the field of epigenetics is evolving and there is limited attention to epigenetics in the counseling profession, our purpose is to inform counseling practitioners and educators about the role epigenetics may play in clinical mental health counseling.

Though many counselors and counselor educators may have taken a biology class that covered genetics sometime during their professional education, we provide pedagogical scaffolding from genetics to epigenetics. Care was taken to ensure accessibility of information for readers across this continuum of genetics knowledge. Much of what we offer below on genetics is putative knowledge, as we desire to establish a foundation for the reader in genetics so they may be able to have a greater

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understanding of epigenetics and a clearer comprehension of the implications we offer leading to application in counseling. We suggest readers review Brooker (2017) for more detailed information on genetics. We will present an overview of genetics and epigenetics, an examination of mental health epigenetics, and implications for the counseling profession.

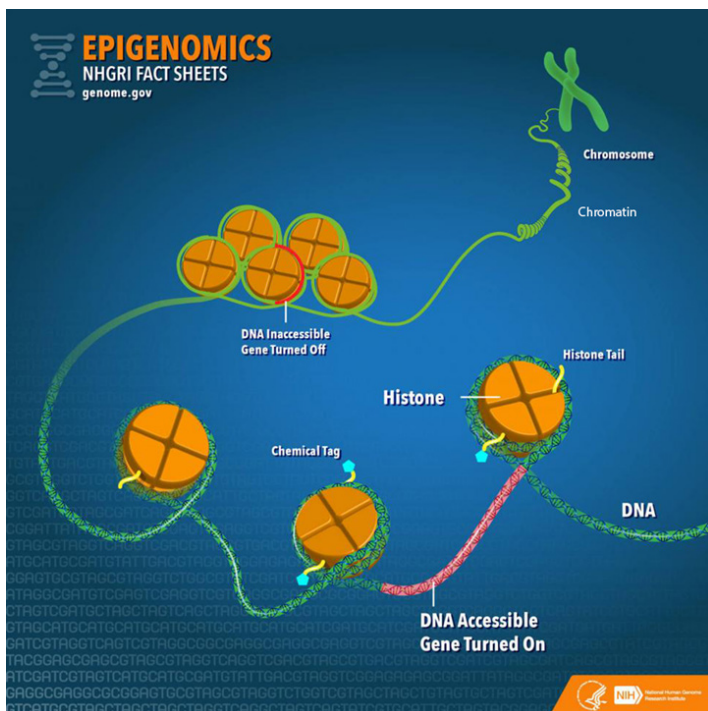
Genetics

Genetics is the study of heredity (Brooker, 2017) and the cellular process by which parents pass on biological information via genes. The child inherits genetic coding from both parents. One can think of these parental genes as a recipe book for molecular operations such as the development of proteins, structure of neurons, and other functions across the human body. This total collection of the combination of genes in the human body is called the *genome* or *genotype*. The presentation of observable human traits (e.g., eye color, height, blood type) is called the *phenotype*. Phenotypes can be seen in our clinical work through behavior (e.g., self-injury, aggression, depression, anxiety, inattentiveness).

Before going further, it is important to establish a fundamental understanding of genetics by examining the varied molecular components and their relationships (Figure 1). *Deoxyribonucleic acid* (DNA) is a long-strand molecule that takes the famous double helix or ladder configuration. DNA is made up of four chemical bases called adenine (A), guanine (G), cytosine (C), and thymine (T). These form base pairs—A with T and C with G—creating a nucleic acid. The DNA is also wrapped around a specialized protein called a *histone*. The collection of DNA wrapped around multiple histones is called the *chromatin*. This wrapping process is essential for the DNA to fit within the cell nucleus. Finally, as this chromatin continues to grow, it develops a structure called a *chromosome*. Within every human cell nucleus, there are 23 chromosomes from each parent, totaling 46 chromosomes.

Figure 1

Gene Structure and Epigenetics



From "Epigenomics Fact Sheet," by National Human Genome Research Institute, 2020 (<https://www.genome.gov/about-genomics/fact-sheets/Epigenomics-Fact-Sheet>). In the public domain.

Beyond the chromosomes, chromatin, histones, DNA, and genes, there is another key component in genetics: *ribonucleic acid* (RNA). RNA can be a cellular messenger that carries instructions from a DNA sequence (specific genes) to other parts of the cell (i.e., messenger RNA [mRNA]). RNA can come in several other forms as well, including transfer RNA (tRNA), microRNA (miRNA), and non-coding RNA (ncRNA). In the sections below, we elaborate on mRNA and tRNA and their impact on the genetic processes. Later in the epigenetics section, we provide fuller details on miRNA and ncRNA.

Besides the aforementioned biological aspects, it is important to understand that a child inherits genes from both parents, but they are not exactly the same genes, (i.e., alternative forms of the same gene may have differing expression). Different versions of the same gene are called *alleles*. Variation in an allele is one reason why we see phenotypic variation between our clients—height, weight, eye color—and this variation can contribute to mental disease susceptibility. Although there are many potential causes of poor mental health, family history is often one of the strongest risk factors because family members most closely represent the unique genetic and environmental interactions that an individual may experience. We also see this as a function of intergenerational epigenetic effects, which are covered later in this paper.

Transcription and Translation

Now that we have provided a foundation of the genetic components, we move toward the primary two-stage processes of genetics: transcription and translation (Brooker, 2017). The first step in the process of gene expression is called *transcription*. Transcription occurs when a sequence of DNA is copied using RNA polymerase (“ase” notes that it is an enzyme) to make mRNA for protein synthesis. We can liken transcription to the process of someone taking down information from a client’s voicemail message. In this visualization, DNA is the caller, the person writing down the message is the RNA polymerase, and the actual written message is the RNA.

A particular section of a gene, called a *promotor region*, is bound by the RNA polymerase (Brooker, 2017). The RNA polymerase acts like scissors to separate the double-stranded DNA helix into two strands. One of the strands, called the *template*, is where the RNA polymerase will read the DNA code A to T, and G to C to build mRNA. There are other modifications that must occur in eukaryotic cells such as splicing introns and exons. In short, sections of unwanted DNA, called *introns*, are removed by the process of splicing, and the remaining DNA codes are connected back together (*exons*).

Now that the mRNA has been created by the process of transcription, the next step is for the mRNA to build a protein necessary for the main functions of the body, in a process known as *translation* (Brooker, 2017). Here, translation is the process in which tRNA decodes or translates the mRNA into a protein in a mobile cellular factory called the *ribosome*. It is translating the language of a DNA sequence (gene) into the language of a protein. To do this, the tRNA uses a translation device called an *anticodon*. This anticodon links to the mRNA-based pairs called a *codon*. A codon is a trinucleotide sequence of DNA or RNA that corresponds to a specific *amino acid*, or building block of a protein. This process then continues to translate and connect many amino acids together until a *polypeptide* (a long chain of amino acids) is created. Later, these polypeptides join to form proteins. Depending on the type of cell, the protein may function in a variety of ways. For example, the neuron has several proteins for its function, and different proteins are used for memory, learning, and neuroplasticity.

Epigenetics

There is a wealth of research conducted on genetics, yet the understanding of epigenetics is more limited when focusing on mental health (Huang et al., 2017). Though the term epigenetics has been

around since the 1940s, the “science” of epigenetics is in its youth. Epigenetic research in humans has grown in the last 10 years and continues to expand rapidly (Januar et al., 2015). The key concept for counselors to remember about epigenetics is that epigenetics supports the idea of coaction. Factors present in the client’s external environment (e.g., stress from caregiver neglect, foods consumed, drug intake like cigarettes) influence the expression of their genes (transcription and translation) and thus cell activity and related behavioral phenotypes. In the sections below, we will dive deeper into the understanding of epigenetic mechanisms and define key terms including *epigenome*, *chromatin*, and *chemical modifications*.

To start, the more formal definition of epigenetics is the differentiation of gene expression via chemical modifications upon the epigenome that do not alter the genetic code (i.e., the DNA sequence; Szyf et al., 2007). The epigenome, which is composed of chromatin (the combination of DNA and protein forming the chromosomes) and modification of DNA by chemical mechanisms (e.g., DNA methylation, histone modification), programs the process of gene expression (Szyf et al., 2007). The epigenome differs from the genome in that the chemical actions or modifications are on the outside of the genome (i.e., the DNA) or “upon” the genome. Specifically, epigenetic processes act “upon” the genome, which may open or close the chromatin to various degrees to govern access for reading DNA sequences (Figure 1). When the chromatin is opened, transcription and translation can take place; however, when the chromatin is closed, gene expression is silenced (Szyf et al., 2007).

It is important for counselors to conceptualize their client’s psychosocial environment in conjunction with the observed behavioral phenotypes, in that the client’s psychosocial environment may have partially mediated epigenetic expression (Januar et al., 2015). For example, with schizophrenia, a client’s adverse environment (e.g., early childhood trauma) influences the epigenome, or gene expression, which may contribute up to 60% of this disorder’s development (Gejman et al., 2011). Other adverse environmental influences have been associated with the development of schizophrenia, including complications during client’s prenatal development and birth, place and season of client’s birth, abuse, and parental loss (Benros et al., 2011). As we highlight below, epigenetic mechanisms (e.g., DNA methylation) may mediate between these environmental influences and genes with outcomes like schizophrenia (Cariaga-Martinez & Alelú-Paz, 2018; Tsankova et al., 2007).

Epigenetic Mechanisms

There are a variety of chemical mechanisms or tags that change the chromatin structure (either opening for expression or closing to inhibit expression). Some of the most investigated mechanisms for changes in chromatin structure are DNA methylation, histone modification, and microRNA (Benoit & Turecki, 2010; Maze & Nestler, 2011).

DNA Methylation. Methylation is the most studied epigenetic modification (Nestler et al., 2016). It occurs when a methyl group binds to a cytosine base (C) of DNA to form 5-methylcytosine. A *methyl group* is three hydrogens bonded to a carbon, identified as CH₃. Most often, the methyl group is attached to a C followed by a G, called a CpG. These methylation changes are carried out by specific enzymes called *DNA methyltransferase*. These enzymes add the methyl group to the C base at the CpG site.

Methylation was initially considered irreversible, but recent research has shown that DNA methylation is more stable compared to other chemical modifications like histone modification and is therefore reversible (Nestler et al., 2016). This DNA methylation adaptability evidence is important, conceivably supporting counseling efficacy across the life span. If methylation is indeed reversible beyond 0 to 5 years of age, counseling efforts hold promise to influence mental health outcomes across the life span.

Beyond noted stability, DNA methylation is also important in that it is *tissue-specific*, meaning it assists in cell differentiation; it may regulate gene expression up or down and is influenced by different environmental exposures (Monk et al., 2012). For example, DNA methylation represses specific areas of a neuron's genes, thus "turning off" their function. This stabilizes the cell by preventing any tissue-specific cell differentiation and inhibits the neuron from changing into another cell type (Szyf et al., 2016), such as becoming a lung cell later in development.

When looking at up- or downregulation, Oberlander et al. (2008) provided an example from a study using mice. When examining attachment style in mice, they found that decreased quality of mothering to offspring increased risk of anxiety, in part, because of the methylation at the glucocorticoid receptor (GR) gene and fewer GR proteins produced by the hippocampus. This change may lead to lifelong silencing or downregulation with an increased risk of anxiety to the mouse over its life span. Stevens et al. (2018) also established a link between diet, epigenetics, and DNA methylation. They found an epigenetic connection between poor dietary intake with increased risk of behavioral problems and poor mental health outcomes such as autism. The authors also remarked that further investigation is required for a clearer picture of this link and potential effects.

Histone Modification. Another process that has been extensively researched is post-translational histone modification, or changes in the histone after the translation process. The most understood histone modifications are *acetylation*, *methylation*, and *phosphorylation* (Nestler et al., 2016). Acetylation, the most common post-translational modification, occurs by adding an acetyl group to the histone tail, such as the amino acid lysine. The enzymes responsible for histone acetylation are histone acetyltransferases or HATs (Haggarty & Tsai, 2011). Conversely, histone deacetylases (HDACs) are enzymes that remove acetyl groups (Saavedra et al., 2016). The acetylation process promotes gene expression (Nestler et al., 2016).

Through histone methyltransferases (HMTs), histone methylation increases methylation, thereby reducing gene expression. Histone demethylases (HDMs) remove methyl groups to increase gene activity. Phosphorylation can increase or decrease gene expression. Overall, there are more than 50 known histone modifications (Nestler et al., 2016).

From a counseling perspective, it is important to note that histone modification is flexible. Unlike DNA methylation, which is more stable over a lifetime, histone modifications are more transient. To illustrate, if an acetyl group is added to a histone, it may loosen the binding between the DNA and histone, increasing transcription and thereby allowing gene expression across the life span (Nestler et al., 2016). Such acetylation processes have been found in maternal neglect to offspring (early in the life span) and mindfulness practices in adult clients (Chaix et al., 2020; Devlin et al., 2010). Yet, although histone modification can be changed across the life span (Nestler et al., 2016), it is still important for counselors to recognize the importance of early counseling interventions because of how highly active epigenetics mechanisms (e.g., DNA methylation) are in children 0 to 5 years of age.

MicroRNA. Beyond histone modification, another known mechanism is *microRNA* (miRNA), which is the least understood and most recently investigated epigenetic mechanism when compared to DNA methylation and histone modification (Saavedra et al., 2016). miRNA is one type of non-coding RNA (ncRNA), or RNA that is changed into proteins. Around 98% of the genome does not code for proteins, leading to a supporting hypothesis that ncRNAs play a significant role in gene expression. For example, humans and chimpanzees share 98.8% of the same DNA code. However, epigenetics and specifically ncRNA contribute to the wide phenotypic variation between the species (Zheng & Xiao, 2016). Further, Zheng and Xiao (2016) estimated that miRNA regulates up to 60% of gene expression.

miRNA has also been found to suppress and activate gene expression at the levels of transcription and translation (Saavedra et al., 2016). miRNAs affect gene expression by directly influencing mRNA. Specifically, the miRNA may attach to mRNA and “block” the mRNA from creating proteins or it may directly degrade mRNA. This then decreases the surplus of mRNA in the cell. If the miRNA binds partially with the mRNA, then it inhibits protein production; but if it binds completely, it is marked for destruction. Once the mRNA is identified for destruction, other proteins and enzymes are attracted to the mRNA, and they degrade the mRNA and eliminate it (Zheng & Xiao, 2016). Moreover, when compared to DNA methylation, which may be isolated to a single gene sequence, miRNA can target hundreds of genes (Lewis et al., 2005). Researchers have discovered that miRNA may mediate anxiety-like symptoms (Cohen et al., 2017).

Human Development and Epigenetics

Over the life of an individual, there are critical or sensitive periods in which epigenetic modifications are more heavily influenced by environmental factors (Mulligan, 2016). Early life (ages 0 to 5 years) appears to be one of the most critical time periods when epigenetics is more active. An example of this is the Dutch Famine of 1944–45, also known as the Dutch Hunger Winter (Champagne, 2010; Szyf, 2009). The Nazis occupied the Netherlands and restricted food to the country, bringing about a famine. The individual daily caloric intake estimate varied between 400 and 1800 calories at the climax of the famine. Most notably, women who gave birth during this time experienced the impact of low maternal caloric intake, which impacted their child and the child’s health outcomes into adulthood. One discovery was that male children had a higher risk of adulthood obesity if their famine exposure occurred early in gestation versus a male fetus who experienced famine in late gestation. Findings suggested that fetuses who experienced restricted caloric intake during the development of their autonomic nervous system may have an increased risk of heart disease in adulthood. The findings of epigenetic mechanisms at work between mother and child during a famine are flagrant enough, yet epigenetic researchers have also discovered that epigenetic tags carry across generations, called *genomic imprinting* (Arnaud, 2010; Yehuda et al., 2016; T.-Y. Zhang & Meaney, 2010).

Genomic imprinting can be defined as the passing on of certain epigenetic modifications to the fetus by parents (Arnaud, 2010). It is allele-specific, and approximately half of the imprinting an offspring receives is from the mother. The imprinting mechanism marks certain areas, or loci, of offspring’s genes as active or repressed. For instance, the loci may exhibit increased or decreased methylation.

An imprinting example is evident in the IGF-2 (insulin-like growth factor II) gene and those fetuses exposed to the Dutch Hunger Winter (Heijmans et al., 2008). Sixty years after the famine, a decrease in DNA methylation on IGF-2 was found in adults with fetal exposure during the famine compared to their older siblings. Researchers also found these intergenerational imprinting effects associated with the grandchildren of women who were pregnant during the Dutch Hunger Winter. Similar imprinting is also apparent in Holocaust survivors (Yehuda et al., 2016) and children born to mothers who experienced PTSD from the World Trade Center collapse of 9/11 (Yehuda et al., 2005). These imprinting mechanisms are important for counselors to understand in that we see the interplay between the client and the environment across generations. The client becomes the embodiment of their environment at the cellular level. This is no longer the dichotomous “nature vs. nurture” debate but the passing on of biological effects from one generation to another through the interplay of nature and nurture.

Epigenetics and Mental Health Disorders

Now we turn our focus to the influence of epigenetics on the profession of counseling. What we do know is that epigenetic mechanisms, (e.g., DNA methylation, histone modifications, miRNA) are associated with various mental health disorders. It is hypothesized that epigenetics contributes to the development of mental disorders after exposure to environmental stressors, such as traumatic life events, but it may also have positive effects based on salutary environments (Szyf, 2009; Yehuda et al., 2005). We will review only those mental health epigenetic findings that have significant implications relative to clinical disorders such as stress, anxiety, childhood maltreatment, depression, schizophrenia, and addiction. We will also offer epigenetic outcomes associated with treatment, including cognitive behavioral therapy (CBT; Roberts et al., 2015), meditation (Chaix et al., 2020), and antidepressants (Lüscher & Möhler, 2019).

Stress and Anxiety

Stress, especially during early life stages, causes long-term effects for neuronal pathways and gene expression (Lester et al., 2016; Palmisano & Pandey, 2017; Perroud et al., 2011; Roberts et al., 2015; Szyf, 2009; T.-Y. Zhang & Meaney, 2010). Currently, research supports the mediating effects of stress on epigenetics through DNA methylation, especially within the gestational environment (Lester & Marsit, 2018). DNA methylation has been associated with upregulation of the hypothalamic-pituitary-adrenal (HPA) axis, increasing anxiety symptoms (McGowan et al., 2009; Oberlander et al., 2008; Romens et al., 2015; Shimada-Sugimoto et al., 2015; Tsankova et al., 2007). DNA methylation has also been linked with increased levels of cortisol for newborns of depressed mothers. This points to an increased HPA stress response in the newborn (Oberlander et al., 2008). Ouellet-Morin et al. (2013) also looked at DNA methylation and stress. They conducted a longitudinal twin study on the effect of bullying on the serotonin transporter gene (SERT) for monozygotic twins and found increased levels of SERT DNA methylation in victims compared to their non-bullied monozygotic co-twin. Finally, Roberts et al. (2015) examined the effect of CBT on DNA methylation for children with severe anxiety, specifically testing changes in the FKBP5 gene. Although the results were not statistically significant, they may be clinically significant. Research participants with a higher DNA methylation on the FKBP5 gene had poorer response to CBT treatment.

Beyond DNA methylation, other researchers have investigated miRNA and its association with stress and anxiety. A study by Harris and Seckl (2011) found that fetal rodents with increased exposure to maternal cortisol suffered from lower birth weights and heightened anxiety. Similarly, Cohen et al. (2017) investigated anxiety in rats for a specific miRNA called miR-101a-3p. The researchers selectively bred rats, one group with low anxiety and the other with high anxiety traits. They then overexpressed miR-101a-3p in low-anxiety rats to see if that would induce greater expressions of anxiety symptomatology. The investigators observed increased anxiety behaviors when increasing the expression of miR-101a-3p in low-anxiety rats. The researchers postulated that miRNA may be a mediator of anxiety-like behaviors. Finally, paternal chronic stress in rats has been associated with intergenerational impact on offspring's HPA axis with sperm cells having increased miRNAs, potentially indicating susceptibility of epigenetic preprogramming in male germ cells post-fertilization (Rodgers et al., 2013). The evidence suggests that paternal stress reprograms the HPA stress response during conception. This reprogramming may begin a cascading effect on the offspring's HPA, creating dysregulation that is associated with disorders like schizophrenia, autism, and depression later in adulthood.

Though some researchers have indicated a negative association between anxiety and epigenetics, others have found positive effects between epigenetics and anxiety. A seminal study by Weaver et al. (2005) illustrated the flexibility of an offspring's biological system to negative and positive environmental

cues. Weaver et al. looked at HPA response of rodent pups who received low licking and grooming from their mother (a negative environmental effect) who exhibited higher HPA response to environmental cues in adulthood. Epigenetically, they found lower DNA methylation in a specific promotor region in these adult rodents. They hypothesized that they could reverse this hypomethylation by giving an infusion of methionine, an essential amino acid that is a methyl group donor. They discovered the ability to reverse low methylation, which improved the minimally licked and groomed adult rodents' response to stress. This connects with counseling in that epigenetic information is not set for life but reversible through interventions such as diet.

Others have investigated mindfulness and its epigenetic effects on stress. Chaix et al. (2020) looked at DNA methylation at the genome level for differences between skilled meditators who meditated for an 8-hour interval compared to members of a control group who engaged in leisure activities for 8 hours. The control group did not have any changes in genome DNA methylation, but the skilled meditators showed 61 differentially methylated sites post-intervention. This evidence can potentially support the use of mindfulness with our clients as an intervention for treatment of stress.

Childhood Maltreatment

Childhood maltreatment includes sexual abuse, physical abuse and/or neglect, and emotional abuse and/or neglect. Through this lens, Suderman et al. (2014) examined differences in 45-year-old males' blood samples between those who experienced abuse in childhood and those who did not, with the aim of determining whether gene promoter DNA methylation is linked with child abuse. After 30 years, the researchers found different DNA methylation patterns between abused versus non-abused individuals and that a specific hypermethylation of a gene was linked with the adults who experienced child abuse. Suderman et al. (2014) believed that adversity, such as child abuse, reorganizes biological pathways that last into adulthood. These DNA methylation differences have been associated with biological pathways leading to cancer, obesity, diabetes, and other inflammatory paths.

Other researchers have also found epigenetic interactions at CpG sites predicting depression and anxiety in participants who experienced abuse. Though these interactions were not statistically significant (Smearman et al., 2016), increased methylation at specific promoter regions was discovered (Perroud et al., 2011; Romens et al., 2015). Furthermore, in a hallmark study, McGowan et al. (2009) discovered that people with child abuse histories who completed suicide possessed hypermethylation of a particular promotor region when compared to controls. Perroud et al. (2011) noted that frequency, age of onset, and severity of maltreatment correlated positively with increased methylation in adult participants suffering from borderline personality disorder, depression, and PTSD. Yehuda et al. (2016) reported that in a smaller subset of an overall sample of Holocaust survivors, the impact of trauma was intergenerationally associated with increased DNA methylation. Continued study of these particular regions may provide evidence of DNA methylation as a predictor of risk in developing anxiety or depressive disorders.

Major Depressive Disorder

Most studies of mental illness, genetics, and depression have used stress animal models. Through these models, histone modification, chromatin remodeling, miRNA, and DNA methylation mechanisms have been found in rats and mice (Albert et al., 2019; Nestler et al., 2016). When an animal or human experiences early life stress, epigenetic biomarkers may serve to detect the development or progression of major depressive disorder (Saavedra et al., 2016). Additionally, histone modification markers may also indicate an increase in depression (Tsankova et al., 2007; Turecki, 2014). Beyond animal models, Januar et al. (2015) found that buccal tissue in older patients with major depressive disorder provided evidence that the BDNF gene modulates depression through hypermethylation of specific CpGs in promoter regions.

Lastly, certain miRNAs may serve as potential biomarkers for major depressive disorder. miRNA may be used in the pharmacologic treatment of depressive disorders (Saavedra et al., 2016). Tsankova et al. (2007) and Saavedra et al. (2016) noted that certain epigenetic mechanisms that influence gene expression may be useful as antidepressant treatments. Medication may induce neurogenesis and greater plasticity in synapses through upregulation and downregulation of miRNAs (Bocchio-Chiavetto et al., 2013; Lüscher & Möhler, 2019). This points to the potential use of epigenetic “engineering” for reducing depression progression and symptomology where a counselor could refer a client for epigenetic antidepressant treatments.

Maternal Depression

Maternal prenatal depression may program the postnatal HPA axis in infants’ responses to the caretaking environment. Such programming may result in decreased expression of certain genes associated with lesser DNA methylation in infants, depending on which trimester maternal depression was most severe, and increased HPA reactivity (Devlin et al., 2010). Further, Devlin et al. discovered that maternal depression in the second trimester affected newborns’ DNA methylation patterns. However, the authors offered key limitations in their study, namely the sample was predominantly male and depressive characteristics differed based on age. Conradt et al. (2016) reported that prenatal depression in mothers may be associated with higher DNA methylation in infants. However, maternal sensitivity (i.e., ability of mother to respond to infants’ needs positively, such as positive touch, attending to distress, and basic social-emotional needs) toward infants buffered the extent of methylation, which points to environmental influences. This finding highlights the risk of infant exposure to maternal depression in conjunction with maternal sensitivity. Yet, overall, the evidence suggests that epigenetic mechanisms are at play across critical periods—prenatal, postnatal, and beyond—that have implications for offspring. When a fetus or offspring experiences adverse conditions, such as maternal depression, there is an increased likelihood of “impaired cognitive, behavioral, and social functioning . . . [including] psychiatric disorders throughout the adult life” (Vaiserman & Koliada, 2017, p. 1). For the practicing counselor, we suggest that clinical work with expecting mothers has the potential to reduce such risk based on these epigenetic findings.

Schizophrenia

Accumulated evidence suggests that schizophrenia arises from the interaction between genetics and the client’s environment (Smigielski et al., 2020). Epigenetics is considered a mediator between a client’s genetics and environment with research showing moderate support for this position. DNA methylation, histone modifications, mRNA, and miRNA epigenetic mechanisms have been linked with schizophrenia (Boks et al., 2018; Cheah et al., 2017; Okazaki et al., 2019).

DNA methylation is a main focus in schizophrenia epigenetic research (Cariaga-Martinez & Alelú-Paz, 2018). For example, Fisher et al. (2015) conducted a longitudinal study investigating epigenetic differences between monozygotic twins who demonstrated differences in psychotic symptoms; at age 12, one twin was symptomatic and the other was asymptomatic. Fisher et al. found DNA methylation differences between these twins. The longitudinal twin study design allowed for the control of genetic contributions to the outcome as well as other internal and external threats. Further, it pointed to a stronger association between epigenetics and schizophrenia.

From a clinical perspective, Ma et al. (2018) identified a potential epigenetic biomarker for detecting schizophrenia. The authors were able to identify three specific miRNAs that may work in combination as a biomarker for the condition. According to the authors, this finding may be helpful in the future for diagnosis and monitoring treatment outcomes. We speculate that future counselors may have

biomarker tests conducted as part of the diagnostic process and in monitoring treatment effectiveness with alternation in miRNA levels.

Addiction

In addictions, a diversity of epigenetic mechanisms have been identified (e.g., DNA methylation, histone acetylation, mRNA, miRNA) across various substance use disorders: cocaine, amphetamine, methamphetamine, and alcohol (Hamilton & Nestler, 2019). Moreover, these epigenetic processes have been hypothesized to contribute to the addiction process by mediating seeking behaviors via dopamine in the neurological system. Also, Hamilton and Nestler (2019) found that epigenetic mechanisms have the potential to combat addiction processes, but further research is needed.

Cadet et al. (2016) conducted a review of cocaine, methamphetamine, and epigenetics in animal models (mice and rats). Chronic cocaine use was linked with histone acetylation in the dopamine system and DNA methylation for both chronic and acute administrations. They concluded that epigenetics may be a facilitating factor for cocaine abuse. Others have supported this conclusion for cocaine specifically, in that cocaine alters the chromatin structure by increasing histone acetylation, thereby temporarily inducing addictive behaviors (Maze & Nestler, 2011; Tsankova et al., 2007). From a treatment perspective, Wright et al. (2015) reported, in a sample of rats, that an injected methyl supplementation appeared to attenuate cocaine-seeking behavior when compared to the control group associated with cocaine-induced DNA methylation.

Regarding methamphetamines, during their review, Cadet et al. (2016) discovered that there were only a few extant studies on epigenetics and methamphetamines. Numachi et al. (2004) linked extended use of methamphetamines to changes in DNA methylation patterns, which seemed to increase vulnerability to neurochemical effects. More recently, Jayanthi et al. (2014) discovered that chronic methamphetamine use in rats induced histone hypoacetylation, making it more difficult for transcription to occur and potentially supporting the addiction process. To counter this histone hypoacetylation, the authors treated the mice with valproic acid, which inhibited the histone hypoacetylation. This study may evidence potential psychopharmacological treatments in the future at the epigenetic level for methamphetamine addiction.

H. Zhang and Gelernter (2017) reviewed the literature on DNA methylation and alcohol use disorder (AUD) and found mixed results. The authors discovered that individuals with an AUD exhibited DNA hypermethylation and hypomethylation in a variety of promoter regions. They also noted generalization limitations due to small tissue samples from the same regions of postmortem brains. They suggested that DNA methylation may account for “missing heritability” (p. 510) among individuals with AUDs.

Histone deacetylation has also been connected to chromatin closing or silencing for chronic users of alcohol, which may be involved in the maintenance of an AUD. Palmisano and Pandey (2017) suggested that there are epigenetic mediating factors between comorbidity of AUDs and anxiety disorders. On a positive note, exercise has been found to have opposite epigenetic modifications when comparing a healthy exercise group to a group who experience AUDs in terms of DNA methylation at CpG sites (Chen et al., 2018). Thus, counselors may incorporate such aspects in psychoeducation when recommending exercise in goal setting and other treatment interventions.

To summarize, epigenetics has been linked to several disorders such as anxiety, stress, depression, schizophrenia, and addiction (Albert et al., 2019; Cadet et al., 2016; Lester et al., 2016; Palmisano & Pandey, 2017; Smigielski et al., 2020). DNA methylation and miRNA may have mediating effects for mental health concerns such as anxiety (Harris & Seckl, 2011; Romens et al., 2015). Additionally,

epigenetic mediating effects have also been discovered in major depressive disorder, maternal depression, and addiction (Albert et al., 2019; Conradt et al., 2016; Hamilton & Nestler, 2019). Moreover, epigenetic imprinting has been associated with trauma and stress, as found in Holocaust survivors and their children (Yehuda et al., 2016). Overall, “evidence accumulates that exposure to social stressors in [childhood], puberty, adolescence, and adulthood can influence behavioral, cellular, and molecular phenotypes and . . . are mediated by epigenetic mechanisms” (Pishva et al., 2014, p. 342).

Implications

A key aim in providing a primer on epigenetics, specifically the coaction between a client’s biology and environment on gene expression, is to illuminate opportunities for counselors to prevent and intervene upon mental health concerns. This is most relevant based on the evidence that epigenetic processes change over a client’s lifetime because of environmental influences, meaning that the client is not in a fixed state per traditional gene theory (Nestler et al., 2016). Epigenetics provides an alternate view of nature and nurture, demonstrating that epigenetic tags may not only be influenced by unfavorable environmental influences (e.g., maternal depression, trauma, bullying, child abuse and neglect) but also by favorable environments and activities (e.g., mindfulness, CBT, exercise, diet, nurturing; Chaix et al., 2020; Chen et al., 2018; Conradt et al., 2016; Roberts et al., 2015; Stevens et al., 2018). Understanding the flexibility of epigenetics has the potential to engender hope for our clients and to guide our work as counselors and counselor educators, because our genetic destinies are not fixed as we once theorized in gene theory.

Bioecological Conceptualization: Proximal and Distal Impact and Interventions

The impact of epigenetics on the counseling profession can be understood using Bronfenbrenner’s (1979) bioecological model. The bioecological model conceptualizes a client’s function over time based on the coaction between the client and their environment (Broderick & Blewitt, 2015; Jones & Tang, 2015). The client’s environment can have both beneficial and deleterious proximal and distal effects. These effects are like concentric rings around the client, which Bronfenbrenner called “subsystems.” The most proximate subsystem is the *microsystem*, the environment that has a direct influence on the client, such as parents, teachers, classmates, coworkers, relatives, etc. The next level is the *mesosystem*, in which the micro entities interact with one another or intersect with influence on the client (e.g., school and home intersect to influence client’s thinking and behavior). The next system, called the *exosystem*, begins the level of indirect influence. This may include neighborhood factors such as the availability of fresh produce, safe neighborhoods, social safety net programs, and employment opportunities. The last subsystem is the *macrosystem*. This system consists of the cultural norms, values, and biases that influence all other systems. The final aspect of this model, called the *chronosystem*, takes into account development over time. The chronosystem directs the counselor’s attention to developmental periods that have differing risks and opportunities, or what can be called “critical” developmental periods.

Below we conceptualize epigenetic counseling implications using Bronfenbrenner’s model but simplify it by grouping systems: proximal effects (micro/meso level) labeled as micro effects and distal effects (exo/macro level) labeled as macro effects. We will also apply the chronosystem by focusing on critical developmental periods that are salient when applying epigenetics to counseling. Ultimately, our central focus is the client and the concentric influences of micro and macro effects. To begin, we will first focus on the important contribution of epigenetics during the critical developmental period of 0 to 5 years of age with implications at the micro and macro levels.

Epigenetics Supports Early Life Span Interventions

Though the evidence does support epigenetic flexibility across a client's life span, we know that early adverse life events may alter a child's epigenome with mediating effects on development and behavior (Lester & Marsit, 2018). We also know that epigenetic processes are most active in the first 5 years of life (Mulligan, 2016; Syzf et al., 2016). These early insults to the genome may elicit poor mental health into adulthood such as anxiety, depression, schizophrenia, and addiction. For example, a client who grew up in an urban environment with a traditionally marginalized group status and parents who experienced drug dependence has an increased risk for schizophrenia above and beyond the genetic, inherited risk. These adverse childhood experiences have the potential to modify the epigenome, increasing the likelihood of developing mental health concerns, including schizophrenia (Cariaga-Martinez & Alelú-Paz, 2018).

At the micro level, the caregiver can be a salutary effect against adverse environmental conditions (Oberlander et al. 2008; Weaver et al., 2005). Prenatally, counseling can work with parents before birth to generate healthy coping strategies (e.g., reduce substance abuse), flexible and adaptive caregiver functioning, and effective parenting strategies. An example of this is to use parent-child interactive therapy (PCIT) pre-clinically, or before the child evidences a disorder (Lieneman et al., 2017). Preventive services using PCIT have been documented as effective with externalizing behaviors, child maltreatment, and developmental delays. Additional micro-level interventions can be found in the use of home-visiting programs to improve child outcomes prenatally to 5 years of age where positive parenting and other combined interventions are utilized to improve the health of mother, father, and child (Every Child Succeeds, 2019; Healthy Families New York, 2021).

Clinically, epigenetics points to earlier care and treatment to prevent the emergence of mental disorders (e.g., major depressive disorder, schizophrenia). Also, epigenetic research has provided evidence that environmental change can be equally important as client change. Regarding treatment planning, examining the client's individual level factors or microsystem (e.g., physical health, mental status, education, race, gender) as well as their macrosystem (e.g., social stigma, poverty, housing quality, green space, pollution) may be crucial before considering what kind of modifications and/or interventions are most appropriate. For example, if a 9-year-old White female presents to a counselor for behavioral concerns in school, it is important for the counselor to gather a holistic life history to build an informed picture of the many variables collectively impacting the child's behavior at each level. At the micro level, a counselor will evaluate for childhood maltreatment, but from an epigenetic lens, other proximal environmental factors could be important to screen for such as poverty, maternal depression, nutrition, classroom dynamics, and exercise (McEwen & McEwen, 2017; Mulligan, 2016). If the 9-year-old child is experiencing parental neglect and food insecurity, the clinician can treat the client's individual needs at the micro level (i.e., working with the family system to overcome any neglect by using treatments such as PCIT, and direct referral to social workers and other agencies to provide food and shelter to meet basic needs).

The science of epigenetics may also inform action taken during assessment and case conceptualization based on the coaction of environment with a client over time. Although intervention at 0–5 years of age is most preventative, it is not practical in all cases. Using assessments that collect information on an adult client's early life may help inform case conceptualization and allow the integration of epigenetics into counseling theories to better understand the etiology of a client's presenting problem(s). For example, using an adverse childhood experiences assessment may help identify individuals at higher risk of epigenetic concerns. Epigenetics highlights the impact of client–

environment interaction and its influence (positive or negative) on overall health. Additionally, early life adversity increases the likelihood of poor health outcomes such as heart disease, anxiety, and depression. However, these poor consequences could be mediated by talking with clients about the importance of exercise and its benefit on epigenetics and, by extension, mental health.

At the macro level, examples could include the reduction of hostile environments (e.g., institutional racism, neighborhood violence, limited employment opportunities, low wages, air pollutants, water pollutants), advocacy for statutes, regulations to decrease instability such as unfair housing in low-income neighborhoods, establishing partnerships in the development of community-based and school-based prevention programs, and applying early interventions such as mindfulness to reduce the effects of stress (Chaix et al., 2020). To illustrate, postnatal depression symptom severity has been associated with residential stability (Jones et al., 2018). By developing policies that would increase housing security, a reduction in maternal depression symptom severity could potentially reduce the DNA methylation that is associated with upregulation of the HPA and child reactivity, but this would need to be investigated further for confirmation. According to Rutten et al. (2013), this change may also increase the resiliency of children by reducing their experience of chronic stress, as sustained maternal depression severity often impacts caregiving because of unstable housing.

Although members of the counseling profession have known the significance of early intervention for years, this epigenetic understanding confirms why human growth and development is a core component of our counseling professional identity (Remley & Herlihy, 2020) and provides a supporting rationale for our efforts. Additionally, epigenetic tags have the potential to cross generations via the process of imprinting (Yehuda et al., 2016). This has potential implications across the life span.

In summary, critical developmental periods must be a focal point for counseling interventions, necessitating upstream action rather than our current dominant approach of downstream activities and a shift toward primary prevention over predominantly tertiary prevention. Such primary prevention would reduce stress and trauma for children before signs and symptoms become apparent and attend to the development and sustainability of healthy environments that would increase both client and community wellness.

Epigenetics Supports Counseling Advocacy and Social Justice Efforts

When reflecting on the implications of epigenetics, it is apparent that place, context, and the client's environment are critical factors for best positioning them for healthy outcomes, engendering a push for advocacy and social justice for clients. Because environments have no boundaries, it is important to think of advocacy across many systems: towns, counties, states, countries, and the world. This reinforces the call for counselors and counselor educators to move beyond the walls of their workplaces in order to collaborate within the larger mental health field (e.g., clinical mental health, school, marriage and family, addiction, rehabilitation). Additionally, said knowledge compels connection with other professions—such as social workers, physicians, psychologists, engineers, housing developers, public health administrators, and members of nonprofit and faith-based organizations, etc.—to enact change on a wider scale and to improve the conditions for clients at a systemic level.

This collaboration also calls for engaging at local and international levels. Global human rights issues such as sex trafficking cross countries, regions, and local communities and necessitate collaboration to ameliorate these practices and the associated trauma. For starters, the American Counseling Association and the International Association for Counseling could partner with other organizations such as the Child Defense Fund to assist in meeting their mission to level the playing field for all children in the United

States. At the local level, counselors and counselor educators could collaborate with local children's hospitals and configure a plan to meet common goals to improve children's health and wellness.

Counseling Research and Epigenetics

Research primarily affects clients on a macro level but can trickle down to directly engage clients within our clinical work and practice. Counselors and counselor educators can partner with members of other disciplines to further the work with epigenetic biomarkers (e.g., depression and DNA methylation). Counseling researchers can also investigate how talk therapy and other adjuncts, such as diet and exercise, may improve our clients' treatment outcomes. As counseling researchers, we can develop research agendas around intervention and prevention for those 0–5 years of age and create and evaluate programs for this age group while also creating community partnerships as noted above. An example of this partnership is The John Hopkins Center for Prevention and Early Intervention. The creators of this program developed sustainable partnerships with public schools, mental health systems, state-level educational programs, universities, and federal programs to focus on early interventions that are school-based and beyond. They collaborated to develop, evaluate, and deliver a variety of programs and research activities to improve outcomes for children and adolescents. They have created dozens of publications based on these efforts that help move the discipline forward. In one such publication, Guintivano et al. (2014) looked at epigenetic and genetic biomarkers for predicting suicide.

Counselor Education, CACREP, and Epigenetics

The counselor educational system affects clients distally but also holds implications for the work counselors conduct at the client level. Counselor educators can provide a more robust understanding of epigenetics to counseling students across the counselor education curriculum. These efforts can include introducing epigenetics in theories, diagnosis, treatment, human and family development, practicum and internship, assessment, professional orientation, and social and cultural foundations courses. By assisting counseling students to comprehend the relationship between client and environment, as well as the importance of prevention, educators will increase their students' ability to carry out a holistic approach with clients and attend to the foundational emphases of the counseling profession on wellness and prevention. Moreover, by learning to include epigenetics in case conceptualization, students can gain a more robust understanding of the determinants of symptomology, potential etiology at the cellular level, and epigenetically supported treatments such as CBT and mindfulness.

It is fairly simple to integrate epigenetics education into programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015). To begin, counselor educators can integrate epigenetics education into professional counseling orientation and ethical practice courses. As counselor educators discuss the history and philosophy of the counseling profession, particularly from a wellness and prevention lens (CACREP, 2015, 2.F.1.a), counselor educators can discuss the connection between epigenetics and wellness. Wellness is a foundational value for the counseling profession and is a part of the definition of counseling (Kaplan et al., 2014). Many wellness models (both theoretical and evidence-based) are rooted in the promotion of a holistic balance of the client in a variety of facets and contexts (Myers & Sweeney, 2011). We can continue to support these findings by integrating epigenetics within our conversations about wellness, as we have epigenetic evidence that the positive or negative coaction between the individual and their environment can impact a person toward increased or decreased wellness.

Counselor educators can also integrate epigenetics education into Social and Cultural Diversity and Human Growth and Development courses. Within Social and Cultural Diversity courses, counselor educators can address how negative environmental conditions have negative influences on offspring.

This is evidenced by the discrimination against Jews and its imprinting that crosses generations (Yehuda et al., 2016). Counselor educators can discuss how discrimination and barriers to positive environmental conditions can impact someone at the epigenetic level (CACREP, 2015, 2.F.2.h). Within Human Growth and Development, counselor educators can discuss how the study of epigenetics provides us a biological theory to understand how development is influenced by environment across the life span (CACREP, 2015, 2.F.3.a, c, d, f). In particular, it can provide an etiology of how negative factors change epigenetic tags, which are correlated with negative mental health that may become full-blown mental health disorders later in adulthood (CACREP, 2015, 2.F.3.c, d, e, g).

Additionally, counselor educators can integrate epigenetic education within specialty counseling areas. Several studies (Maze & Nestler, 2011; Palmisano & Pandey, 2017; Tsankova et al., 2007; Wong et al., 2011; H. Zhang & Gelernter, 2017) have noted how epigenetic mechanisms may support the addiction process and counselor educators can interweave this information when discussing theories and models of addiction and mental health problems (CACREP, 2015, 5.A.1.b; 5.C.1.d; 5.C.2.g). Counselor educators can also discuss epigenetics as it applies to counseling practice. Because epigenetics research supports treatments like CBT, mindfulness, nutrition, and exercise (Chaix et al., 2020; Chen et al., 2018; Roberts et al., 2015; Stevens et al., 2018), counselor educators can address these topics in courses when discussing techniques and interventions that work toward prevention and treatment of mental health issues (CACREP, 2015, 5.C.3.b).

Generally, CACREP (2015) standards support programs that infuse counseling-related research into the curriculum (2.E). We support the integration of articles, books, websites, and videos that will engender an understanding of epigenetics across the curriculum, so long as the integration supports student learning and practice.

Conclusion and Future Directions

In summary, there are numerous epigenetic processes at work in the symptoms we attend to as counselors. We have provided information that illustrates how epigenetics may mediate outcomes such as depression, anxiety, schizophrenia, and addiction. We have also illustrated how CBT, exercise, diet, and meditation may have positive epigenetic influences supporting our craft. We have discovered that epigenetic processes are most malleable in early life. This information offers incremental evidence for our actions as professional counselors, educators, and researchers, leading to a potential examination of our efforts in areas of prevention, social justice, clinical practice, and counseling program development. However, we must note that epigenetics as a science is relatively new and much of the research is correlational.

Based on the current limits of epigenetic science and a lack of investigation of mental health epigenetics in professional counseling, one of our first recommendations for future research efforts is to collaborate across professions with other researchers such as geneticists, as we did for this manuscript. From this partnership, our profession's connection to epigenetics is elucidated. Interdisciplinary collaboration allows the professional counselor to offer their expertise in mental health and the geneticist their deep understanding of epigenetics and the tools to examine the nature and nurture relationships in mental health outcomes. We can also make efforts to look at our wellness-based preventions and interventions to document changes at the epigenetic level in our clients and communities. Ideally, as the science of epigenetics advances, we will have epigenetic research in our profession of counseling that is beyond correlation and evidences the effectiveness of our work down to the cellular level.

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References

- Albert, P. R., Le François, B., & Vahid-Ansari, F. (2019). Genetic, epigenetic and posttranscriptional mechanisms for treatment of major depression: The 5-HT_{1A} receptor gene as a paradigm. *Journal of Psychiatry & Neuroscience*, 44(3), 164–176. <https://doi.org/10.1503/jpn.180209>
- Arnaud, P. (2010). Genomic imprinting in germ cells: Imprints are under control. *Reproduction*, 140(3), 411–423. <https://doi.org/10.1530/REP-10-0173>
- Benoit, L., & Turecki, G. (2010). The epigenetics of suicide: Explaining the biological effects of early life environmental adversity. *Archives of Suicide Research*, 14(4), 291–310. <https://doi.org/10.1080/13811118.2010.524025>
- Benros, M. E., Nielsen, P. R., Nordentoft, M., Eaton, W. W., Dalton, S. O., & Mortensen, P. B. (2011). Autoimmune diseases and severe infections as risk factors for schizophrenia: A 30-year population-based register study. *The American Journal of Psychiatry*, 168(12), 1303–1310. <https://doi.org/10.1176/appi.ajp.2011.11030516>
- Bocchio-Chiavetto, L., Maffioletti, E., Bettinsoli, P., Giovannini, C., Bignotti, S., Tardito, D., Corrada, D., Milanese, L., & Gennarelli, M. (2013). Blood microRNA changes in depressed patients during antidepressant treatment. *European Neuropsychopharmacology*, 23(7), 602–611. <https://doi.org/10.1016/j.euroneuro.2012.06.013>
- Boks, M. P., Houtepen, L. C., Xu, Z., He, Y., Ursini, G., Maihofer, A. X., Rajarajan, P., Yu, Q., Xu, H., Wu, Y., Wang, S., Shi, J. P., Hulshoff Pol, H. E., Strengman, E., Rutten, B. P. F., Jaffe, A. E., Kleinman, J. E., Baker, D. G., Hol, E. M., . . . Kahn, R. S. (2018). Genetic vulnerability to DUSP22 promoter hypermethylation is involved in the relation between in utero famine exposure and schizophrenia. *Nature Partner Journals Schizophrenia*, 4(1), 1–8. <https://doi.org/10.1038/s41537-018-0058-4>
- Broderick, P. C., & Blewitt, P. (2015). *The life span: Human development for helping professionals* (4th ed.). Pearson.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.
- Brooker, R. J. (2017). *Genetics: Analysis and principles* (6th ed.). McGraw-Hill.
- Cadet, J. L., McCoy, M. T., & Jayanthi, S. (2016). Epigenetics and addiction. *Clinical Pharmacology & Therapeutics*, 99(5), 502–511. <https://doi.org/10.1002/cpt.345>
- Cariaga-Martinez, A., & Alelú-Paz, R. (2018). Epigenetic and schizophrenia. In F. Durbano (Ed.), *Psychotic disorders - An update* (pp. 147–162). IntechOpen. <https://doi.org/10.5772/intechopen.73242>
- Chaix, R., Fagny, M., Cosin-Tomás, M., Alvarez-López, M., Lemee, L., Regnault, B., Davidson, R. J., Lutz, A., & Kaliman, P. (2020). Differential DNA methylation in experienced meditators after an intensive day of mindfulness-based practice: Implications for immune-related pathways. *Brain, Behavior, and Immunity*, 84, 36–44. <https://doi.org/10.1016/j.bbi.2019.11.003>
- Champagne, F. A. (2010). Early adversity and developmental outcomes: Interaction between genetics, epigenetics, and social experiences across the life span. *Perspectives on Psychological Science*, 5(5), 564–574. <https://doi.org/10.1177/1745691610383494>
- Cheah, S.-Y., Lawford, B. R., Young, R. M., Morris, C. P., & Voisey, J. (2017). mRNA expression and DNA methylation analysis of serotonin receptor 2A (*HTR2A*) in the human schizophrenic brain. *Genes*, 8(1), 1–11. <https://doi.org/10.3390/genes8010014>
- Chen, J., Hutchinson, K. E., Bryan, A. D., Filbey, F. M., Calhoun, V. D., Claus, E. D., Lin, D., Sui, J., Du, Y., & Liu, J. (2018). Opposite epigenetic associations with alcohol use and exercise intervention. *Frontiers in Psychiatry*, 9(594), 1–12. <https://doi.org/10.3389/fpsy.2018.00594>
- Cohen, J. L., Jackson, N. L., Ballestas, M. E., Webb, W. M., Lubin, F. D., & Clinton, S. M. (2017). miR-101a-3p and Ezh2 modulate anxiety-like behavior in high-responder rats. *European Journal of Neuroscience*, 46(7), 2241–2252.

- Conradt, E., Hawes, K., Guerin, D., Armstrong, D. A., Marsit, C. J., Tronick, E., & Lester, B. M. (2016). The contributions of maternal sensitivity and maternal depressive symptoms to epigenetic processes and neuroendocrine functioning. *Child Development*, 87(1), 73–85. <https://doi.org/10.1111/cdev.12483>
- Council for Accreditation of Counseling and Related Educational Programs. (2015). 2016 CACREP standards. <http://www.cacrep.org/wp-content/uploads/2017/08/2016-Standards-with-citations.pdf>
- Devlin, A. M., Brain, U., Austin, J., & Oberlander, T. F. (2010). Prenatal exposure to maternal depressed mood and the MTHFR C677T variant affect SLC6A4 methylation in infants at birth. *PloS ONE*, 5(8), e12201. <https://doi.org/10.1371/journal.pone.0012201>
- Every Child Succeeds. (2019). 2019 report to the community. <https://static1.squarespace.com/static/5df9251a492ba56bc96bc96f/t/5e73b2a333e8127c09daabf2/1584640684722/Final2019Report.pdf>
- Fisher, H. L., Murphy, T. M., Arseneault, L., Caspi, A., Moffitt, T. E., Viana, J., Hannon, E., Pidsley, R., Burrage, J., Dempster, E. L., Wong, C. C. Y., Pariante, C. M., & Mill, J. (2015). Methylomic analysis of monozygotic twins discordant for childhood psychotic symptoms. *Epigenetics*, 10(11), 1014–1023. <https://doi.org/10.1080/15592294.2015.1099797>
- Gejman, P. V., Sanders, A. R., & Kendler, K. S. (2011). Genetics of schizophrenia: New findings and challenges. *Annual Review of Genomics and Human Genetics*, 12, 121–144. <https://doi.org/10.1146/annurev-genom-082410-101459>
- Guintivano, J., Brown, T., Newcomer, A., Jones, M., Cox, O., Maher, B. S., Eaton, W. W., Payne, J. L., Wilcox, H. C., & Kaminsky, Z. A. (2014). Identification and replication of a combined epigenetic and genetic biomarker predicting suicide and suicidal behaviors. *The American Journal of Psychiatry*, 171(12), 1287–1296. <https://doi.org/10.1176/appi.ajp.2014.14010008>
- Haggarty, S. J., & Tsai, L.-H. (2011). Probing the role of HDACs and mechanisms of chromatin-mediated neuroplasticity. *Neurobiology of Learning and Memory*, 96(1), 41–52. <https://doi.org/10.1016/j.nlm.2011.04.009>
- Hamilton, P. J., & Nestler, E. J. (2019). Epigenetics and addiction. *Current Opinion in Neurobiology*, 59, 128–136. <https://doi.org/10.1016/j.conb.2019.05.005>
- Harris, A., & Seckl, J. (2011). Glucocorticoids, prenatal stress and the programming of disease. *Hormones and Behavior*, 59(3), 279–289. <https://doi.org/10.1016/j.yhbeh.2010.06.007>
- Healthy Families New York. (2021, January 4). [Website.] <https://www.healthyfamiliesnewyork.org>
- Heijmans, B. T., Tobi, E. W., Stein, A. D., Putter, H., Blauw, G. J., Susser, E. S., Slagboom, P. E., & Lumey, L. H. (2008). Persistent epigenetic differences associated with prenatal exposure to famine in humans. *Proceedings of the National Academy of Sciences*, 105(44), 17046–17049. <https://doi.org/10.1073/pnas.0806560105>
- Huang, W.-C., Ferris, E., Cheng, T., Hörndli, C. S., Gleason, K., Tamminga, C., Wagner, J. D., Boucher, K. M., Christian, J. L., & Gregg, C. (2017). Diverse non-genetic, allele-specific expression effects shape genetic architecture at the cellular level in the mammalian brain. *Neuron*, 93(5), 1094–1109.e7. <https://doi.org/10.1016/j.neuron.2017.01.033>
- Januar, V., Ancelin, M.-L., Ritchie, K., Saffery, R., & Ryan, J. (2015). BDNF promoter methylation and genetic variation in late-life depression. *Translational Psychiatry*, 5, e619. <https://doi.org/10.1038/tp.2015.114>
- Jayanthi, S., McCoy, M. T., Chen, B., Britt, J. P., Kourrich, S., Yau, H.-J., Ladenheim, B., Krasnova, I. N., Bonci, A., & Cadet, J. L. (2014). Methamphetamine downregulates striatal glutamate receptors via diverse epigenetic mechanisms. *Biological Psychiatry*, 76(1), 47–56. <https://doi.org/10.1016/j.biopsych.2013.09.034>
- Jones, D. E., & Tang, M. (2015). Health inequality: What counselors need to know to act. In *Ideas and research you can use: VISTAS 2015*. https://www.counseling.org/docs/default-source/vistas/article_60785a22f16116603abcacff0000bee5e7.pdf?sfvrsn=4
- Jones, D. E., Tang, M., Folger, A., Ammerman, R. T., Hossain, M. M., Short, J. A., & Van Ginkel, J. B. (2018). Neighborhood effects on PND symptom severity for women enrolled in a home visiting program. *Community Mental Health Journal*, 54(4), 420–428. <https://doi.org/10.1007/s10597-017-0175-y>
- Kaplan, D. M., Tarvydas, V. M., & Gladding, S. T. (2014). 20/20: A vision for the future of counseling: The new consensus definition of counseling. *Journal of Counseling & Development*, 92, 366–372. https://www.counseling.org/docs/default-source/20-20/2020-jcd-article-consensus-definition.pdf?sfvrsn=76017f2c_2
- Lester, B. M., Conradt, E., & Marsit, C. (2016). Introduction to the special section on epigenetics. *Child Development*, 87(1), 29–37. <https://doi.org/10.1111/cdev.12489>

- Lester, B. M., & Marsit, C. J. (2018). Epigenetic mechanisms in the placenta related to infant neurodevelopment. *Epigenomics*, 10(3), 321–333. <https://doi.org/10.2217/epi-2016-0171>
- Lewis, B. P., Burge, C. B., & Bartel, D. P. (2005). Conserved seed pairing, often flanked by adenosines, indicates that thousands of human genes are microRNA targets. *Cell*, 120(1), 15–20. <https://doi.org/10.1016/j.cell.2004.12.035>
- Lieneman, C. C., Brabson, L. A., Highlander, A., Wallace, N. M., & McNeil, C. B. (2017). Parent–child interaction therapy: Current perspectives. *Psychology Research and Behavior Management*, 10, 239–256. <https://doi.org/10.2147/PRBM.S91200>
- Lüscher, B., & Möhler, H. (2019). Brexanolone, a neurosteroid antidepressant, vindicates the GABAergic deficit hypothesis of depression and may foster resilience. *F1000Research*, 8(May), 1–14. <https://doi.org/10.12688/f1000research.18758.1>
- Ma, J., Shang, S., Wang, J., Zhang, T., Nie, F., Song, X., Zhao, H., Zhu, C., Zhang, R., & Hao, D. (2018). Identification of miR-22-3p, miR-92a-3p, and miR-137 in peripheral blood as biomarker for schizophrenia. *Psychiatry Research*, 265, 70–76. <https://doi.org/10.1016/j.psychres.2018.03.080>
- Maze, I., & Nestler, E. J. (2011). The epigenetic landscape of addiction. *Annals of the New York Academy of Sciences*, 1216(1), 99–113. <https://doi.org/10.1111/j.1749-6632.2010.05893.x>
- McEwen, C. A., & McEwen, B. S. (2017). Social structure, adversity, toxic stress, and intergenerational poverty: An early childhood model. *Annual Review of Sociology*, 43, 445–472. <https://doi.org/10.1146/annurev-soc-060116-053252>
- McGowan, P. O., Sasaki, A., D'Alessio, A. C., Dymov, S., Labonté, B., Szyf, M., Turecki, G., & Meaney, M. J. (2009). Epigenetic regulation of the glucocorticoid receptor in human brain associates with childhood abuse. *Nature Neuroscience*, 12(3), 342–348. <https://doi.org/10.1038/nn.2270>
- Monk, C., Spicer, J., & Champagne, F. A. (2012). Linking prenatal maternal adversity to developmental outcomes in infants: The role of epigenetic pathways. *Development and Psychopathology*, 24(4), 1361–1376. <https://doi.org/10.1017/S0954579412000764>
- Mulligan, C. J. (2016). Early environments, stress, and the epigenetics of human health. *Annual Review of Anthropology*, 45(1), 233–249. <https://doi.org/10.1146/annurev-anthro-102215-095954>
- Myers, J. E., & Sweeney, T. J. (2011). Wellness counseling: The evidence base for practice. *Journal of Counseling & Development*, 86(4), 482–493. <https://doi.org/10.1002/j.1556-6678.2008.tb00536.x>
- National Human Genome Research Institute. (2020). *Epigenomics fact sheet*. <https://www.genome.gov/about-genomics/fact-sheets/Epigenomics-Fact-Sheet>
- Nestler, E. J., Peña, C. J., Kundakovic, M., Mitchell, A., & Akbarian, S. (2016). Epigenetic basis of mental illness. *The Neuroscientist*, 22(5), 447–463. <https://doi.org/10.1177/1073858415608147>
- Numachi, Y., Yoshida, S., Yamashita, M., Fujiyama, K., Naka, M., Matsuoka, H., Sato, M., & Sora, I. (2004). Psychostimulant alters expression of DNA methyltransferase mRNA in the rat brain. *Annals of the New York Academy of Sciences*, 1025(1), 102–109. <https://doi.org/10.1196/annals.1316.013>
- Oberlander, T. F., Weinberg, J., Papsdorf, M., Grunau, R., Misri, S., & Devlin, A. M. (2008). Prenatal exposure to maternal depression, neonatal methylation of human glucocorticoid receptor gene (NR3C1) and infant cortisol stress responses. *Epigenetics*, 3(2), 97–106. <https://doi.org/10.4161/epi.3.2.6034>
- Okazaki, S., Otsuka, I., Numata, S., Horai, T., Mouri, K., Boku, S., Ohmori, T., Sora, I., & Hishimoto, A. (2019). Epigenetic clock analysis of blood samples from Japanese schizophrenia patients. *npj Schizophrenia*, 5(9), 1–7. <https://doi.org/10.1038/s41537-019-0072-1>
- Ouellet-Morin, I., Wong, C. C. Y., Danese, A., Pariante, C. M., Papadopoulos, A. S., Mill, J., & Arseneault, L. (2013). Increased serotonin transporter gene (SERT) DNA methylation is associated with bullying victimization and blunted cortisol response to stress in childhood: A longitudinal study of discordant monozygotic twins. *Psychology of Medicine*, 43(9), 1813–1823. <https://doi.org/10.107/S0033291712002784>
- Palmisano, M., & Pandey, S. C. (2017). Epigenetic mechanisms of alcoholism and stress-related disorders. *Alcohol*, 60, 7–18. <https://doi.org/10.1016/j.alcohol.2017.01.001>
- Perroud, N., Paoloni-Giacobini, A., Prada, P., Olié, E., Salzmann, A., Nicastro, R., Guillaume, S., Mouthon, D., Stouder, C., Dieben, K., Huguelet, P., Courtet, P., & Malafosse, A. (2011). Increased methylation of glucocorticoid receptor gene (NR3C1) in adults with a history of childhood maltreatment: A link with the severity and type of trauma. *Translational Psychiatry*, 1, e59. <https://doi.org/10.1038/tp.2011.60>

- Pishva, E., Kenis, G., van den Hove, D., Lesch, K.-P., Boks, M. P. M., van Os, J., & Rutten, B. P. F. (2014). The epigenome and postnatal environmental influences in psychotic disorders. *Social Psychiatry and Psychiatric Epidemiology*, 49, 337–348. <https://doi.org/10.1007/s00127-014-0831-2>
- Provençal, N., & Binder, E. B. (2015). The effects of early life stress on the epigenome: From the womb to adulthood and even before. *Experimental Neurology*, 268, 10–20. <https://doi.org/10.1016/j.expneurol.2014.09.001>
- Remley, T. P., Jr., & Herlihy, B. (2020). *Ethical, legal, and professional issues in counseling* (6th ed.). Pearson.
- Roberts, S., Keers, R., Lester, K. J., Coleman, J. R. I., Breen, G., Arendt, K., Blatter-Meunier, J., Cooper, P., Creswell, C., Fjermestad, K., Havik, O. E., Herren, C., Hogendoorn, S. M., Hudson, J. L., Krause, K., Lyneham, H. J., Morris, T., Nauta, M., Rapee, R. M., . . . Wong, C. C. Y. (2015). HPA axis related genes and response to psychological therapies: Genetics and epigenetics. *Depression and Anxiety*, 32(12), 861–870. <https://doi.org/10.1002/da.22430>
- Rodgers, A. B., Morgan, C. P., Bronson, S. L., Revello, S., & Bale, T. L. (2013). Paternal stress exposure alters sperm microRNA content and reprograms offspring HPA stress axis regulation. *Journal of Neuroscience*, 33(21), 9003–9012. <https://doi.org/10.1523/JNEUROSCI.0914-13.2013>
- Romens, S. E., McDonald, J., Svaren, J., & Pollak, S. D. (2015). Associations between early life stress and gene methylation in children. *Child Development*, 86(1), 303–309. <https://doi.org/10.1111/cdev.12270>
- Rutten, B. P. F., Hammels, C., Geschwind, N., Menne-Lothmann, C., Pishva, E., Schruers, K., van den Hove, D., Kenis, G., van Os, J., & Wichers, M. (2013). Resilience in mental health: Linking psychological and neurobiological perspectives. *Acta Psychiatrica Scandinavica*, 128(1), 3–20. <https://doi.org/10.1111/acps.12095>
- Saavedra, K., Molina-Márquez, A. M., Saavedra, N., Zambrano, T., & Salazar, L. A. (2016). Epigenetic modifications of major depressive disorder. *International Journal of Molecular Sciences*, 17(8), 1279. <https://doi.org/10.3390/ijms17081279>
- Shimada-Sugimoto, M., Otowa, T., & Hettema, J. M. (2015). Genetics of anxiety disorders: Genetic epidemiological and molecular studies in humans. *Psychiatry and Clinical Neurosciences*, 69(7), 388–401. <https://doi.org/10.1111/pcn.12291>
- Smearman, E. L., Almli, L. M., Conneely, K. N., Brody, G. H., Sales, J. M., Bradley, B., Ressler, K. J., & Smith, A. K. (2016). Oxytocin receptor genetic and epigenetic variations: Association with child abuse and adult psychiatric symptoms. *Child Development*, 87(1), 122–134. <https://doi.org/10.1111/cdev.12493>
- Smigielski, L., Jagannath, V., Rössler, W., Walitza, S., & Grünblatt, E. (2020). Epigenetic mechanisms in schizophrenia and other psychotic disorders: A systematic review of empirical human findings. *Molecular Psychiatry*, 25, 1718–1748. <https://doi.org/10.1038/s41380-019-0601-3>
- Stevens, A. J., Rucklidge, J. J., & Kennedy, M. A. (2018). Epigenetics, nutrition and mental health: Is there a relationship? *Nutritional Neuroscience*, 21(9), 602–613. <https://doi.org/10.1080/1028415X.2017.1331524>
- Suderman, M., Borghol, N., Pappas, J. J., Pinto Pereira, S. M., Pembrey, M., Hertzman, C., Power, C., & Szyf, M. (2014). Childhood abuse is associated with methylation of multiple loci in adult DNA. *BMC Medical Genomics*, 7, 1–12. <https://doi.org/10.1186/1755-8794-7-13>
- Szyf, M. (2009). The early life environment and the epigenome. *Biochimica et Biophysica Acta*, 1790(9), 878–885. <https://doi.org/10.1016/j.bbagen.2009.01.009>
- Szyf, M., Tang, Y.-Y., Hill, K. G., & Musci, R. (2016). The dynamic epigenome and its implications for behavioral interventions: A role for epigenetics to inform disorder prevention and health promotion. *Translational Behavioral Medicine*, 6(1), 55–62. <https://doi.org/10.1007/s13142-016-0387-7>
- Szyf, M., Weaver, I., & Meaney, M. (2007). Maternal care, the epigenome and phenotypic differences in behavior. *Reproductive Toxicology*, 24(1), 9–19. <https://doi.org/10.1016/j.reprotox.2007.05.001>
- Tsankova, N., Renthal, W., Kumar, A., & Nestler, E. J. (2007). Epigenetic regulation in psychiatric disorders. *Nature Reviews Neuroscience*, 8, 355–367. <https://doi.org/10.1038/nrn2132>
- Turecki, G. (2014). Epigenetics and suicidal behavior research pathways. *American Journal of Preventive Medicine*, 47(3), S144–S151. <https://doi.org/10.1016/j.amepre.2014.06.011>
- Vaiserman, A. M., & Koliada, A. K. (2017). Early-life adversity and long-term neurobehavioral outcomes: Epigenome as a bridge? *Human Genomics*, 11(34), 1–15. <https://doi.org/10.1186/s40246-017-0129-z>
- Weaver, I. C. G., Champagne, F. A., Brown, S. E., Dymov, S., Sharma, S., Meaney, M. J., & Szyf, M. (2005). Reversal of maternal programming of stress responses in adult offspring through methyl supplementation: Altering epigenetic marking later in life. *Journal of Neuroscience*, 25(47), 11045–11054. <https://doi.org/10.1523/JNEUROSCI.3652-05.2005>

- Wong, C. C. Y., Mill, J., & Fernandes, C. (2011). Drugs and addiction: An introduction to epigenetics. *Addiction*, 106(3), 480–489. <https://doi.org/10.1111/j.1360-0443.2010.03321.x>
- Wright, K. N., Hollis, F., Duclot, F., Dossat, A. M., Strong, C. E., Francis, T. C., Mercer, R., Feng, J., Dietz, D. M., Lobo, M. K., Nestler, E. J., & Kabbaj, M. (2015). Methyl supplementation attenuates cocaine-seeking behaviors and cocaine-induced c-Fos activation in a DNA methylation-dependent manner. *The Journal of Neuroscience*, 35(23), 8948–8958. <https://doi.org/10.1523/JNEUROSCI.5227-14.2015>
- Yehuda, R., Daskalakis, N. P., Bierer, L. M., Bader, H. N., Klengel, T., Holsboer, F., & Binder, E. B. (2016). Holocaust exposure induced intergenerational effects on FKBP5 methylation. *Biological Psychiatry*, 80, 372–380. <https://doi.org/10.1016/j.biopsych.2015.08.005>
- Yehuda, R., Engel, S. M., Brand, S. R., Seckl, J., Marcus, S. M., & Berkowitz, G. S. (2005). Transgenerational effects of posttraumatic stress disorder in babies of mothers exposed to the World Trade Center attacks during pregnancy. *The Journal of Clinical Endocrinology & Metabolism*, 90(7), 4115–4118. <https://doi.org/10.1210/jc.2005-0550>
- Zhang, H., & Gelernter, J. (2017). Review: DNA methylation and alcohol use disorders: Progress and challenges. *The American Journal on Addictions*, 26(5), 502–515. <https://doi.org/10.1111/ajad.12465>
- Zhang, T.-Y., & Meaney, M. J. (2010). Epigenetics and the environmental regulation of the genome and its function. *Annual Review of Psychology*, 61, 439–466. <https://doi.org/10.1146/annurev.psych.60.110707.163625>
- Zheng, J., & Xiao, X. (2016). Epigenetic modifications and developmental origin of health and diseases (DOHaD). In Y. Dincer (Ed.), *Epigenetics: Mechanisms and clinical perspectives* (pp. 1–14). Nova Biomedical.

Lifetime Achievement in Counseling Series

An Interview With Michael Ryan



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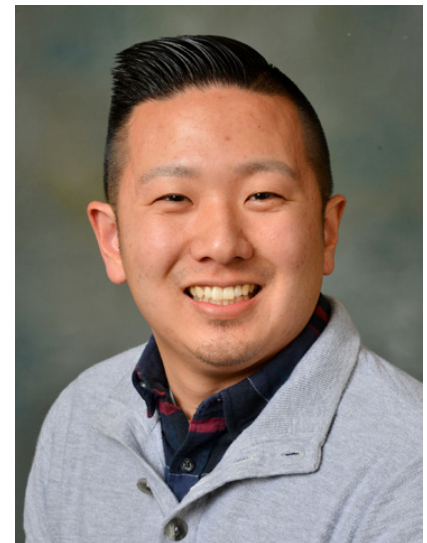
Joshua D. Smith, Neal D. Gray

Each year TPC presents an interview with a seminal figure in counseling as part of its Lifetime Achievement in Counseling series. This year I am honored to introduce Michael Ryan. He identifies as a professional school counselor and advocate and shares his experiences and perspective on the professionalization of school counseling. I am grateful to Dr. Joshua Smith and Dr. Neal Gray, who continue to bring the contributions and vision of leaders in the profession to TPC readers. Their interview with Ryan provides a view to his path to school counseling, his work to meet the needs of underrepresented student populations, and how he empowers students and staff as agents of change and in so doing promotes a clear understanding of the roles and responsibilities of professional school counselors within his community. I imagine his approach may both resonate with and energize TPC readers.

—Amie A. Manis, Editor

Michael Ryan, MEd, NCC, is a certified school counselor and currently is the Coordinator of Student Supports for Monongalia County Schools in Morgantown, West Virginia. He holds a BA in psychology from West Virginia University, an MEd with a school counseling concentration from California University of Pennsylvania, and a higher education certification from Salem International University with his Principal, District Administrator, and Superintendent certification.

Prior to his current position, Ryan was an elementary school counselor for 6 years in Monongalia County. During that time, he was named the 2018 West Virginia School Counselor of the Year. He also did work in career counseling at a college as well as community mental health counseling prior to becoming a school counselor.



In Ryan's current position, he is responsible for providing student supports for almost 12,000 students in the county across Pre-K through 12th grade. He has been instrumental in coordinating social-emotional learning practices for the county and helping to implement a multi-tiered system of supports (MTSS) model that looks at the whole student and is consistent from school to school. He is the head of the Diversity, Equity, and Inclusion Department of the county, which he had the privilege of building from the ground up. He is also responsible for providing professional development to the county staff in areas such as social-emotional learning, trauma-informed practices, and diversity and inclusion.

Ryan is an active member of the surrounding community and multiple organizations, through which he builds relationships to help find support for the students of the county. He is a part of the West Virginia School Counseling Association governing board and a member of the American School Counselor Association.

In this interview, Ryan shares his insights on growth and change within the school counseling profession, his path to becoming a school counselor, his passion for advocacy, and the importance of unified practices to benefit each person in the community.

1. What led you to pursue a degree in counseling compared to other helping professions?

I didn't have a typical path to my career. I was one of those students coming out of high school who didn't really have an idea of what I wanted to do. I went to a small, rural high school and didn't have a lot of exposure to things. Sports were pretty much my life, and when I was deciding on majors, I went through the sports programs and settled on sports management because it made the most sense to me at that time. I ended up going to West Virginia University (WVU) because it was close to home and I was around WVU all my life. My family had season tickets to the football games, and those were some of the earliest memories that I have. It was my second home.

After my first year at WVU, I ended up taking a year off. I was very lost on what I wanted to do for the rest of my life, and nothing made sense to me. Every time someone brought something up as a suggestion, I struggled because I couldn't picture myself doing any of those things. I knew I didn't want to do something that wasn't going to make me happy.

During this time Texas hold 'em poker was big. I remember being intrigued by it and wanting to learn how to play. I started out playing for fun online with fake money, but eventually I started to play with real money. I had no idea what I wanted in life, but gambling gave me an escape from the real world, whether I won or lost (I lost more than I won). This year off was not a productive year for me, and I ended up becoming addicted to gambling and losing all the money that I had. It was at the point where I needed to borrow money from my friends that I realized I had a problem. I knew I couldn't keep going down the road I was on and I needed a change of scenery.

Then, I watched the movie *Ladder 49* and all of a sudden, I had this urge to be a firefighter. So, I applied to fire school in Fairfax, Virginia, but it wasn't meant to be—I failed the physical test by 2 seconds. So, I decided to go back to school, and I transferred to George Mason University for a year. Even though it was only a year, it allowed me to learn a lot about myself and who I was as a person. I had removed myself from the negative people in my life and learned I wanted more for myself. I still didn't know what I wanted to do, but I knew I wanted to do something that was fulfilling and helpful to people.

I ended up changing my major in my undergraduate degree seven times before finally choosing psychology. In all honesty, I think I chose that at the time because it was the quickest way to graduation. I had no idea what I was going to do with a psychology degree, but I was intrigued by it. I had thought about going into human resources and even went on a couple of interviews before listening to my mother's suggestion to apply to the WVU hospitals and their mental health hospital.

My first job after graduating was as a mental health specialist. I enjoyed the work that I was doing, but I knew that I couldn't make a career out of it. So, with the support and encouragement of my girlfriend (now wife), I applied to graduate school to get my master's degree in counseling. I was hesitant at first because the road to my undergraduate degree was long, but I knew this was what I wanted to do. I have a love and passion for working with people and helping make a difference in their lives, which led me to my counseling degree. I went the school counseling path because I felt like I could make a difference early on in a child's life. From there, the rest is history.

2. As a school counselor, you created a comprehensive school counseling program from the ground up. What were the challenges, barriers, and supports during that time?

Some of the challenges that I faced—and I think a lot of school counselors face when starting or creating something—was changing the perception of school counselors. We always hear the term *guidance counselor* instead of *school counselor*, and while they are the same in some ways, they are also very different. As the profession and practice of school counseling have evolved, the roles and responsibilities of counselors in schools have expanded, and this is reflected in the title of *professional school counselor*. Currently, the profession is trying to move away from the title of guidance counselor. It is outdated and does not represent what school counselors do. When people think of a guidance counselor, they may think of or remember someone that helps you schedule classes and apply to colleges, but the role of the school counselor has expanded far beyond that. School counselors look at ways that we can help students grow. Data is a big component of the work that we do. School counselors can look at academics, attendance, needs assessment data, and student screener data and determine what interventions the school can put in place to help students succeed. These interventions can include group counseling, individual counseling, or participating in a school program (e.g., mentoring program). As you can see, school counselors do more than people think when they hear the title guidance counselor. Everyone must be mindful of this when starting to implement a comprehensive school counseling program. You will likely discover a need to help the community and school personnel understand that not only the title but also the services a professional school counselor can offer have expanded, and the title of guidance counselor is no longer appropriate.

I had to do a lot of explaining and advocating for my role in the school. I had to explain what my true role was and what I could do for administrators, teachers, and families and their students. I had to demonstrate that I could do more than facilitate groups and guidance lessons. To have a comprehensive school counseling program, you need data to drive the work you are doing. I had to show how data could make a difference in the interventions with students. School counselors cannot effectively do their job without the support of the school administration and staff. Data allows us to demonstrate that our interventions are effective in supporting student achievement and development.

Another challenge was trying to stay the course. Creating a program does not happen overnight, and it requires a lot of time and attention. I had to keep reminding myself of the end goal and that there would be days that were harder to deal with, but my end goal was still the same: to have a comprehensive school counseling program. But there were days where I was doing a lot of administrative work that made it tougher. I knew if I kept at it that I would get there. It took 4 years for me to fully create a comprehensive school counseling program.

The process was made easier by the support from the administrators and staff that I worked with. They saw the need for the program and knew how impactful it could be in the students' lives. I can honestly say that without the staff I would not have gotten anywhere close to where I wanted to be.

3. In your view, what can be done, or needs to change, to address or overcome these challenges and barriers?

As school counselors, we need to continue to advocate for our profession and the work that we do. If we sit back and don't speak up, then nothing is going to change—the same things will be done year in and year out. We can't be afraid of the reaction and responses that we may get. The answer is always going to be "no" to the question we never ask.

I also think that as school counselors it is our job to help shape and mold future school counselors. I encourage all school counselors, once you are settled in and ready, to work with local colleges and universities that have school counseling programs and become a supervisor for their students.

I had the pleasure of being a supervisor for students in the school counseling program at WVU for 4 years. It was an honor and privilege to work with those students. It was a way of teaching our future school counselors how to advocate for themselves, their programs, and their profession. I think it is important that we take on these roles. We need to show students how to navigate the challenges and barriers that they will experience as school counselors.

I think the biggest change needs to come from the people that we vote into office. We need to educate political leaders on our role and the job that we do. It is interesting to me that when it comes to education, people making the decisions usually have the least amount of experience. We need laws that protect our jobs and our professional roles. We need laws that require schools to have school counselors, regulate usage of time, establish a counselor ratio to number of students, etc. Having these things in place will allow school counselors to focus their time and energy on building their programs and providing supports for students.

4. When discussing systemic change and social justice, how do you view your role as a school counselor, and now the Coordinator of Student Supports, when working with school administrators, teachers, parents, and community members?

This is a very good question, especially now. I view the role of school counselors as vital and important when it comes to discussing systemic change and social justice. In education, you are always following policies. As a school counselor, I have always followed the American School Counselor Association (ASCA) ethical standards. The ASCA ethical standards state that we are ethically responsible to advocate for our students regarding equity and access. It is our role to foster an awareness and understanding of cultural diversity and to ensure that we are creating a welcoming environment for our students.

It is also our role not only to provide support for underrepresented populations in schools, but to educate our students on social justice, cultural diversity, racism, implicit bias, etc. We have an opportunity to help change the world that these students grow up and live in. We cannot be afraid to tackle these sensitive topics. They are a part of our students' world and we need to be prepared to address them.

In my role as Coordinator of Student Supports, I am able to extend my impact with our school administrators, teachers, parents, and community members. I am the county-wide chair over our Diversity, Inclusion, and Equity Committee, a new committee that I was asked to start up when I took my current position. I am very grateful and excited for this opportunity, and I plan to take full advantage of it.

When I started thinking about how I wanted the committee to look, I made sure that it was composed of administrators, teachers, parents, and community members. When we talk about change, we need input from multiple sources throughout the school and community. We need to work as one cohesive unit. I have found it beneficial to involve everyone because we gain more insight. Having parents and community members present really makes a difference because their voice is heard, and we are able to better understand the needs of our students and how to address those needs. I also think it gives stakeholders a little insight into what we are doing as a school system.

5. School counselors are often relied upon to be political advocates for students. What has been your experience as an advocate for issues such as social reform, educational policy, administrative functions, and multicultural issues? How can school counselors become more active in advocating for students?

My experiences regarding these issues have been challenging but also positive. When you discuss any of these issues you will always have two sides. I have always advocated for the best interest of the students; I always want what is best for them. I may be a little different in that I advocate, but I also try and look at the bigger picture. I think so many times when people say they are advocating for one thing or another it can become one-sided. They are only advocating and focusing on the one side. I always take the approach that I need to advocate but also to listen and educate.

I always wanted to understand perspectives from both sides. I felt this always helped me advocate better for students. For example, when it comes to multicultural issues or social reform, I always want to know why some people feel that multicultural issues may not be as big of a deal as they are, or why others feel social reform isn't necessary. If I can stop and listen to both sides, then when I advocate for my students, I have a better understanding of where there seems to be a gap. For me that is how I have been most successful as an advocate. I know I can't go in with an agenda and tell parents or community members how they are wrong about things, because then they will become defensive and all is lost; but if I go in and have a conversation, then in the end it is more productive.

I think that's important for students to see, too. It is important to show students that things are not always going to be how you want them to be. Life is not always going to be kind to you, but keeping a calm head and being able to have constructive conversations will go further than screaming and yelling back and forth.

School counselors can be more active in advocating for students by making sure to speak up when the opportunity presents itself. Advocating does not always need to be on a big stage with politicians involved. I will say that most of the advocating I did for my students was in my office on phone calls or in meetings with parents. Sometimes the small battles are more impactful than the big ones.

6. Has advocacy changed or shifted with COVID-19? What additional challenges or concerns have emerged due to remote and virtual learning experiences?

In the situation we are currently living in, with COVID-19 and schools facing decisions of going back to school or staying in a remote setting, I think it is more important than ever to continue to advocate for our students and their needs. A lot of the discussions we hear are about academics and students falling behind academically, which I am not going to argue against. I do not think that our focus should be on academics right now, and my job in advocating for students is to make sure that their social and emotional needs are being met. That is where I will advocate our time and resources need to be spent.

Kids are resilient, but that does not mean that we should act like nothing happened and try and get our students to catch back up academically. We need to check on our students and make sure they are okay and that time is built in throughout their day where they can be a kid and have time to have their social and emotional needs met. That is how I will continue advocating for students during the time we are in, by making sure we do not put social and emotional needs on the back burner—that they are constantly being discussed and things are being put into place to address them.

7. What has been your experience when interacting with national and local organizations, such as ACA, ASCA, etc.? Do you feel supported by professional organizations and leaders, and has this changed throughout your career?

I love our national organizations. I do not think that I could feel any more supported by these professional organizations. I was always skeptical and hesitant to be a part of them due to experiences with non-counseling organizations that left a bad taste in my mouth. With those past organizations, I felt that I was just paying a yearly subscription but not getting anything for it.

I would recommend the American Counseling Association (ACA) or ASCA to anyone that is contemplating membership. My career has been greatly influenced by being a part of national and local organizations. I am very grateful for the opportunities that I have had because of the organizations that I have been a part of. The West Virginia School Counseling Association and ASCA each see the importance in recognizing individuals for the work that they are doing. They are helping make us better professionals through the content that they continue to provide for their members. Being able to put West Virginia School Counselor of the Year and ASCA State Representative on my résumé has been great for me because people take notice of that; they want individuals who are the best at what they do. I know if I ever need something or have a question, all I need to do is reach out to those organizational contacts and they will answer and support me and the work that I am doing.

8. Throughout your years of practice, what has been your experience when collaborating with other mental health and medical professionals?

My experiences have been positive when collaborating with other mental health and medical professionals. I think it has been that way because we are seeing each other as vital to the overall success of helping the students that we serve. It is no longer a territorial thing that it might have been in the past. We are finding ways to work together with each other and do what is best for the students.

That is how it needs to be. Not too long ago, before I was a school counselor, I did work as a mobile therapist and I had the capability to go into schools to help support the students that I served. I remember one child who I was working with had a lot of things going on at school, and that was where my focus needed to be. Well, the school did not want me coming into the school or working with the child while in school because they had concerns that there would be problems, as the resident school counselor was also working with this student, and they did not want two different therapeutic approaches being utilized with the student. It is best when you can collaborate with one another and come up with a consistent approach.

I always told myself that one of the first things I would do if I ever became a school counselor would be to build relationships within the community. I recognized the importance of working together and that one person cannot do everything. In my last few years before I took my current position, I set up opportunities for the student support staff in the school (nurses, attendance officer, school social worker, teachers, etc.) to meet and discuss the needs of the students. I would make time to connect with outside agencies to make sure that we were all on the same page and working toward the same goal. This proved to be very beneficial, and I feel that the relationships with our outside mental health and medical professionals are stronger than ever. Being in my new position has also allowed me to continue to build those relationships and coordinate not only at a school level, but at a county level that will benefit all of our schools.

9. For future school counselors, what advice would you have regarding their involvement in advancement and future development of the profession?

My advice for future school counselors is to never settle. We are living in a time where the landscape of school counseling will be changing over the next 5–10 years. I think you will see a greater importance placed on student well-being and student supports. We are understanding more about adverse childhood experiences (ACEs), trauma, brain development, and more. The need for school counselors is higher than ever.

It is up to us, and future school counselors, to step up and take on the challenge. When there is a greater importance placed on a need, it will be closely watched and monitored. If we settle in our roles and keep doing the same things, we won't be successful as a profession. School counselors have a great opportunity right now to change the landscape of our profession. We need to allow ourselves to learn and be open to new things. It is so easy to settle into what you are used to, especially when it is working. Working in the profession, you can get into a rhythm, which isn't always a good thing; sometimes we can get so used to doing the same thing that works that we keep doing it, but we aren't challenging ourselves to see if there is something else out there that works better. My go-to as a primary orientation when working with students is choice theory. I am good at it, and I could probably use that for the rest of my career, but I also know that I can't and shouldn't. Just because it works doesn't mean it is the best for everyone. There may be something better, and we need to allow ourselves to be open to that.

One of the things I've been really proud of is a mentoring program that I started. It mirrored Big Brothers Big Sisters, but I used high school students to come to the elementary school. I trained the students and matched students up based on their shared interests. It was very successful and worked for 3 years. Going into my fourth year, I could have kept things the same, but I knew my results could be better. I changed the age group and some of the activities and had better results. I didn't keep doing something just because it worked; I looked at how to make it better.

Another thing I used to always tell my interns is to not be afraid to take risks. Whenever we are open to trying new things, it opens up a door of possibilities. It makes us even better at what we do. We need to allow ourselves to get to that point. When I was building my program, there were a lot of risks that I had to take. Failure is okay. It means that you tried something. Too many times our fear of failure stops us from trying, but I encourage not only future but current school counselors to take risks and see where it takes you.

This concludes the sixth interview for the annual Lifetime Achievement in Counseling Series. TPC is grateful to Joshua D. Smith, PhD, NCC, LCMHC, LCASA, and Neal D. Gray, PhD, LCMHC-S, for providing this interview. Joshua D. Smith is a counselor at the Center for Emotional Health in Concord, North Carolina. Neal D. Gray is a professor and Chair of the School of Counseling and Human Services at Lenoir-Rhyne University. Correspondence can be emailed to Joshua D. Smith at jsmit643@uncc.edu.



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