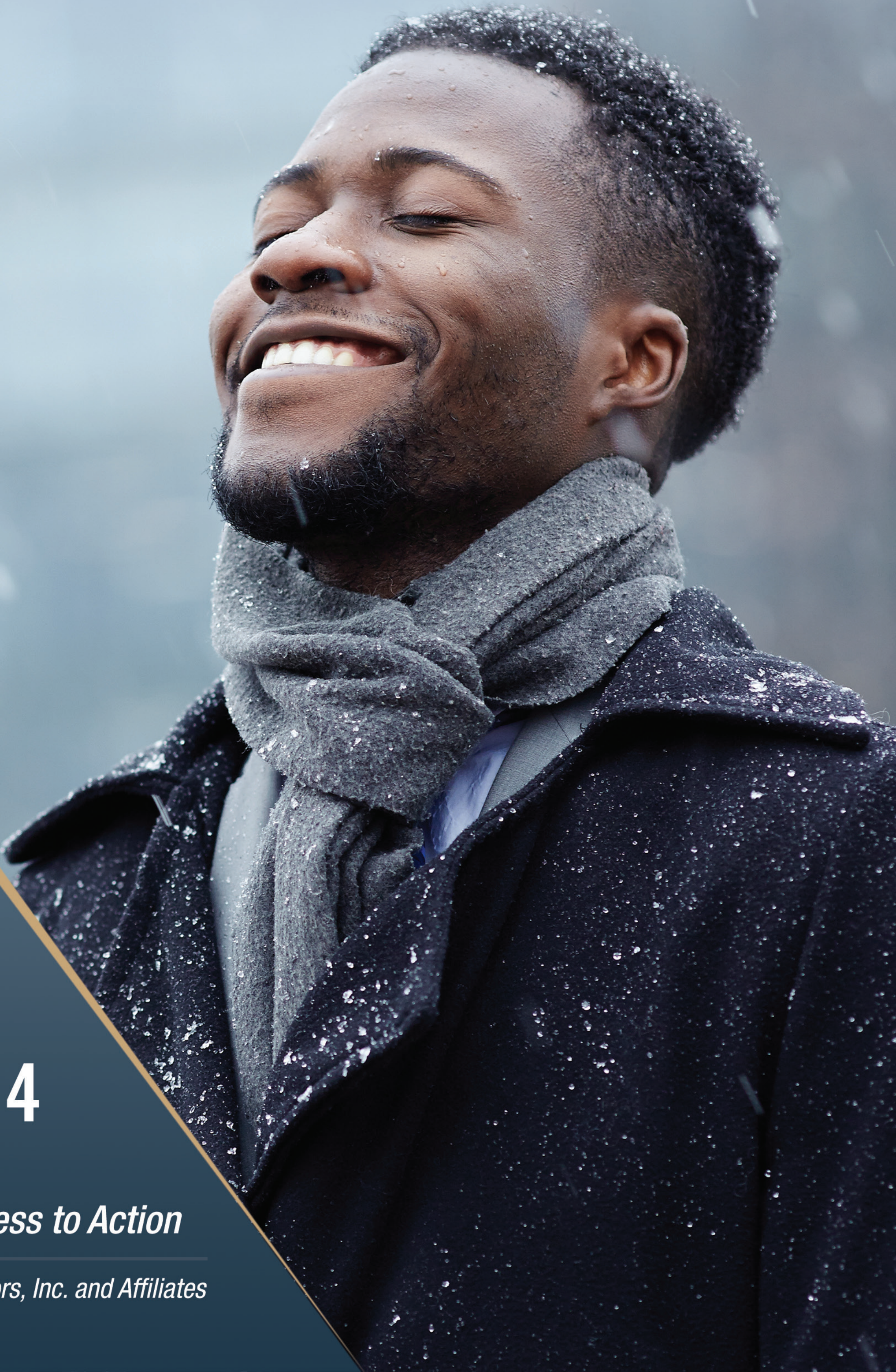
The Professional Counselor™



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Special Issue

Bridging the Gap: From Awareness to Action

From the *National Board for Certified Counselors, Inc. and Affiliates*

The Professional Counselor (*TPC*) is the official journal of the National Board for Certified Counselors, Inc. and Affiliates (NBCC), dedicated to publishing original and innovative peer-reviewed research and scholarship in an electronic, open-access format to inform counselors and members of related helping professions.

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Jennifer M. Cook, Camille Y. Humes

This special issue of *The Professional Counselor* (*TPC*) is in honor of the NBCC Foundation (NBCCF)'s 2023 Bridging the Gap Symposium: Eliminating Mental Health Disparities. The theme for the 2023 Symposium, *From Awareness to Action*, represented the importance of attendee reflection on current issues and the need for intentional engagement in meaningful work that empowers underserved and never-served clients and communities. The event was attended by over 500 counselors and counselors-in-training who connected with peers and had the opportunity to learn from presenters of 70 sessions. Unique to this year's Symposium was the celebration of the 10th anniversary of the Minority Fellowship Program (MFP). Members of the inaugural cohort, affectionately known as the *Dream Team*, came together to share memories of receiving their awards and spent time engaging in discussions about their remarkable contributions to the counseling profession over the past decade.

In this special edition of *TPC*, guest editors from the first and second cohorts of the MFP reviewed submissions and selected articles for publication. Keeping the 2023 Symposium theme in mind, we worked hard to ensure that the articles in this issue reflect the purpose and vision of the event. Submissions covered a wide range of topics that provided perspectives about mental health disparities across diverse populations. Our hope is that this issue, like Symposium, will provoke thought and promote action.

We divided the articles in this issue into two sections: The first section is comprised of articles that align with the special issue theme but were not presented at Symposium. The second section is comprised of articles that were written by authors who presented at this year's Symposium and transformed their presented work into articles.

The three articles in the first section of this issue are those that align with the Symposium's theme. Although the authors of these articles did not present at Symposium, we think you will find what the authors share captures the Symposium's purpose beautifully. In "'A Learning Curve': Counselors' Experiences Working With Sex Trafficking," the authors present findings from their qualitative study with clinicians who work with clients who have experienced sex trafficking to offer recommendations for working with this population. "Ableist Microaggressions, Disability Characteristics, and Nondominant Identities" reveals how ableist microaggressions manifest most frequently for people with a range of disabilities and sociocultural identities, and the authors suggest ways to better support clients with disabilities. In the third article of the issue, "Using the Cultural Formulation Interview with Afro Latinx Immigrants in Counseling: A Practical Application," the authors utilize a case study to demonstrate how to use this assessment tool with an Afro Latinx immigrant client from Mexico.

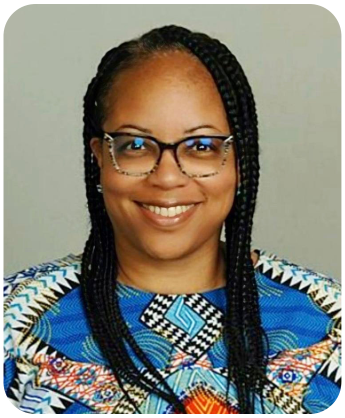
In the second section of the issue, "Diondre Also Has Bad Days: Cannabis Use and the Criminalization of Black Youth" and "Utilizing Collective Wisdom: Ceremony-Assisted Treatment for Native and Non-Native Clients" introduce readers to communities, concepts, and skills with which they may be less familiar. The authors convey clearly that counselors must develop these skills in order to serve populations who are in need of their identity-affirming, empathetic services. In "Diondre Also Has Bad Days," the author challenges readers to examine how they treat Black and

White youth and to overcome potentially biased approaches that have traditionally served one group more affirmatively than the other. "Ceremony-Assisted Treatment for Native and Non-Native Clients" presents readers with intervention options that integrate Indigenous practices, such as smudging and drumming.

The final three articles in the second section are "*Taking Action*: Reflections on Forming and Facilitating a Peer-Led Social Justice Advocacy Group," "Comorbidity of Obsessive-Compulsive Disorder in Youth Diagnosed With Oppositional Defiant Disorder," and "Bridging the Gap Between Intentions and Impact: Understanding Disability Culture to Support Disability Justice." In "Reflections on Forming and Facilitating a Peer-Led Social Justice Advocacy Group," the authors provide their individual insights about their experiences as students who established a social justice advocacy group for peers in their counseling program. "Comorbidity of Obsessive-Compulsive Disorder in Youth Diagnosed With Oppositional Defiant Disorder" gives readers insight into the complexity of distinguishing between OCD and ODD in youth and the potential for misdiagnosis, while "Bridging the Gap Between Intentions and Impact" offers counseling professionals strategies for competent care and allyship for disabled clients through a disability justice framework.

As you read the articles in this issue, we hope you will accept the opportunity to discover new ways to engage in the profession and to reflect on the *why* behind your commitment to your work. May this special issue serve as an inspiration for lifelong learning and lasting impact in the spaces where it is needed the most.

Jennifer M. Cook, PhD, NCC, ACS, LPC, is an associate professor in the Department of Counseling at the University of Texas at San Antonio. Dr. Cook is a multiculturally focused counselor educator who utilizes strength-based methods, culturally relevant practices, and social justice advocacy in her work and teaching. Her research focuses on counselor preparation and counselor cultural competence development, with emphasis on social class, socioeconomic status, and multiple identities. Dr. Cook has published extensively, completed over 40 national and international peer-reviewed presentations, and will publish a co-edited multicultural counseling textbook, *Multicultural and Social Justice Counseling: A Systemic, Person-Centered, and Ethical Approach*, later this year. Dr. Cook is a 2013 NBCC doctoral Minority Fellowship Program recipient, part of the *Dream Team* cohort.



Camille Y. Humes, EdD, NCC, LCPC (IL), LPC (MI), I/ECMH-C, is an assistant professor in the School of Counseling at Divine Mercy University in Sterling, Virginia. Dr. Humes holds an Endorsement® from the Michigan Association for Infant Mental Health, where she currently serves on the Board of Directors. For over 20 years Dr. Humes has worked as a counselor, mental health consultant, and leader in the mental health profession, advocating both nationally and internationally to inform policies that support mental health services. She is a writer, professor, and a regular grant reviewer for the United States Department of Education. Dr. Humes enjoys speaking to audiences about various topics, including the social/emotional health of young children.

“A Learning Curve”: Counselors’ Experiences Working With Sex Trafficking

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**Claudia G. Interiano-Shiverdecker, Devon E. Romero,
Katherine E. McVay, Emily Satel, Kendra Smith**

In this transcendental phenomenological study, we interviewed 10 counselors who have clinical experience working with sex trafficking survivors. Through in-depth individual interviews, participants discussed their lived experiences providing counseling to this population. Our analysis revealed four primary themes: (a) counselor knowledge: “learning curve,” (b) counselor skills: “creating a safe space to dive into work,” (c) counselor attitudes: “being able to listen to the client’s story,” and (d) counselor action: “more than just a counselor.” The findings indicated that counselors working with sex trafficking survivors needed to understand and address the different aspects of trauma. Our findings also demonstrate that working with sex trafficking survivors requires additional competencies such as recognizing the signs of sex trafficking, vulnerable populations, and the processes by which traffickers force people into sex trafficking. We discuss these findings in more detail and identify implications for counselor training and practice.

Keywords: **sex trafficking survivors, counseling, phenomenological, trauma, competencies**

Sex trafficking of any individual is a significant concern globally. In 2000, the United States government enacted the Victims of Trafficking and Violence Protection Act of 2000, which defined sex trafficking as “the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery” or “when the person induced to perform such act has not attained 18 years of age” (§ 103). Although the United States’s efforts fully meet the minimum standards established by the Victims of Trafficking and Violence Protection Act of 2000 to eliminate severe forms of trafficking, the Department of Justice initiated a total of 210 federal human trafficking prosecutions in 2020, of which 195 involved predominantly sex trafficking (U.S. Department of State, 2021). As stated in the *Trafficking in Persons Report* (U.S. Department of State, 2021), all 50 states, the District of Columbia, and U.S. territories have reported all forms of human trafficking over the past 5 years. With an estimated 4.8 million people victimized by sex trafficking (International Labour Organization, 2017), it is important to understand how counselors identify, provide services to, and advocate on behalf of sex trafficking survivors within the counseling setting.

Sex Trafficking and Mental Health

As a form of human trafficking, sex trafficking exposes individuals to torture; kidnapping; and severe psychological, physical, and sexual abuse. Physical health consequences of sex trafficking include general health complications (e.g., malnutrition), reproductive health consequences (e.g., sexually transmitted diseases, unwanted pregnancies), substance abuse, and physical injuries (Grosso et al., 2018; Lutnik, 2016; Muftić & Finn, 2013). Psychological abuses are numerous and can include intimidation, threats against loved ones, lies, deception, blackmail, isolation, and forced dependency (Thompson & Haley, 2018).

Claudia G. Interiano-Shiverdecker, PhD, LPC-A, is an assistant professor at the University of Texas at San Antonio. Devon E. Romero, PhD, LPC, NCC, is an assistant professor at the University of Texas at San Antonio. Katherine E. McVay, PhD, LPC, is an assistant professor at Texas A&M University–Corpus Christi. Emily Satel is a graduate of the master’s program in clinical mental health counseling at the University of Texas at San Antonio. Kendra Smith is a graduate of the master’s program in clinical mental health counseling at the University of Texas at San Antonio. Correspondence may be addressed to Claudia G. Interiano-Shiverdecker, College of Education and Human Development, One UTSA Circle, San Antonio, TX 78249, claudia.interiano-shiverdecker@utsa.edu.

Constantly experiencing atrocious physical and psychological abuses creates mental health consequences such as depression, post-traumatic stress, dissociation, irritability, suicidal ideation, self-harm, and suicide (Cole et al., 2016; O'Brien et al., 2017). Survivors of sex trafficking may exhibit severe mental illness, including schizophrenia and psychotic disorders, increased risk of compulsory psychiatric admission, and longer duration of psychiatric hospitalizations (Oram et al., 2016). Moreover, social distancing and the global economic downturn due to the COVID-19 pandemic increased online sexual exploitation and the number of individuals vulnerable to sex trafficking (U.S. Department of State, 2021).

Because of the prevalence of sex trafficking, the health consequences that result from it, and the diverse areas in which counselors practice (e.g., community clinics, private practices, behavioral health departments, college/universities, K–12 schools), counselors must be prepared to work with sex trafficking survivors (Interiano-Shiverdecker et al., 2022, 2023; Litam, 2017, 2019; Romero et al., 2021; Thompson & Haley, 2018). Standards required by the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015) prepare counselors to demonstrate clinical competencies to address a variety of circumstances, including traumatic experiences, across various continuums of care (e.g., inpatient, outpatient). Clinical mental health counselors with specialization in substance abuse and marriage, couple, and family counseling can also address other comorbid issues typically encountered with sex trafficking clients such as substance abuse and relational difficulties (CACREP, 2015; Litam & Lam, 2020). Early incidence of sex trafficking (12–16 years for girls, 11–13 for boys and transgender youth; Franchino-Olsen, 2019) demands the attention of school counselors trained to promote the academic, career, and personal/social development of school-aged children (American School Counselor Association [ASCA], 2022; CACREP, 2015). Therefore, first-hand accounts of counselors providing services to this population can provide an overview of current needs, challenges, and recommendations for clinical practice and research.

Sex Trafficking Research in the Counseling Profession

A recent review of the literature showed increased attention to sex trafficking coverage in top-tier counseling journals. Conceptual pieces reviewed relevant information on sex trafficking, counselor awareness, and counseling implications (Browne-James et al., 2021; Burt, 2019; Litam, 2017; Thompson & Haley, 2018). Empirical studies explored counselors' attitudes toward sex trafficking (Litam, 2019; Litam & Lam, 2020), assessment for the screening of sex trafficking (Interiano-Shiverdecker et al., 2022, 2023; Romero et al., 2021), mental health treatment programs and modalities for sex trafficking (Johnson, 2020; Kenny et al., 2018; Schmidt et al., 2022; Woehler & Akers, 2022), and survivors' recovery stories (Bruhns et al., 2018). Thompson and Haley (2018) reported a need for more training and education for counselors on sex trafficking. In a study done by Litam and Lam (2020), results indicated that counselor training in sex trafficking increased awareness. As a response, Interiano-Shiverdecker et al. (2023) developed an initial list of child sex trafficking competencies for counselors.

Although these studies provide relevant information for counselors' work with sex trafficking, they do not focus on the *experience* of providing care for sex trafficking victims and survivors. Exploring counselors' experiences provides a significant breakdown of current mental health care for this population. In other words, what does providing care for this population look and feel like in reality and what competencies work when serving sex trafficking victims and survivors? Only one phenomenological study focused on this inquiry, but this study examined therapists' experiences working with foreign-national survivors of sex trafficking in the United States (Wang & Park-Taylor, 2021). Although this study presents important findings, it explored counselors' work with only a certain group of sex trafficking individuals. Despite incomplete records, most data indicate that U.S. citizens are equally vulnerable to sex trafficking. For example, the National Human Trafficking Hotline (n.d.), which maintains one of the most extensive data sets on human trafficking in the United States, indicates that U.S. citizens comprised approximately 40% of their callers. The current study seeks to expand on the work of Wang and Park-Taylor (2021) by obtaining first-hand accounts of counselors providing services to sex trafficking clients in the United States and providing an overview of needs, challenges, and recommendations for clinical practice and research. The guiding research question for this study was: What are the lived experiences of counselors working with sex trafficking survivors in the United States?

Method

Using transcendental phenomenological research, the researchers—Claudia G. Interiano-Shiverdecker, Devon E. Romero, Katherine E. McVay, Emily Satel, and Kendra Smith—sought to understand counselors' experiences working with sex trafficking survivors. A transcendental phenomenological method was best suited for this study because it allowed us to provide thick descriptions of the phenomena while employing bracketing techniques to explore participants' experiences outside of our perspectives (Hays & Singh, 2012). Utilizing Moustakas's (1994) modification of Van Kaam's method, we sought to explore the occurrences of counselors working with sex trafficking survivors and collectively met to address any biases that came up during data analysis.

Researchers as Instruments

At the time of the study, Interiano-Shiverdecker and Romero were counselor educators at a university in the Southern United States with recent sex trafficking publications and experience working with youth vulnerable to sex trafficking in community and school settings. McVay was a doctoral candidate and a licensed professional counselor who was practicing as a social–emotional wellness counselor at a private school. Satel and Smith were master's students in a clinical mental health program. Our desire to explore this topic stemmed from a limited discussion of sex trafficking in the literature and sought to include the voices of counselors. As the research team, we are all involved in a research lab dedicated to understanding sex trafficking and how counselors can better serve sex trafficking survivors. As such, we had varying levels of experience with research and engagement with sex trafficking. Satel and Smith were new to research, including topics surrounding sex trafficking. Therefore, Interiano-Shiverdecker and Romero's broader understanding of the topic could have influenced newer members. For example, Interiano-Shiverdecker assumed that codes would resemble counseling competency categories (e.g., knowledge, skills, awareness). To reduce researcher bias, we engaged in weekly debriefing meetings for approximately 5 months for ongoing discussion of our perspectives and preconceived notions throughout data analysis. We documented our biases in journals, checked in on them during meetings, and referenced participants' quotes to prevent imposing our assumptions of the data.

Participants and Sampling

After receiving IRB approval from the university, we sought participants through purposeful sampling and snowball sampling. Purposeful sampling strategies included reaching out directly via email to counselors who fit the study criteria and sending two calls for participants on an email mailing list for counselors and counselor educators (i.e., CESNET). For direct emails, McVay created a list of individuals who fit the criteria from Interiano-Shiverdecker and Romero's professional network and an internet search. We also engaged in snowball sampling methods through recruited participants involved in the study. Inclusion criteria included counselors over the age of 18, who had previously or were currently working with children or adults who had been sex trafficked. Participants confirmed meeting the inclusion criteria by responding to a demographic questionnaire before beginning the interview. Following the qualitative researcher's recommendation of sample size, we sought a range between five and 25 participants for this study (Creswell, 2013; Moustakas, 1994). Counselors who agreed to participate completed the consent forms, a demographic form, and a one-time Zoom interview. Participants received a $25 gift card for their involvement in the study. We recruited for about 5 weeks after interviewing 10 counselors. After the tenth interview was completed and we concluded the first round of analysis for all interviews, we felt that data saturation was achieved when similar codes showed up throughout the data.

The resulting participant pool consisted of 10 counselors (nine female and one male) ranging in age from 27 to 61 years ($M = 40.7$, $Mdn = 38.5$, $SD = 11.1$). Seven participants identified as White, two participants identified as Hispanic, and one participant identified as Asian. The participants also identified their employment setting: university ($n = 1$), agency ($n = 3$), and private practice ($n = 6$). Participants disclosed providing services in one or several states such as Alabama ($n = 1$), Florida ($n = 1$), Missouri ($n = 1$), Nevada ($n = 1$), North Carolina ($n = 1$), and Texas ($n = 7$). One participant also reported providing services to sex trafficking survivors in the United Kingdom. Years working with survivors of sex trafficking ranged from 1 to 13+ years, with a range of three to 50+ clients who disclosed their sex trafficking experience. One participant (Alejandra) who had worked primarily with survivors of sexual abuse did not indicate their number "since a lot of clients I have worked with do not readily admit to being sex trafficked, I'm not sure." Table 1 outlines participant demographics in more detail.

Table 1

Participant Demographics

Pseudonym	Age	Gender	Race/ Ethnicity	Work Setting	Years of Service	# ST Clients	CACREP
Kimberly	48	Female	White	Private Practice	11	30	Yes
John	38	Male	White	University	11	5	Yes
Stacy	33	Female	White	Private Practice	8	3+	Yes
Alejandra	54	Female	Hispanic	Agency	Unsure	Most of career	No
Fen	39	Female	Asian	Private Practice	5	4	Yes
Cassandra	33	Female	White	Private Practice	5	50+	Yes
Tiffany	27	Female	White	Private Practice	1	25	Yes
Amanda	29	Female	White	Private Practice	4	5	Yes
Ana	61	Female	Hispanic	Agency	13+	20	Yes
Cristina	45	Female	White	Agency	3	10+	No

Note. Years of Service = Years providing services to ST survivors; ST = Sex trafficking; CACREP = Program accredited by the Council for Accreditation of Counseling and Related Educational Programs.

Data Collection Procedures

To follow phenomenological research methods, Interiano-Shiverdecker trained the doctoral student (McVay) in conducting semi-structured interviews. The researchers developed interview questions based on the purpose of the study and from a review of the literature. Interiano-Shiverdecker and McVay completed the interviews. Following Moustakas's (1994) recommendations, the interview protocol consisted of 12 semi-structured, open-ended questions that invited an in-depth discussion of their experiences. To create our interview protocol, we reviewed current literature in counseling on sex trafficking, particularly qualitative studies (Browne-James et al., 2021; Bruhns et al., 2018; Johnson, 2020; Wang & Park-Taylor, 2021; Woehler & Akers, 2022). Based on this review and Interiano-Shiverdecker's experience in qualitative research, we decided to focus not only on counselors' experiences with working with this population but also on their perspectives on the identification, prevention, and impact of sex trafficking on their clients. The complete interview protocol can be found in the Appendix. Interviews lasted from 26 to 69 minutes in length and occurred via Zoom because data collection occurred in 2021 and it was the most appropriate medium to respect social distancing and obtain a national sample. According to our IRB approval, our data collection presented no more than minimal risks for the participants. All interview questions followed a respectful disposition using open-ended questions to engage participants. However, McVay explained before beginning the interviews that participants could stop, pause, or opt out of the interview if the questions brought too much emotional distress. No participant requested the interview to be stopped or paused. During the interviews, we used counseling skills to facilitate the conversation and to build upon the experiences discussed. We recorded and de-identified all interviews for verbatim transcription.

Participants also completed a demographic questionnaire before the interview to confirm their eligibility for the interview and obtain information on their age, gender, race/ethnicity, work setting, CACREP accreditation and degree, years working with sex trafficking survivors, and the number of clients they worked with who identified as trafficked.

Data Analysis

Utilizing Moustakas's (1994) modification of Van Kaam's data analysis, the research team engaged in the seven steps proposed by this approach. Data analysis and management relied on the use of NVivo software (Version 12). Interiano-Shiverdecker provided training in data analysis to McVay, Satel, and Smith. Interiano-Shiverdecker, McVay, Satel, and Smith engaged in the first step by individually analyzing transcripts and engaging in horizontalization of meaning units (Hays & Singh, 2012) to create in vivo codes for all nonrepetitive, nonoverlapping statements (meaning units). Second, we merged all files to determine the invariant constituents through a process of reduction and elimination. This first process of reduction allowed us to determine what was necessary and sufficient data to understand the phenomenon (Moustakas, 1994). The team then assigned themes or clusters of meaning to similar statements (third step). From the clusters of meaning, we created an initial codebook based on the discussions and findings from individual data analysis. We used the initial codebook to examine the themes against the dataset, ensuring that it was representative of participants' experiences (fourth and fifth steps). As a team, we discussed any disagreements and worked on the data until we achieved a consensus. We worked out disagreements by discussing any opposing views and voting as a group on the best decision. We subsequently created textural descriptions through participants' verbatim quotes, as well as created structural descriptions by examining the emotional, social, and cultural connections between what participants said (sixth step). Finally, we created composite textural-structural descriptions that outlined the reoccurring and prominent themes across all participants by organizing the themes into subthemes and ensuring that they represented all (if not most) participants' experiences. After this analysis, we felt we achieved data saturation. After the completion of the initial analysis, Romero reviewed the data as a peer reviewer and offered suggestions. The entire research team reviewed the suggestions and came together to incorporate them until we reached a consensus and developed the final codebook.

Strategies for Trustworthiness

To limit the effects of researcher bias, we employed several strategies for trustworthiness. These included reflexive journals, triangulation of researchers, peer debriefers, an external auditor, member checking, and thick descriptions to ensure ethical validation, credibility, transferability, confirmability, sampling adequacy, and authenticity of our analysis (Hays & Singh, 2012). We engaged in reflexive journaling and weekly bracketing meetings during our individual and group data analysis to discuss codes, potential themes, and our assumptions shadowing the participants' words. Researchers on the team brought varying levels of experience with research and the topic of sex trafficking, which we believe helped balance our subjective analysis of the data. We engaged in two rounds of member checking with the participants, one occurring after the transcription of the interviews and the second one after we wrote the themes. No participants changed the transcription of their interview or disagreed with the presentation of the themes. After the formulation of the themes from the original coding team, Romero served as a peer debriefer and reviewed the themes, key terms, and raw data, allowing participants to make recommendations on the content presented. This division in the research team allowed for another check outside of the original designated research team. An external auditor, a counselor educator with experience in conducting qualitative research, also reviewed the NVivo file and the write-up of the findings. The external auditor agreed with our data analysis procedures and presentation of the findings. He did provide suggestions to reduce the repetition of our first and second themes, which we implemented. Finally, we provide thick descriptions of our data collection and analysis procedures and present our results with direct quotes to ground our work.

Results

We identified four prevalent themes about mental health counselors' experiences with sex trafficking survivors: (a) counselor knowledge: "learning curve," (b) counselor skills: "creating a safe space to dive into work," (c) counselor attitudes: "being able to listen to the client's story," and (d) counselor action: "more than just a counselor." We use pseudonyms to present our results.

Counselor Knowledge: "Learning Curve"

All participants emphasized the importance not only of understanding trauma but also of gaining sex trafficking–specific knowledge throughout their work with survivors. Tiffany noted a "learning curve" when working with this population, despite working with trauma for most of her career. We categorized this theme into two subthemes: (a) *understanding trauma work* and (b) *understanding sex trafficking and survivors.*

Understanding Trauma Work

To work with sex trafficking, all counselors spoke about the importance of having general knowledge of trauma work. The most prominent topics included multicultural, legal, and ethical considerations. Important multicultural considerations for counselors involve understanding group differences between their clients (e.g., gender, race, age) and working from a culturally sensitive framework. Kimberly emphasized that "we really need people to not only have cultural sensitivity but also encourage those who are of other races to counsel these girls," adding that "they need someone that's like them from the same culture . . . to relate culturally to somebody." Legal implications included understanding consent, informing clients of their limits of confidentiality when assessing for risk, and their role as mandated reporters. In reference to ethical practices, consultation and supervision arose as with any other trauma work. Stacy noted that it was "important for us to talk to one another if something's going awry."

Many participants conveyed how crucial it was for them to understand healing and its complexities. Cristina shared that clients are "going to have their ups and downs," with Amanda echoing that there are "so many layers to the healing process." Kimberly felt it important to remind herself that "you're probably not going to see the seeds that you plant develop a lot of times." Another important aspect of healing trauma, mentioned by half of the sample, was understanding clients' stages of change. Stacy shared that one of her clients "went back to her hometown and relapsed immediately. And that's also a hard thing to deal with—to know that I felt like we had some good sessions . . . and then it's, 'Wait a minute. You went back to the relapse [sex trafficking].'" Cristina noted that "especially [when they're] first out and they're not quite sure, that pre-contemplation if they want to leave or stay" was very important.

Another important aspect of their work included boundaries and self-care. All participants acknowledged that at some point in their careers, it was challenging to practice healthy boundaries. Cassandra acknowledged the following when working with individuals forced into sexual acts, "I wish I could take all the ladies I've ever worked [with], that have danced on stripper poles for money, unwillingly, and just like put clothes on them and wrap them up and hug them." She added,

> [It] can get really tricky when we start answering our phone because it's an emergency all the time . . . and it'll wear you out, your batteries will wear out, and you'll end up having this dual relationship that will end up hurting her because . . . you're not her friend.

It was helpful for Cassandra to remind herself that she was not the client's parent. Rather, she shared, "when I hear things like that, I have to remind them that this is my job, this is what I do for a living." Implementing healthy professional boundaries reduced burnout and facilitated self-care. Participants highlighted activities such as meditating, doing yoga, or taking the occasional day off. The counselors heeded that self-care also included managing their caseload to limit emotionally heavy clients or seeing a personal counselor themselves, as Cassandra and Amanda respectively noted. Amanda said, "you definitely have to secure your oxygen before you can secure other people's."

Understanding Sex Trafficking and Survivors

All participants explained that working with this population required them "to understand what sex trafficking is and . . . the many different ways that it looks," as stated by John. He elaborated that "it takes many different forms and shapes," some of which may not be immediately recognized as trafficking. Participants agreed that sex trafficking can often be much more discreet than one might anticipate. Tiffany commented on media portrayals like the film *Taken,* stating that the real experience is often much less dramatic: "Listening to their stories, it's very, very subtle . . . like, if you do this then I'll pay for your college tuition . . . and then from there it gets bigger." Similarly, Cassandra noted that sex trafficking "can be, like, a bunch of underaged females, thrown in the back of a truck and trafficked across the United States" or people that "have their own residences, that don't actually live with the trafficker, or they live with a family member that's trafficking them."

Counselors learned that although anyone can be trafficked, some populations are more vulnerable. According to Fen, these populations include clients with cognitive disabilities, immigrants, emotional abuse survivors, clients with PTSD, and clients with addictions. Other populations mentioned included the LGBTQ+ population, people recently released from jail/juvenile detention centers, college students with debt, and people in financial need.

The participants' work also required them to learn how clients were recruited and what kept them from leaving sex trafficking. John and Amanda noted that many survivors knew their traffickers or were introduced to them by family, friends, or a romantic partner. Ana explained that traffickers may kidnap people from big sporting events or from opposing gang(s) or may train survivors to recruit and groom for them. She also worked with women recruited online from abroad and trafficked once they arrived in the United States. Counselors also learned about the numerous tactics used by traffickers, including the trauma bond, coercion, and control. John noted that traffickers often use manipulation: "The common theme was 'If you do this, you'd really be helping me out. You wanna see me be okay?' or 'You don't want me to go to jail, do you?'" Cassandra reported working with a client whose parents used "an odd twist on Christianity" and the principle of "respect your elders" to traffic her. Other tactics mentioned were threats of violence against survivors and their families, branding or tattooing survivors, stalking, taking survivors' IDs, gaslighting, and fear. Cassandra also observed that trafficking was "so alluring . . . there's a lot of money in that . . . so much about leaving sex trafficking is starting from zero and creating something new." Amanda recalled a client who "was very upscale and so they lived kind of a lavish lifestyle, and I could see and understand, really emphasize the struggle to like give that up," particularly when they were worried about providing for their families. Factors that forced individuals into sex trafficking were multilayered. Amanda continued, "so many other facets and like layers to this. It's like an onion."

As a result, counselors learned about the overall impact of sex trafficking on survivors' mindsets, behaviors, and presenting symptomology. As noted by Kimberly, sex trafficking impacted every aspect of survivors' lives. Tiffany noticed that many of her clients were initially very fragile and mistrusting of everyone, while Cristina and Stacy shared that it was common for their clients to display guarded and closed-off body language. John's work taught him that sex trafficking "affects [clients] in terms of intimacy and trust, and that trickles into their relationships, whether it's with family, roommates, or romantic partners." The counselors' work with sex trafficking survivors included clients with an array of presenting concerns. Cassandra observed clients with complex PTSD, substance use issues, self-harm behaviors, suicidal ideation, self-hatred, self-blame, feelings of insecurity, an inability to trust, and eating disorders. Ana also noted that clients presented with anxiety, depression, paranoia, and physical concerns such as sexually transmitted diseases (STDs) and sleep problems.

Counselor Skills: "Creating a Safe Space to Dive Into Work"

All participants recognized that because of the nature of their work and their clients, they needed to "create a safe space to dive into work," as stated by Tiffany. To do so, they needed to build skills in two main categories: (a) *assessment and ensuring safety* and (b) *processing trauma*. Amanda explained, "I think all of that stuff [assessment and ensuring safety] really has to come first before we can do any really heavy work and therapy. . . They have to be stable before they can really dig into whatever they want to dig into." Although this separation provides clarity, counselors' experiences were also more fluid, at times requiring them to use skills particular to ensuring safety while processing trauma and vice versa.

Assessment and Ensuring Safety

All counselors' experiences of assessment and ensuring safety consisted of effectively engaging with their clients during the intake interview, assessing risk, applying crisis skills, and formulating personalized treatment plans. Based on her experiences, Cristina spoke about the importance of building rapport during that initial interview: “When I do our initial assessment with them . . . I have the assessment, but I’m having a conversation with them.” She also learned to discuss confidentiality and mandated reporting with her clients to explain her role as the counselor while also giving them a choice: “I tell them straight out, like, ‘Hey, you tell me this, I have to report it, I have to call law enforcement . . . so how do you want to do it?’” Cassandra found that obtaining a thorough history of the client was a critical part of the process:

> When addressing trauma, I don’t just go back to when the trafficking started. I go all the way back, make sure that I have that thorough history, because 99 times out of a 100, from my experience, that was not the first trauma that person experienced.

Seven participants spoke about learning the signs of sex trafficking and knowing what questions to ask to obtain more information and determine a person’s exposure to sex trafficking. Amanda explained, “I don’t think I’ve ever had somebody start off within an intake session be, like, ‘Hiya, so I was trafficked.’” Participants learned to ask about phone use and the number of phones owned, the extent of drug use, sexually transmitted diseases, wanted and unwanted pregnancies, boyfriends and their ages, and sexual behaviors such as the use of a condom. When assessing, Alejandra learned to “ask questions that minimize you coming across as being shaming or judging.” At the same time, some counselors spoke about the lack of sex trafficking assessments that could facilitate this part of their work. Alejandra explained that she “did an assessment at work yesterday, and there, there are no questions about sex trafficking. . . . There are questions about abuse, but it is inferring more [about] sexual abuse, physical abuse, emotional abuse versus sex trafficking.” Fen echoed this sentiment by wishing there was a more rigorous psychosocial interview that assessed risks associated with sex trafficking because “at times people do hide and at times people don’t disclose.”

All counselors agreed that a significant aspect of ensuring safety for their clients was collaborating with clients on safety plans. Counselors took the time to develop a “well thought out” safety plan with their clients, as stated by Alejandra. Stacy explained how she helped the client brainstorm ways to feel safer, including leaving town for a while or taking steps to “create a new account, changing her look a little bit . . . getting [a] new phone number.” Collaboration was not only utilized to respect clients’ autonomy but also to instill hope—“Hope that you know that you have a future,” stated Cristina. Ana elaborated, “seeing what they want for themselves and their lives, like, where do you want to go with your life . . . if you didn’t have this going on, you know, what is it you would like to do for yourself?”

Processing Trauma

To process trauma, all counselors listed skills, interventions, and therapies they found helpful with this population. Utilizing foundational skills (e.g., reflection, open-ended questions, appropriate self-disclosure) to build rapport was the most referenced code in this section, addressed by all participants. Cristina saw the benefit of learning how “to connect very quickly.” Stacy added, “I would definitely start relying a lot more on the rapport when I work with trauma.” Counselors also found it helpful to have a toolbox that included creative approaches and interventions that helped clients reclaim power, develop a support system, improve self-esteem, build and discover resiliency, and utilize the client’s strengths. Psychoeducation, mentioned by nine participants, included teaching their clients about sex trafficking because as John explained, “clients don’t always know that they are being trafficked.” Psychoeducation of sex trafficking requires explaining fraud, force, and manipulation. Kimberly explained how a client did not think she was trafficked because her partner did not have her “locked in a closet. I don’t got chains around me. I’m not his slave . . . I get up and get myself dressed.

I go out there and meet these guys . . . I cooperate when he's taking pictures of me." To help her client reevaluate her situation, Kimberly utilized motivational interviewing–based questions such as "Would you let your sister do this?" or "What would be the benefits of leaving your situation?"

Although most counselors felt that an integrative approach to counseling worked best with sex trafficking clients, the therapies most mentioned included dialectical behavioral therapy, narrative therapy, and eye movement desensitization and reprocessing therapy. Counselors recommended individual treatment to process trauma, although four participants also mentioned family and group counseling. Fen found family therapy helpful "if the family wants to get involved in the practice" and "if there are family members who are ready to support them and come with them and who are aware of this." Other participants mentioned the benefits of providing group counseling for sex trafficking survivors. Cassandra recalled how members of a support group she facilitated "connect with each other, they know that they're not alone, they give each other honest feedback. . . . It has been super empowering." Yet Alejandra, Fen, and Tiffany found that group counseling may not be well suited for all clients. "Group therapy doesn't work really well because you know every survivor is different, and they don't want to open up in front of others until they have worked through the process for a long time," explained Fen.

Because of the nature of their work, counselors recognized that an essential skill to processing trauma was learning how to manage countertransference. Cristina spoke about how as "clinicians, we want to save all of them." For this reason, Kimberly recognized that it was important for her to understand her attachment style. Cassandra recalled nights when she would go home and "worry about [if] I am going to see this client again." Ana left sessions "shaking sometimes from those places . . . 'cause the stories I would hear." Stacy highlighted that it was also difficult at times to manage the lies. She explained, "I was a little frustrated because I knew that she was hiding things . . . obviously it just wasn't that time and that's okay." As a result, counselors found it essential to process their emotions. Kimberly explained that "if you haven't emptied your cup of all the sad, mad, bad before you come into that office with them . . . you're going to flip your lid whether it's in front of them or behind closed doors."

Counselor Attitudes: "Being Able to Listen to the Client's Story"

All participant interviews illuminated thought patterns and beliefs they needed "to listen to the client's story," as stated by John. Counselors learned to personify certain attitudes by (a) *valuing empathy and validation* and (b) *embodying a sense of safety.*

Valuing Empathy and Validation

All participants highlighted the importance of embracing a philosophy of empathy and validation in their work with clients by being warm, genuine, open-minded, patient, and nonjudgmental. Participant interviews described various mechanisms to embody these attitudes. For instance, a consistent approach they took was to respect and empower the clients' choices and, ultimately, believe in and provide client autonomy through supportive and nonjudgmental means. Ana emphasized, "I think that's huge for those whose choices were taken away. . . . It's offering them a choice, and I think that's very empowering for them." Fen echoed this message stating, "You can't push—you can definitely motivate—but you cannot just push." Kimberly learned to be patient: "You'll end up getting there eventually, just take your time. . . . You have to build that rapport and trust." Cassandra stated, "Another thing I would say is don't make any assumptions. . . . Everybody's experiences, although there are similarities, every experience is so different." Cristina described the shock value of hearing survivors' stories and how essential it was for her to remain nonjudgmental and aware of her biases. Amanda embodied "those Rogerian qualities, like that open-mindedness, empathy, warmth, genuineness, authenticity—those things are all really important to utilize when meeting with that population, or any population." Cristina provided an example of how she conveyed this to a client by saying, "I'm here if you need me. . . . There's no judgment happening, I'm just glad you're here."

Counselors also shared a philosophy that validated clients' experiences. Fen believed in "just making clients feel normal," while Cassandra noted how helpful it was for her to approach clients' behaviors as "normal reactions to abnormal situations." An important attitude communicated by John was that "they are survivors." Even though others and possibly even the client themselves might use the word victim, he found it helpful to have "the conversation about being a survivor versus a victim." Tiffany further explained, "I've noticed just in working with sex trafficking survivors . . . it seems very hard for them to say the word 'abuse' or view themselves as anything other than a victim." She found value in seeing the client as "a survivor" and teaching this perspective to the client.

Embodying a Sense of Safety

All participants embraced attitudes that created and maintained a safe environment for their clients. Fen explained that as the counselor, "you're the only safety net for that person" who provides safety and trust. Cristina reflected on a client who was still in "the life" and returned for help and services when needed. She stated, "she knows that I'm a safe person" and "this [shelter name] is her home, this is where she felt safe. But [she] knew she couldn't get out of this life yet because she wasn't ready to." Fen explained that "there is shame, there is guilt, there is fear, and apprehension of being caught . . . so, one has to make them feel safe." Some participants communicated and provided safety by creating a "homier and safer" office space or by buying a client's favorite snacks and beverages, as described by Cassandra. Alejandra spoke of establishing "an environment where it's safe to talk about taboo subjects" such as "having been a mule or whatever they did, you know, whatever sexual acts."

Six of the participants also spoke of attitudes that promoted consistency and predictability. Kimberly stated, "That's something they've never had in their life; you know, so while you're doing all this other stuff, be consistent." Several participants noted how difficult it was for their clients to have continuity with counselors. Kimberly shared:

> Counseling someone who's had this kind of trauma takes a long time . . . once you leave and can't continue that counseling process, the likelihood of them going back to the counseling is very slim to none. . . . Even though they were resistant to building that rapport with you at the same time, deep down inside they're connecting with you.

Similarly, a few participants learned to be consistent in their messages shared with clients and accessibility to clients. For instance, Stacy spoke of the need for congruency between actions and words when working with these individuals: "Trust is such a fleeting word . . . it has to be action, sometimes, speaks louder than the words."

Counselor Action: "More Than Just a Counselor"

All participants realized that working with this population required them to reevaluate their role as the counselor. They learned that clients required "more than just a counselor," as stated by Kimberly. Therefore, the fourth theme elucidated actions that counselors found necessary to help clients recover from their experiences. We categorized counselor action into two subthemes: (a) *client advocacy* and (b) *engaging with social work/workers*.

Client Advocacy

Over half of our participants spoke about the importance of advocating for clients. Cristina talked about how some clients did not have a caseworker and needed someone "that's in their corner." Counselors spoke about specific needs they advocated on behalf of clients in the life or in recovery. Kimberly spoke about advocating for prison reform, particularly for minority women who went to prison for some of the things they got involved in while being trafficked. Cristina advocated for "easier access to get into drug treatment." She explained that this was necessary because certain insurances did not pay for certain drug treatments, or it would take too long to get clients into treatment. Although clients would sometimes agree to treatment, it would take several days "to get everything going. . . . by then the kids change their minds, or they run. . . .The obstacles shouldn't be that hard." Other forms of advocacy focused on working with and educating police officers to best work with this population. Tiffany explained how many women didn't trust law enforcement. She believed it was crucial to bridge these services because law enforcement could "get them out of that lifestyle, but then on the other hand, they're very much like, 'Don't trust them.'" Stacy also spoke about advocating for shelters specific to sex trafficking. She remembered a client who visited a shelter once a month and loved it because "she felt safe there versus just, like, a domestic violence clinic . . . they had the awareness of sex trafficking versus just, like, you know, an overnight shelter type of place."

Participants also taught clients how to advocate for themselves while also respecting their choices. Stacy explained, "It's not my job to fix what they're going through, but it is my job to be as supportive as I can." She understood that she needed to "advocate for them but also having the respect that if they don't want me to advocate for them, then that's the place that they're at too." Stacy also clarified that at times she does not "really know exactly 100% how I would want to advocate" for clients who had been trafficked. Yet as she continued to reflect, she realized her desire to "seek out more education about it because I do think that it needs to be navigated in a specific way."

Engaging With Social Work/Workers

The call for advocacy led all counselors to speak about how their work required them to expand their roles to connect clients to resources and collaborate with social workers. Kimberly explained that this population requires "more than just a counselor while they're in session . . . you've really got to start with building a community around them before you get into the deep trauma work." Counselors provided resources to obtain transportation, financial assistance, government assistance, their GED or college degree, food, employment, stable housing, legal support, childcare, hygiene products, substance treatment, and medical care. Amanda explained that this population requires that their basic-level needs be met to help them feel like they "can function in society and be comfortable," and Kimberly elaborated:

> As a counselor, I used to have a huge list of resources that I could give them, but they also needed guidance from outside of the counseling office. . . . I have, like, eight people with one survivor, that's how much it took us 'cause it's so much work for one person. You're talking about every aspect, everything that you learned as a child growing up. . . . If you want counseling to be successful, they have to have that outside component to help them . . . a counselor can't do all of that.

Ana partnered up with organizations already doing this work. She particularly spoke about an organization that not only focused on "educating people but also helping these women with resources." She added that "the residential places they were able to stay in, they were able to finish their education and get an education there, and they also helped them with finding jobs, which was really important for them, too." She explained that this was particularly important because many of the women she worked with had a violent criminal history. Many company insurances refused to hire women with criminal records, preventing their clients from a second chance at improving their lives. However, John learned to support clients with resources. "I don't think it's sufficient to just say 'Here you go, here's the resource guide. They have lots of options in there. Good luck.' . . . Our job doesn't end with giving the resources," he explained.

An important point to make is that although some counselors spoke about collaborating with social workers, it seemed that most believe their work resembled "a little more of that, like, case management–type stuff to make sure that they have the resources if and when they want out," added Cassandra. Kimberly elaborated, "You're the one that's helping to get them to [a] place where they can have a relatively stable life . . . but without the resources that come alongside that, they're gonna go nowhere, [they're] going to hit a wall every time."

Discussion

We sought to understand counselors' experiences working with sex trafficking survivors through a phenomenological analysis. The participants in our study needed to understand and address the different aspects of trauma. Because of clients' traumatic experiences that resulted in psychological injuries (Cole et al., 2016; Grosso et al., 2018; Lutnik, 2016; Muftić & Finn, 2013; O'Brien et al., 2017), counselors benefited from respecting the process of healing, addressing stages of change, and building a safe and trusting relationship. Counselors overall possessed knowledge of the development of post-trauma responses over time. They knew what to look for and how to best treat traumatic symptoms that permeated all aspects of their client's lives, particularly sex trafficking survivors' ability to trust others. Counselors believed that having a trauma-informed approach could reduce instances of re-victimization. Counselors also recognized the importance of self-awareness such as assessment of personal trauma, self-care, restorative practice, and biases regarding how youth are trafficked and by whom.

Yet, our findings demonstrate that working with sex trafficking survivors requires additional competencies as illustrated in previous research (Interiano-Shiverdecker et al., 2023). The participants discussed the need to become educated in recognizing the signs of sex trafficking, vulnerable populations, and the processes by which traffickers force people into sex trafficking to obtain a deeper understanding of the client's worldview and provide appropriate support (Interiano-Shiverdecker et al., 2023). Participants addressed components—namely force, fraud, coercion, exploitation, power, grooming, and solicitation—commonly used in sex trafficking literature (Bruhns et al., 2018). When asked about the nature of their work, their focus naturally divided into sections that focused on assessing risk and safety planning, processing trauma, and helping the client re-establish their life and their identity. Our findings align with CACREP (2015) recommendations for clinical crisis skills and knowledge while also elucidating their application to sex trafficking survivors. Participants learned to assess for specific sex trafficking signs (e.g., phone usage, boyfriends and their ages, sexual behaviors) and to ask questions that differentiated sex trafficking from other forms of abuse.

Counselors must also understand the differences between sex work (i.e., the voluntary exchange of sexual services for compensation) and sex trafficking (i.e., subjection to the exchange of sexual services due to force, fraud, or coercion or from any person under the age of 18). As Ana shared, most counselors felt that the notion to detect was on their end "because I don't always think it's the responsibility of the client to be able to say 'Hey, I've been trafficked.'" Thus, participants indicated that possessing these competencies could help increase the identification of sex trafficking. As such, some counselors may desire more guidance on specific sex trafficking assessments, which scholars have previously noted (Interiano-Shiverdecker et al., 2022; Romero et al., 2021). A content analysis on sex trafficking instruments (Interiano-Shiverdecker et al., 2022) illustrated the importance of asking specific questions to assess for control, confinement, threat, and isolation, as these are the main indicators of sex trafficking. Example items included: "Have you ever felt you could not leave the place where you worked [or did other activities]?" (confinement; Simich et al., 2014, p. 20); "Are you kept from contacting your friends and/or family whenever you would like?" (isolation; Mumma et al., 2017, p. 619); "Do you have to ask permission to eat, sleep, use the bathroom, or go to the doctor?" (control; Mumma et al., 2017, p. 619); and "Has anyone threatened your family?" (threat; Mumma et al., 2017, p. 619).

Moreover, for some sex trafficking victims, the relationship with their traffickers represented an affirming, reliable, and secure relationship in their lives, later used to coerce or force them into sexual, violent, or illegal behavior. Therefore, participants realized that processing trauma would require attitudes and skills that provided emotional safety, patience, and a nonjudgmental process. Survivors' lack of choice throughout their sex trafficking experience fomented counselors' abilities to empower clients over their bodies, boundaries, and choices, and help clients reintegrate into society (Interiano-Shiverdecker et al., 2023; Thompson & Haley, 2018). Participants seemed to emphasize that without all the elements mentioned, clients might not disclose their situation or trust the counselor enough to open up, and they might even terminate counseling abruptly.

This last point is connected to our fourth finding, *counselor action.* Aligned with the Multicultural and Social Justice Counseling Competencies (Ratts et al., 2016), the participants in our study recognized the need to engage in work that advocated for clients within and outside of the session. Despite their dedicated work with clients to process the emotional repercussions of sex trafficking and rebuild their lives, their efforts did not seem enough to support clients in their recovery. So much of what ailed their clients fell on systemic or external forces (e.g., poverty, employment, lack of resources). Although that existed outside of the counselor's role and verged into another profession, our participants embraced these responsibilities or connected with other professionals. They believed that otherwise, clients would not succeed in their recovery. Our findings present an important reminder that sex trafficking, a modern form of human slavery, is an act of social injustice affecting individuals vulnerable to historical and systemic oppression.

Implications

Our themes add to the existing research with implications for counseling practice, supervision, and education. Scholars (Romero et al., 2021; Thompson & Haley, 2018) have identified counselors as first-hand responders to the early detection and prevention of sex trafficking. Although each trafficking scenario is unique, counselors need to refer to sex trafficking indicators, recruitment and grooming tactics, and manipulative dynamics that prevent individuals from disclosing or leaving sex trafficking. It is important for counselors to dispel common myths of sex trafficking and understand that sex trafficking may appear differently than one may expect. Amanda alluded to clients who defined their experience as a "lavish lifestyle" and were lured by the financial benefits of sex trafficking. We caution counselors not to misinterpret sex trafficking as a "lifestyle," as this implies choice. There may be a myriad of invisible factors contributing to their circumstances such as trauma bonding and financial instability.

Participants agreed that an integrative approach with interventions that addressed complex trauma (e.g., dialectical behavior therapy, eye movement desensitization and reprocessing therapy) worked best when working with sex trafficking. We encourage counselors to not only become familiar with such modalities but also to conceptualize any treatment modality through a trauma-focused lens that considers how sex trafficking impacts all aspects of a client's life and how they will interact in session. Participant narratives indicated that clients could present with defiant behaviors, distrust, angry or irritable mood, and refusal to comply with treatment. These themes underscore the importance of a counselor's ability to create safe, trusting, and empathic relationships that allow the client to disclose risk and eventually process trauma. Counselors should also integrate a strong rapport with sex trafficking clients by demonstrating unconditional positive regard, authenticity, and empathy with any treatment modality chosen. Although counselors establish a strong therapeutic relationship, they can integrate other counseling goals, including psychoeducation, assessing for risk, supporting clients through the stages of personal change, and helping the client rebuild and reintegrate into society. Based on the nature of their work, managing countertransference and self-care represents an essential instrument to maintain balance while engaging in emotionally draining clinical work. We encourage counselors to seek supervision, connect with colleagues, and practice regular self-care routines to avoid experiencing burnout, secondary trauma, and countertransference. Additionally, counselors should connect clients to services that provide basic needs (e.g., safe and stable housing, food). When clients lack basic physiological needs, they may struggle to focus on higher-order needs such as developing a safety plan or emotion regulation. Counselors can engage in legislative advocacy by writing letters to judges, sharing clinical experiences with senators, and providing training on sex trafficking victim identification and treatment. It is important for counselors to build constituency groups with education, governmental task forces, and legislators to lobby for bills that benefit clients, as sex trafficking exists in an ecosystem of community and social contexts (Farrell & Barrio Minton, 2019). Our findings also underscore the limitations of intake interviews when assessing for sex trafficking risk. Although identification and screening tools exist (Interiano-Shiverdecker et al., 2022; Romero et al., 2021), counselors are not always in a setting where a formal assessment is appropriate or accessible.

We encourage educators and supervisors to emphasize the value of informal assessment methods with counselors-in-training. Counselor knowledge of signs, symptoms, and questions to ask during an intake can improve identification efforts. Our findings also hold some implications for training beyond counselor education. Because of the complexities of working with trauma and sex trafficking, counselors intending to work with this population should seek out specialized training. For instance, they may review conference programs for trauma or sex trafficking–specific education sessions. At the same time, counseling programs should evaluate their preparation for counselors to work with sex trafficking. Requiring a trauma course, including content on sex trafficking and complex trauma throughout the curriculum (e.g., trauma, grief, addiction counseling courses), inviting guest speakers, and providing training opportunities and workshops for students and community counselors are all suggestions to ensure that counselors obtain the necessary knowledge and skills to work with this population. We believe that more training opportunities can minimize any possible misunderstanding of sex trafficking, expectations on clients to disclose, and re-victimization of clients that leads to early termination of counseling.

Limitations and Future Directions

The nature of our sample holds some limitations for the interpretation and application of the themes from this study. We collected data from single data sources (i.e., individual interviews); additional interview sources (e.g., focus groups) may have contributed more information. Moreover, lack of racial and gender diversity was a limitation in this study because most participants identified as White and female. We noticed that participants did not discuss racial and gender differences in clients' experiences of sex trafficking. This result could have originated from our interview protocol that sought to gain an overall understanding of sex trafficking experiences and therefore did not request this information. Participants' demographic profiles may have also provided a limited perspective of the experiences of Black, Indigenous, and/or people of color. We also did not require CACREP accreditation or specific years of practice as part of our inclusion criteria. Although all our participants were licensed professional counselors, they had different degrees in mental health, a variety of clinical practice, and did not all graduate from CACREP-accredited programs. During our interviews, we did not define sex trafficking to the participants and engaged in open-ended questions that inquired about their experiences. Participants' responses are based on their definition of sex trafficking, which can vary and might not be accurately distinguishable from sex work. As is the case with all qualitative research, counselors and scholars should consider the transferability of these findings to other client populations and with counselors. For example, the findings of this study can be applicable to professional school counselors, but the recruitment of school counselors as participants would have provided greater insight into the roles and responsibilities of counselors in schools. Furthermore, we did not include client perspectives in this study; therefore, even though our participants' perspectives when working with sex trafficking survivors is very insightful, they may not have an accurate representation of clients' experiences in session.

Based on these limitations, we recommend scholars explore individual and external factors that can impact counselors' work with sex trafficking survivors. For example, we did not explore within-group differences (e.g., race, gender, sexual orientation, religion) between counselors and cross-cultural interactions between clients and counselors. These factors are important to consider and reflect on when building trust and a sense of safety for the client, particularly when considering current conversations around racial tension in the United States. A more in-depth analysis of these considerations could facilitate a better understanding of how multicultural traits play a role in counselors' experiences when working with sex trafficking survivors. Participants' emphasis on the need for specialized knowledge and skills to work with sex trafficking also warrants research on evidence-based interventions for sex trafficking survivors. Moreover, an examination of the client's experiences is necessary to garner a holistic picture of the impact of sex trafficking on the client's healing and counseling process. We also believe that researchers should consider external factors that might impact counselors' experiences when working with sex trafficking. Considering participants' discussion of advocacy and engaging with social work/workers, it seems necessary to consider sociopolitical and institutional elements that either hinder or support clients' ability to leave sex trafficking and obtain access to services that allow them to heal and flourish. As such, counselors working with sex trafficking survivors must consider specific training that allows them to assess for risk, process the emotional ramifications of sex trafficking, and rebuild their lives.

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References

American School Counselor Association. (2022). *ASCA ethical standards for school counselors.* https://www.schoolcounselor.org/getmedia/44f30280-ffe8-4b41-9ad8-f15909c3d164/EthicalStandards.pdf

Browne-James, L., Litam, S. D. A., & McRae, L. (2021). Child sex trafficking: Strategies for identification, counseling, and advocacy. *International Journal for the Advancement of Counselling*, *43*, 113–125. https://doi.org/10.1007/s10447-020-09420-y

Bruhns, M. E., del Prado, A., Slezakova, J., Lapinski, A. J., Li, T., & Pizer, B. (2018). Survivors' perspectives on recovery from commercial sexual exploitation beginning in childhood. *The Counseling Psychologist*, *46*(4), 413–455. https://doi.org/10.1177/0011000018777544

Burt, I. (2019). Modern-day slavery in the U.S.: Human trafficking and counselor awareness. *International Journal for the Advancement of Counselling*, *41*, 187–200. https://doi.org/10.1007/s10447-018-9366-7

Cole, J., Sprang, G., Lee, R., & Cohen, J. (2016). The trauma of commercial sexual exploitation of youth: A comparison of CSE victims to sexual abuse victims in a clinical sample. *Journal of Interpersonal Violence*, *31*(1), 122–146. https://doi.org/10.1177/0886260514555133

Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP standards.* http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). SAGE.

Farrell, I. C., & Barrio Minton, C. A. (2019). Advocacy among counseling leaders: The three-tiered legislative professional advocacy model. *Journal of Counselor Leadership and Advocacy*, *6*(2), 144–159. https://doi.org/10.1080/2326716X.2019.1644254

Franchino-Olsen, H. (2019). Vulnerabilities relevant for commercial sexual exploitation of children/domestic minor sex trafficking: A systematic review of risk factors. *Trauma, Violence & Abuse*, *22*(1), 99–111. https://doi.org/10.1177/1524838018821956

Grosso, A., Busch, S., Mothopeng, T., Sweitzer, S., Nkonyana, J., Mpooa, N., Taruberekera, T., & Baral, S. (2018). HIV risks and needs related to the sustainable development goals among female sex workers who were commercially sexually exploited as children in Lesotho. *Journal of the International AIDS Society*, *21*(S1), e25042. https://doi.org/10.1002/jia2.25042

Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. Guilford.

Interiano-Shiverdecker, C. G., Romero, D. E., Anderson, A., & Castellon, N. E. (2022). A content analysis of sex trafficking instruments. *International Journal for the Advancement of Counselling*, *44*, 373–394. https://doi.org/10.1007/s10447-021-09463-9

Interiano-Shiverdecker, C. G., Romero, D. E., & Elliot, J. (2023). Development of child sex trafficking counseling competencies in the United States: A Delphi study. *Journal of Interpersonal Violence*, *38*(1–2), 1397–1423. https://doi.org/10.1177/08862605221090569

International Labour Organization. (2017). *Global estimates of modern slavery: Forced labour and forced marriage.* https://www.ilo.org/global/topics/forced-labour/publications/WCMS_854733/lang--en/index.htm

Johnson, B. C. (2020). Featured counter-trafficking program: Trauma recovery for victims of sex trafficking. *Child Abuse & Neglect*, *100*, 104–153. https://doi.org/10.1016/j.chiabu.2019.104153

Kenny, M. C., Helpingstine, C. E., Harrington, M. C., & McEachern, A. G. (2018). A comprehensive group approach for commercially sexually exploited girls. *The Journal for Specialists in Group Work*, *43*(4), 376–398. https://doi.org/10.1080/01933922.2018.1484540

Litam, S. D. A. (2017). Human sex trafficking in America: What counselors need to know. *The Professional Counselor*, *7*(1), 45–61. https://doi.org/10.15241/sdal.7.1.45

Litam, S. D. A. (2019). She's just a prostitute: The effects of labels on counselor attitudes, empathy, and rape myth acceptance. *The Professional Counselor*, *9*(4), 396–415. https://doi.org/10.15241/sdal.9.4.396

Litam, S. D. A., & Lam, E. T. C. (2020). Sex trafficking beliefs in counselors: Establishing the need for human trafficking training in counselor education programs. *International Journal for the Advancement of Counselling*, *43*(1), 1–18. https://doi.org/10.1007/s10447-020-09408-8

Lutnik, A. (2016). *Domestic minor sex trafficking: Beyond victims and villains*. Columbia University Press.

Moustakas, C. (1994). *Phenomenological research methods*. SAGE.

Muftić, L. R., & Finn, M. A. (2013). Health outcomes among women trafficked for sex in the United States: A closer look. *Journal of Interpersonal Violence*, *28*(9), 1859–1885. https://doi.org/10.1177/0886260512469102

Mumma, B. E., Scofield, M. E., Mendoza, L. P., Toofan, Y., Youngyunpipatkul, J., & Hernandez, B. (2017). Screening for victims of sex trafficking in the emergency department: A pilot program. *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health*, *18*(4). https://doi.org/10.5811/westjem.2017.2.31924

National Human Trafficking Hotline. (n.d.). *National statistics*. https://humantraffickinghotline.org/states

O'Brien, J., Li, W., Givens, A., & Leibowitz, G. S. (2017). Domestic minor sex trafficking among adjudicated male youth: Prevalence and links to treatment. *Children and Youth Services Review*, *82*, 392–399. https://doi.org/10.1016/j.childyouth.2017.09.026

Oram, S., Abas, M., Bick, D., Boyle, A., French, R., Jakobowitz, S., Khondoker, M., Stanley, N., Trevillion, K., Howard, L., & Zimmerman, C. (2016). Human trafficking and health: A survey of male and female survivors in England. *American Journal of Public Health*, *106*(6), 1073–1078. https://doi.org/10.2105/AJPH.2016.303095

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

Romero, D. E., Interiano-Shiverdecker, C. G., Castellon, N. E., & Strentzsch, J. (2021). A review of child sex trafficking instruments. *Journal of Child and Adolescent Counseling*, *7*(1), 56–69. https://doi.org/10.1080/23727810.2020.1835421

Schmidt, C., Lenz, A. S., & Oliver, M. (2022). Effectiveness of TF-CBT with sex trafficking victims in a secure post-adjudication facility. *Journal of Counseling & Development*, *100*(4), 1–13. https://doi.org/10.1002/jcad/12438

Simich, L., Goyen, L., Powell, A., & Berberich, K. (2014). *Out of the shadows: A tool for the identification of victims of human trafficking*. Vera Institute of Justice. https://www.vera.org/publications/out-of-the-shadows-identification-of-victims-of-human-trafficking

Thompson, J., & Haley, M. (2018). Human trafficking: Preparing counselors to work with survivors. *International Journal for the Advancement of Counselling*, *40*(3), 298–309. https://doi.org/10.1007/s10447-018-9327-1

U.S. Department of State. (2021). *Trafficking of persons report*. https://www.state.gov/wp-content/uploads/2021/09/TIPR-GPA-upload-07222021.pdf

Victims of Trafficking and Violence Protection Act of 2000, Pub. L. No. 106-386, § 103, 114 Stat. 1470.

Wang, X., & Park-Taylor, J. (2021). Therapists' experiences of counseling foreign-national sex-trafficking survivors in the U.S. and the impact of COVID-19. *Traumatology*, *27*(4), 419–431. https://doi.org/10.1037/trm0000349

Woehler, E., & Akers, L. (2022). Repairing the trauma bonds of sex trafficking victim-survivors with animal-assisted therapy. *Journal of Creativity in Mental Health*, *17*(4), 456–458. https://doi.org/10.1080/15401383.2021.1921646

Appendix

Icebreaker

- Please tell me a little about yourself, your professional background, and clinical experience.

Counseling

- What is important for counselors to know when working with sex trafficking survivors?
- How can counselors best detect when individuals are being sex trafficked or are vulnerable to sex trafficking?
- How can counselors support individuals while they are being trafficked?
- How can counselors help individuals leave their traffickers?
- How can counselors support individuals from returning to their traffickers?
- What do counselors have to know about supporting sex trafficking survivors after sex trafficking?

Personal Experiences and Mental Health

- Please share, to the extent that you are comfortable, your experiences with working with sex trafficking survivors.
    - What is the age range in which most of your clients experienced sex trafficking?
- How have these experiences impacted your clients?
    - Emotionally and mentally?
    - Physically?
    - Relationships with others?
    - Spiritual/religious beliefs?
- What do you believe has helped them overcome the impact of sex trafficking?
- What services or resources do you believe were most helpful to them?
- What is important about your experience that I haven't asked you and you haven't had the chance to tell me?

Ableist Microaggressions, Disability Characteristics, and Nondominant Identities

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Melissa D. Deroche, Lee Za Ong, Jennifer M. Cook

Microaggressions are commonplace overt and covert forms of discrimination that convey disparaging messages to individuals who hold marginalized identities, including people with disabilities (PWD). Although PWD are a prevalent nondominant identity group in the United States, little is known about the occurrence of ableist microaggressions in this culturally diverse community, including how ableist microaggressions are experienced based on disability characteristics and other nondominant identities. A sample consisting of 201 PWD completed an electronic survey that examined the occurrence of ableist microaggressions based on visibility of disability, type of disability, and nondominant sociocultural identities. We found that PWD have a moderate level of lifetime occurrences with ableist microaggressions, the visibility of disability impacts the occurrence of ableist microaggressions and the types of ableist microaggressions experienced, and sociocultural identities may predict minimization types of ableist microaggressions.

Keywords: **microaggressions, disability, nondominant identities, ableist, visibility**

People with disabilities (PWD), similar to other minoritized groups, encounter stereotypes, stigma, prejudice, and discrimination. Stereotypes are generalized beliefs about a group with shared characteristics that can result in prejudice (Sue & Spanierman, 2022). Discrimination occurs when individuals or systems act on prejudices by limiting or restricting access to opportunities, resources, and services (Olkin et al., 2019). Discrimination results in *ableism* when it is perpetrated against PWD based on their disability status. *Microaggressions* are one form of discrimination and are defined as intentional or unintentional verbal, non-verbal, and/or environmental slights that convey disparaging messages to individuals based solely on their marginalized group membership status (Sue & Spanierman, 2022).

In recent decades, scholars have examined the occurrence of microaggressions with individuals who hold several different minority group identities and found that microaggressions are present in everyday life for minoritized individuals, negatively impacting their mental health (Capodilupo et al., 2010; Keller & Galgay, 2010; Nadal et al., 2014). Although there are a significant number of studies addressing microaggressions associated with race and ethnicity (Forrest-Bank & Cuellar, 2018; Nadal et al., 2014) and gender and sexual identity (Capodilupo et al., 2010), research regarding microaggressions experienced by PWD is only in its infancy.

In their foundational work, Keller and Galgay (2010) qualitatively explored the existence of microaggressions directed at PWD. Using two focus groups ($N = 12$) with PWD who had a range of visible and hidden disabilities, they identified eight microaggression domains experienced by PWD: (a) denial of identity, (b) denial of privacy, (c) helplessness, (d) secondary gain, (e) spread effect, (f) patronization, (g) second-class citizen, and (h) desexualization. Their work spurred both qualitative and quantitative studies focused on the ableist microaggression experiences within the general

Melissa D. Deroche, PhD, NCC, ACS, LPC-S, is an assistant professor at Tarleton State University. Lee Za Ong, PhD, LPC, CRC, is an assistant professor at Marquette University. Jennifer M. Cook, PhD, NCC, ACS, LPC, is an associate professor at the University of Texas at San Antonio. Correspondence may be addressed to Melissa D. Deroche, Tarleton State University, Department of Counseling, 10850 Texan Rider Dr., Ft. Worth, TX 76036, mderoche@tarleton.edu.

disability community (Kattari, 2020; Lett et al., 2020) and specific disability communities, including people with mental illness (Gonzales et al., 2015), physical disabilities (Conover et al., 2017a), and intellectual disabilities (Eisenman et al., 2020). Also, researchers have examined ableist microaggressions within specific settings such as schools (Dávila, 2015), the workplace (Lee et al., 2019), and higher education (Lett et al., 2020). Collectively, these results supported the initial eight ableist microaggression domains Keller and Galgay identified and expanded how they were understood.

The multidimensionality of disability has led scholars to examine the influence of disability characteristics—including visibility, severity, type, and age of onset of disability—on the occurrence of ableist microaggressions. Visible or apparent disabilities are defined primarily by the use of an adaptive aid or accommodation such as a cane, crutches, service animal, hearing aid, or wheelchair that results in others immediately labeling the person as disabled; whereas people with hidden, invisible, or non-apparent disabilities are likely to *pass* as nondisabled and must navigate how, when, and to whom to disclose their disability status. Using two different ableist microaggression scales with relatively large samples of PWD, both Conover et al. (2017a) and Kattari (2020) reported that level of visibility of disability impacts the occurrence of ableist microaggressions, with individuals with visible disabilities consistently experiencing more ableist microaggressions than their counterparts. Further examination of these differences resulted in Andreou et al. (2021) reporting that people with visible disabilities encountered more helplessness- and otherization-related ableist microaggressions, while persons with hidden disabilities encountered more minimization-type ableist microaggressions. In contrast, the impact of severity, age of onset, and type of disability on the occurrence of ableist microaggressions have yielded mixed findings, suggesting more research is warranted. For instance, Conover et al. (2017a) found that people with severe and early onset of disability (i.e., 0–40 years) reported greater lifetime experiences of ableist microaggressions, while Andreou et al. (2021) noted no differences based on severity or age of onset. With respect to type of disability, Conover et al. (2017a) reported no differences, while Andreou et al. (2021) found overall differences in the occurrence of ableist microaggressions, as well as type of ableist microaggressions, experienced by people with different types of disabilities.

Although some scholars have considered PWD's intersecting cultural identities in their research studies, including sexual minorities (e.g., Conover & Israel, 2019; Hunt et al., 2006), gender identities (measured as male and female; Conover et al., 2017a), women with visible and invisible disabilities (Olkin et al., 2019), and racial or ethnic minorities (Conover et al., 2017a; Dávila, 2015), few studies have added to our understanding of ableist microaggressions across intersecting sociocultural identities. For example, Conover and Israel (2019) found that PWD who were also sexual minorities encountered ableist microaggressions in sexual minority communities, while Conover et al. (2017a) discovered that gender (as measured by male and female) and race (as measured by White or Person of Color) did not impact the occurrence of ableist microaggressions; these results contrast Dávila (2015), who found that Latinx PWD encountered microaggressions that aligned with both racial and disability microaggressions.

Although scholars have provided valuable data about ableist microaggressions they have not considered the full range of sociocultural identities PWD hold or the differences in the types of ableist microaggressions (i.e., helplessness, minimization, denial of personhood, and otherization) PWD experience combined with their nondominant sociocultural identities. The purpose of this study was to examine the occurrence and types of ableist microaggressions PWD experience and whether their nondominant sociocultural identities impact their experiences of ableist microaggressions. Our intention was to reveal critical information counselors can use to better serve their clients who have disabilities and experience ableist microaggressions.

Methodology

For this quantitative study, we utilized surveys and online data collection to investigate our three research questions that aligned with the study purpose.

Research Question 1: What are the participants' experiences of ableist microaggressions based on the Ableist Microaggressions Scale (AMS; Conover et al., 2017b) scores and subscale scores?

Research Question 2: Do AMS scores and AMS subscales (i.e., Helplessness, Minimization, Denial of Personhood, and Otherization) have a relationship with the type of disability and the visibility of the disability?

Research Question 3: Are other nondominant sociocultural identity factors associated with or predictive of AMS scores and AMS subscales?

We anticipated participants would report differences in the occurrence and types of ableist microaggressions they experienced based on visibility of disability and disability type and that having nondominant identities would influence the occurrence of ableist microaggressions. More specifically, we expected people with visible disabilities to report higher occurrences of ableist microaggressions than their counterparts and that disability visibility would influence the type of ableist microaggressions. We anticipated variations based on disability type regarding frequency and type of ableist microaggressions. Finally, we expected PWD nondominant sociocultural identities to be associated with the occurrence of ableist microaggressions.

Procedures

This study was approved by the first author's IRB. We recruited participants through targeted disability organizations (e.g., Council of State Administrators of Vocational Rehabilitation, Wisconsin's Centers for Independent Living, Alabama Department of Rehabilitation Services) and social media platforms, many of which were specifically for PWD (e.g., Blind Pen Pals, VR Professionals, Cerebral Palsy Support, and Spinal Cord Injury Peer Mentor Program Facebook groups). Additionally, we sent email invitations to professional and personal contacts and posted on listservs of various professional organizations that serve PWD. The email invitation and posting included a brief description of the research study; inclusion criteria; an informed consent document; and a URL link to the secure, confidential survey via Qualtrics. To proceed to the study questionnaires, participants had to meet the following criteria: 1) at least 18 years old, 2) have a high school diploma or GED, and 3) have a diagnosed disability. The online survey portal was divided into six parts: informed consent, consent, screening questions, demographics, AMS questions, and two optional open-ended questions regarding their personal microaggression experiences and their interest in participating in future related studies. This study was Section 508 compliant and accessible to participants with disabilities. In total, 254 participants responded to the online survey; 53 participants were excluded because of vastly incomplete or unusable data, resulting in a final sample of 201 participants.

Data Collection

Demographic Questionnaire

We used a self-report demographic questionnaire to collect information about age, sex, gender identity, sexual orientation, racial/ethnic identity, religion/spiritual identity, education, employment status, and source of income (see Table 1). In light of the diversity within the disability community and to allow for within-group comparisons, we asked for type of disability (i.e., physical, sensory, psychiatric, and neurodevelopmental) and visibility of disability (i.e., visible/apparent, invisible/hidden, or both). Participants reported their highest level of education and their job responsibilities as they apply to their training, education, and skills. Because income level is subjective in terms of individual needs and geographic U.S. region, and PWD often have more than one income source, we asked participants to name their sources of income instead of a dollar amount.

Ableist Microaggressions Scale

The AMS (Conover et al., 2017b) is a 20-item self-report measure of PWD's lifetime experiences with disability-related microaggressions. The AMS has four subscales: Helplessness, Minimization, Denial of Personhood, and Otherization. Item examples include: "People offer me unsolicited, unwanted, or unneeded help because I have a disability" (Helplessness); "People are unwilling to accept I have a disability because I appear able-bodied" (Minimization); "People don't see me as a whole person because I have a disability" (Denial of Personhood); and "People suggest that living with a disability would not be a worthwhile existence" (Otherization). Participants were instructed to think only about their personal ableist microaggression experiences when responding to the AMS items.

Responses were rated on a 6-point Likert-type scale, ranging from 1 (*never*) to 6 (*very frequently*), and three items included a *not applicable* response option, as these items may not be relevant for individuals with invisible/hidden disabilities. Possible total scores range from 17 to 120, with higher scores indicating greater levels of lifetime experiences with ableist microaggressions. The overall internal consistency reliability was .92 (Conover et al., 2017a) and .95 (Conover & Israel, 2019), and the internal consistency reliability scores for the AMS subscales were .85 for Helplessness, .65 for Minimization, .90 for Denial of Personhood, and .84 for Otherization (Conover et al., 2017a). Cronbach's alpha for the AMS in this sample was .90.

Data Analysis

All statistical analyses were performed using IBM SPSS Statistics Standard V27. To answer Research Question 1, we ran descriptive statistics for all measured variables of AMS scales and subscales (see Table 2). For Research Question 2, we conducted factorial analysis of variance (ANOVA) and multivariate analysis of variance (MANOVA) to understand whether the AMS scores and subscale scores differed based on the type of disability and the visibility of the disability as independent factors. To answer Research Question 3, we utilized multiple regression analyses to investigate the predictive variables of participants' sociocultural identities and AMS scores and subscale scores.

Table 1

Demographic Characteristics of Participants (N = 201)

Variable	*n*	%
Disability Type [a]		
Physical	100	49.8
Sensory	89	44.3
Psychiatric/Mental	61	30.3
Neurodevelopmental	43	21.4
Disability Type		
Physical only	55	26.8
Sensory only	55	26.8
Psychiatric/Mental only	12	5.9
Neurodevelopmental only	11	5.4
Two or more disabilities	68	33.2
Disability Visibility		
Visible/apparent	62	30.8
Invisible/hidden	84	41.8
Both visible and invisible	55	27.4
Age		
18–29	33	16.4
30–39	44	21.9
40–49	57	28.4
50–59	39	19.4
60–69	20	10.0
70+	8	4.0
Biological Sex		
Female	158	78.6
Male	43	21.4
Gender Identity		
Woman	150	74.6
Man	43	21.4
Gender queer	5	2.5
Self-identify in another way	3	1.5
Affectual/Sexual Orientation		
Heterosexual	155	77.1
Bisexual	20	10.0
Gay	5	2.5
Lesbian	3	1.5
Pansexual	5	2.5
Queer	7	3.5
Self-identify in another way	6	3.0
Racial/Ethnic Identity		
African American/Black	15	7.5
Asian or Pacific Islander American	5	2.5

Variable	*n*	%
Euro American/White	153	76.1
Jewish	6	3.0
Latino/a or Hispanic	8	4.0
Native American	1	.5
Middle Eastern	3	1.5
Biracial	2	1.0
Multiracial	2	1.0
Self-identify in another way	6	3.0
Religious/Spiritual Identity		
Agnostic	34	16.9
Atheist	20	10.0
Buddhist	2	1.0
Christian: Catholic	32	15.9
Christian: Protestant	72	35.8
Jewish	6	3.0
Muslim	2	1.0
Self-identify in another way	33	16.4
Education		
High school diploma/GED	15	7.5
Some college, but no degree	27	13.4
Associate or trade school degree	19	9.5
Bachelor's degree	44	21.9
Master's degree	72	35.8
PhD, EdD, JD, MD, etc.	24	11.9
Employment Status		
Full time	94	46.8
Part time	30	14.9
Unemployed	34	16.9
Student	22	10.9
Retired	21	10.4
Training/Education/Skills Compared to Job Responsibilities		
On par	85	42.3
Exceeding	54	26.9
Lower	4	2.0
Not applicable	58	28.9
Source of Income		
Job	120	59.7
SSI	27	13.4
SSDI	37	18.4
Retirement/pension	22	10.9
Unemployment benefits	2	1.0
Other income sources	43	21.4

Note. SSI = Supplemental Security Income; SSDI = Supplemental Security Disability Income.

[a] Participants had the option to indicate more than one response; therefore, totals are greater than 100%.

Table 2

Descriptive Statistics for AMS Items by Subscale

		M	*SD*
Total AMS score		61.01	20.60
Overall AMS item		3.05	1.03
Subscale: Helplessness		3.30	1.34
H1.	People feel they need to do something to help me because I have a disability.	3.29	1.61
H2.	People express admiration for me or describe me as inspirational simply because I live with a disability.	3.65	1.80
H3.	People express pity for me because I have a disability.	3.11	1.59
H4.	People do not expect me to have a job or volunteer activities because I have a disability.	2.95	1.82
H5.	People offer me unsolicited, unwanted, or unneeded help because I have a disability.	3.47	1.76
Subscale: Minimization		3.60	1.56
M6.	People are unwilling to accept I have a disability because I appear able-bodied.[a]	3.63	2.01
M7.	People minimize my disability or suggest it could be worse.	3.62	1.81
M8.	People act as if accommodations for my disability are unnecessary.[a]	3.56	1.76
Subscale: Denial of Personhood		3.07	1.47
D9.	People don’t see me as a whole person because I have a disability.	3.32	1.66
D10.	People act as if I am nothing more than my disability.	2.66	1.52
D11.	People speak to me as if I am a child or do not take me seriously because I have a disability.	3.16	1.74
D12.	People assume I have low intelligence because I have a disability.	3.08	1.84
D13.	Because I have a disability, people attempt to make decisions for me that I can make for myself.	3.11	1.70
Subscale:	Otherization	2.63	1.22
O14.	People think I should not date or pursue sexual relationships because I have a disability.	2.09	1.54
O15.	People indicate they would not date a person with a disability.	2.93	1.73
O16.	People suggest that I cannot or should not have children because I have a disability.	2.37	1.60
O17.	People stare at me because I have a disability.[a]	3.18	1.93
O18.	Because I have a disability, people seem surprised to see me outside my home.	2.42	1.65
O19.	Because I have a disability, people assume I have an extraordinary gift or talent.	2.49	1.72
O20.	People suggest that living with a disability would not be a worthwhile existence.	2.91	1.74

Note. AMS = Ableist Microaggressions Scale; H = Helplessness; M = Minimization; D = Denial of Personhood; O = Otherization; *M* = Mean; *SD* = Standard Deviation

[a] Item includes “not applicable” response option.

Results

For Research Question 1, there was substantial variability in participants' responses to individual AMS items (see Table 2). Participants had an overall total AMS mean score of 61.01 (*SD* = 20.60). The response mean score was 3.05 (*SD* = 1.03). The response means for the AMS items ranged from a high value of 3.65 (*SD* = 1.80) to a low value of 2.09 (*SD* = 1.54). In the Minimization subscale, the response mean was 3.60 (*SD* = 1.56) and ranged from a high value of 3.63 (*SD* = 2.01) for "People are unwilling to accept I have a disability because I appear able-bodied" to a low value of 3.56 (*SD* = 1.76) for "People act as if accommodations for my disability are unnecessary." For the Helplessness subscale, the response mean was 3.30 (*SD* = 1.34) and ranged from a high value of 3.65 (*SD* = 1.80) for "People express admiration for me or describe me as inspirational simply because I live with a disability" to a low value of 2.95 (*SD* = 1.82) for "People do not expect me to have a job or volunteer activities because I have a disability." In the Denial of Personhood subscale (*M* = 3.07; *SD* = 1.47) the responses ranged from *M* = 3.32 (*SD* = 1.66) for "People don't see me as a whole person because I have a disability" to *M* = 2.66 (*SD* = 1.52) for "People act as if I am nothing more than my disability." For Otherization, the response mean was lower than the other subscales (*M* = 2.63; *SD* = 1.22) and ranged from a high value of 3.18 (*SD* = 1.93) for "People stare at me because I have a disability" to a low value of 2.42 (*SD* = 1.65) for "Because I have a disability, people seem surprised to see me outside my home."

For Research Question 2, we conducted a factorial ANOVA to understand the relationship between AMS scores, type of disability, and visibility of disability. Main effect results revealed that ableist microaggression experiences were significantly different for the visibility of disability factor—that is, whether the participant had visible, hidden, or both visible and hidden disabilities, $F(2, 189) = 6.12$, $p = .003$, partial $\eta^2 = .061$; however, ableist microaggression experiences were not significantly different based on disability type, $F(4, 189) = 2.26$, $p = .064$, partial $\eta^2 = .046$. The Scheffe post hoc test revealed visibility categories were significantly different. The invisible/hidden disability group significantly differed in ableist microaggression experiences from the visible/apparent disability group and the visible and hidden group. The invisible/hidden group (*M* = 2.57, *SD* = 0.11) scored significantly lower in their AMS compared with the visible/apparent disability group (*M* = 3.31, *SD* = 0.14) and visible and hidden disability group (*M* = 3.41, *SD* = 0.26). Calculated effect size revealed a small proportion of AMS variance was accounted for by visibility of disability, while interactions between type of disability were not significant, $F(5, 189) = 1.69$, $p = .138$, partial $\eta^2 = .043$.

We utilized a MANOVA to determine the effect of disability types and visibility of disability using four dependent variables that represented the AMS subscales (i.e., Helplessness, Minimization, Denial of Personhood, and Otherization). The Box's Test was significant ($p = .01$), indicating that homogeneity of variance was not fulfilled, so we used Pillai's trace test statistic to interpret the results. The results revealed that visibility of disability, Pillai's V = .323, $F(8, 374) = 8.99$, $p < .001$, $\eta^2 = .161$, significantly affected the combination of the AMS subscales. The factor interaction indicated no statistical significance, $F(20, 756) = .94$, $p = .535$, $\eta^2 = .024$, nor was there statistical significance for the main effect of types of disability, Pillai's V = .097, $F(16, 756) = 1.17$, $p = .285$, $\eta^2 = .024$.

The multivariate effect sizes were very small based on univariate ANOVA and Scheffe post hoc tests. ANOVA results indicated that visibility of disability significantly differed for all AMS subscales: Helplessness, $F(2, 189) = 17.25$, $p < .001$, $\eta^2 = .154$; Minimization, $F(2, 189) = 16.02$, $p < .001$, $\eta^2 = .145$; Denial of Personhood, $F(2, 189) = 4.74$, $p = .01$, $\eta^2 = .048$; and Otherization, $F(2, 189) = 11.99$, $p < .001$, $\eta^2 = .113$. Participants with visible disabilities experienced more Helplessness and Otherization microaggression types, while participants with invisible disabilities experienced more Minimization microaggressions. Participants with both visible and invisible disabilities experienced Denial of Personhood microaggressions more frequently. Table 3 presents the adjusted and unadjusted group means for AMS subscales by type of disability and visibility of disability.

Table 3

Adjusted and Unadjusted Means for AMS Subscales by Disability Types and Visibility of Disability

Subscale	Helplessness		Minimization		Denial of Personhood		Otherization	
	ADJ *M*	UA *M*	ADJ *M*	UA *M*	ADJ *M*	UA *M*	ADJ *M*	UA *M*
Disability Types								
Physical only	3.09	3.38	3.00	2.80	2.66	2.85	2.45	2.69
Sensory only	3.57	3.64	3.49	3.41	3.48	3.46	2.77	2.82
Psychiatric/Mental only	2.17	2.17	4.47	4.47	2.25	2.25	1.76	1.76
Neurodevelopment only	2.95	2.25	3.70	3.73	3.05	2.11	2.77	1.88
2 or more disabilities	3.41	3.31	3.85	4.23	3.21	3.23	2.75	2.69
Visibility								
Visible/apparent	4.02	4.07	2.56	2.51	3.29	3.30	3.15	3.19
Invisible/hidden	2.41	2.51	4.17	4.30	2.40	2.51	1.95	2.01
Both visible and invisible	3.54	3.63	3.59	3.76	3.64	3.65	3.01	2.93

Note. AMS = Ableist Microaggressions Scale; ADJ = Adjusted Mean; UA = Unadjusted Mean.

For Research Question 3, predictors were transformed and collapsed into dummy variables so they were useful for data analysis. Standard multiple regressions were conducted to determine the accuracy of the sociocultural identities (i.e., age, sex, gender identity, sexual orientation, racial/ethnic identity, religion/spiritual identity, education, and employment status) to predict AMS scores. Regression results indicated that the overall model does not significantly predict AMS scores, $R^2 = .052$, $R^2\text{adj} = .019$, $F(14, 186) = .73$, $p = .74$. Although the results did not predict AMS scores overall, they significantly predicted Minimization scores, $R^2 = .157$, $R^2\text{adj} = .093$, $F(14, 186) = 2.47$, $p = .003$. This model accounts for 9% of variance in the Minimization score. We found that race/ethnicity ($\beta = -.51$, $p = .04$), education level ($\beta = -.69$, $p = .03$), and employment status ($\beta = 1.18$, $p = .03$) significantly predicted AMS Minimization scores.

Discussion

Our findings both support and extend our understanding of the occurrence of ableist microaggressions and the types experienced by PWD who have different disability characteristics and who have a range of sociocultural identities. Participants in our study reported, on average, higher lifetime occurrences of ableist microaggressions ($M = 3.05$) than what Conover et al. (2017a) found ($M = 1.70$). These differences may be due, in part, to an increased recognition and awareness of ableist microaggressions. The high average scores reported in each subscale are consistent with the Helplessness, Minimization, Denial of Personhood, and Otherization scores reported by other researchers (Gonzales et al., 2015; Keller & Galgay, 2010; Olkin et al., 2019).

In our study, visibility of disability differentially impacted the overall occurrence and types of ableist microaggressions PWD experienced. Like in previous studies (Andreou et al., 2021; Conover et al., 2017a; Kattari, 2020), participants in our study with visible disabilities reported higher occurrences of ableist microaggressions than people with hidden disabilities or those with both visible and hidden disabilities, and they reported more Helplessness and Otherization types of microaggressions. It is plausible that people with visible disabilities experience Helplessness and Otherization ableist microaggressions more frequently because of the dominant culture's perception that disability is catastrophic and results in functional limitations beyond their disability, presuming that PWD need unsolicited help from able-bodied individuals and that PWD are burdensome (Keller & Galgay, 2010; Olkin et al., 2019). Like Andreou et al. (2021) found, participants with hidden disabilities indicated fewer overall ableist microaggression experiences, but they reported higher Minimization microaggressions than their counterparts. Because people with hidden disabilities generally do not fit the stereotypical representation of a person with a disability, they may pass as nondisabled and must prove their disability status. This is consistent with findings that individuals living with concealable chronic and mental illnesses encounter experiences in which the existence or severity of their symptoms are denied by others (Gonzales et al., 2015; Olkin et al., 2019). Unique to our study is the result that participants who identified as having both visible and hidden disabilities experienced more Denial of Personhood microaggressions, indicating PWD being reduced to their disability status (Conover et al., 2017a) and/or PWD's other sociocultural identities being ignored or denied (Keller & Galgay, 2010).

PWD with different types of disabilities did not differ in the overall occurrence of and types of ableist microaggressions they experienced. Partly, our results concur with Conover et al. (2017a), who noted no differences in the occurrence of ableist microaggressions among people with different types of physical disabilities. In contrast, Andreou et al. (2021) reported that people with medical conditions/chronic illnesses indicated fewer ableist microaggressions than their counterparts and that disability type was related to Helplessness, Minimization, and Otherization. The variability across these studies may be due to real differences or the ways in which scholars classified disability types.

The sociocultural identities we examined did not predict the lifetime experiences of ableist microaggressions, aligning with prior researchers' results (Conover et al., 2017a). However, unique to our study is that we found that race/ethnicity, education level, and employment status are predictive of Minimization ableist microaggressions for people of color (POC), those with graduate degrees, and PWD who are employed full time. We proffer these results may be understood from the standpoint that microaggressions toward PWD are pervasive and may intersect with other nondominant identities (Sue & Spanierman, 2022). It is not surprising that participants with nondominant racial identities had higher Minimization scores given that POC frequently report being dismissed and ignored within U.S. culture (Nadal et al., 2014); based on our study results, this holds true for POC with disabilities. Additionally, because society typically views people with graduate degrees and those who work full time as more capable, PWD who fit these categories may be more likely to experience microaggressions that minimize the existence or severity of their disabilities because they are perceived as more capable based on education and employment.

Implications

Given the ubiquitous nature of ableist microaggressions experienced in the disability community, it is vital for counselors to recognize, acknowledge, validate, and be culturally aware of and sensitive to the presence of microaggressions in the lives of PWD, and in turn, consider that socioemotional problems may be a product of microaggressions rather than attributes related to their disability (Chapin et al., 2018; Sue & Spanierman, 2022). However, counselors must understand that PWD may not use the terms *microaggressions*, *ableist*, or *ableism* explicitly, so they need to listen and attend to client stories that communicate such experiences and determine whether or not these experiences are part of their symptomology. Grounded in the AMS domains evident in the study results, we proffer that clients may share stories that communicate instances in which PWD experience:

- Helplessness: PWD are given unsolicited assistance, restricted in performing daily activities, denied their independence, or not directly communicated with by others.
- Minimization: PWD are required to continuously prove, substantiate, or explain the existence of their disability.
- Denial of Personhood: PWD must endure others' singular focus on their disability or disregard of their additional sociocultural identities.
- Otherization: PWD experience others denying, questioning, or expressing irritation regarding accommodation requests or must deal with people assuming that impairment in one area results in impairment in other areas.

Failure to appropriately attend to these inequities experienced by PWD or to engage in cultural humility can lead to early termination, impede the working alliance, and/or result in additional psychological harm (Sue & Spanierman, 2022).

Because counselors are products of their environments, they are at risk of developing unconscious biases toward PWD with visible and hidden disabilities, and left unchecked, they can unintentionally communicate these biases within the counseling process. Biased beliefs can unwittingly drive actions that can damage the counseling relationship and result in microaggressions, including seemingly well-intended, innocuous actions like holding a door (i.e., Helplessness) or unilaterally determining a treatment plan without client input (i.e., Otherization). Such actions can usurp the autonomy of clients with disabilities and result in denying clients their basic ethical rights. Additionally, counselors may inadvertently overlook disability identity when they do not include ability/disability status or questions about disability or chronic illness as part of their intake and assessment procedures (i.e., Denial of Personhood; Cook et al., 2020). Without this knowledge, they may mistakenly minimize a client's hidden, undisclosed disability because they were unaware of it (i.e., Minimization), yet our results support that this may occur with apparent/disclosed disabilities, too. Consequently, we recommend counselors provide intake questions that give clients the opportunity to identify their disabilities, to include additional self-determined relevant information about their disability, and to express how they would like the counselor to refer to their disability. Furthermore, counselors must follow up about intake form information during the clinical interview (Cook et al., 2020).

PWD with multiple intersecting nondominant sociocultural identities experience the inherent complexities associated with possessing overt cultural identities (e.g., POC) and concealed cultural identities (e.g., sexual/affectual orientation). It is essential for counselors to explore clients' identities that are most important to them (i.e., identity salience; Hunt et al., 2006) and their experiences of privilege and marginalization. Accordingly, counselors must work to understand the privileged and marginalized statuses related to all of their identities and specifically related to ability/disability in order to broach effectively. To do so, counselors must examine their attitudes, beliefs, and assumptions about PWD to combat unconscious biases that could influence their behavior or interpretations in the counseling relationship (Chapin et al., 2018). To do so, Deroche et al. (2020) recommended reading autobiographies or blogs written by PWD (e.g., Heumann & Joiner, 2021), listening to or watching Ted Talks given by PWD (e.g., Young, 2014), following or joining social media pages specific to disability or PWD, and/or reading scholarly literature centered on the lives of PWD. Additionally, we recommend counselors engage in culturally responsive care, including use of disability-inclusive language (Kattari, 2020); discuss specific accessibility and accommodation needs (Chapin et al., 2018); assess office accessibility; and create disability-friendly policies (Chapin et al., 2018; Olkin et al., 2019).

Counselor educators and supervisors are responsible for preparing students and supervisees to work with PWD. Consequently, professional counselors need more than one day slated for disability topics in their multicultural counseling course. Most importantly, professional counselors need to know that PWD have historically been and are continually on the frontlines advocating for their civil rights and promoting social justice and equality. Although it is likely impossible for most programs to add another course to their curriculum, it is reasonable and doable to integrate disability into established courses as they have for other cultural topics and for supervisors to make intentional efforts to address ability/disability within clinical supervision. Strategies include creating case studies that portray PWD or disability identity (see Smart, 2012 for examples); developing activities, assignments, or projects that require counselor trainees to explore negative attitudinal barriers and social inequities experienced by PWD (Deroche et al., 2020); discussing how disability impacts family roles, responsibilities, and dynamics; using cultural broaching in the classroom and in supervision (Day-Vines et al., 2021); and designing program policies and materials that reduce attitudinal and access-related barriers for students and supervisees with disabilities.

Limitations and Future Research

The study results must be understood in the context of its limitations. Self-selection bias may have influenced who decided to participate in the study. Although we included a definition and examples of ableist microaggressions in our informed consent document, PWD who were more familiar with or had an interest in this topic may have chosen to participate compared to PWD who were less familiar or knowledgeable about ableist microaggressions. Our use of the AMS (Conover et al., 2017b) introduces limitations associated with its psychometric properties, as no normative data is available. Additionally, the AMS purports to measure the lifetime occurrence of ableist microaggressions, requiring participants to retrospectively report information from years prior; retrospective recall of ableist microaggressions may result in inaccurate data (Kattari, 2019). Although there is benefit to understanding the long-term effects of ableist microaggressions, we suggest that researchers pursue longitudinal studies rather than utilizing a one-time measure that relies on participants' recollections.

Although our sample included people with a range of disability types and visibility of disability, the majority identified as White, heterosexual women who are employed and who had some level of higher education experience. The racial (Goyat et al., 2016), educational (Paul et al., 2021), and employment (U.S. Bureau of Labor Statistics, 2023) inequities reported in the disability community are not representative of our sample. We suggest that future studies intentionally sample individuals who are more representative of the disability community. Finally, counseling researchers must continue to investigate how ableist microaggressions manifest in the counseling relationship, best practices for helping clients heal from microaggressive experiences, and appropriate supervision and educational interventions to prepare counselors and counselors-in-training to work with PWD who have experienced ableist microaggressions.

Conclusion

The results of our study add to the paucity of research specific to ableist microaggressions, particularly with respect to visibility of disability and other nondominant sociocultural identities of PWD. Like other studies, we found high average scores in all domains, and that visibility of disability resulted in higher AMS scores and impacted the type of ableist microaggressions experienced. Although the sociocultural identities we examined did not predict the lifetime experiences of ableist microaggressions, we found race/ethnicity, education level, and employment status are predictive of Minimization ableist microaggressions for POC, those with graduate degrees, and PWD who are employed full time. We offered that all counseling professionals—counselors, counselors-in-training, counselor educators, and supervisors—must attend to disability microaggressions regularly within their professional roles and specifically, we urged researchers to increase their attention to ableist microaggression research. Together, we can reduce ableist microaggressions and eventually increase access for PWD within professional counseling.

Conflict of Interest and Funding Disclosure
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References

Andreou, E., Psyllou, A., Vlachou, A., Fyssa, A., & Saridaki, M. (2021). Microaggressions and psychosocial adjustment among Greek university students with disabilities. *Education Sciences*, *11*(12), 781–799. https://doi.org/10.3390/educsci11120781

Capodilupo, C. M., Nadal, K. L., Corman, L., Hamit, S., Lyons, O. B., & Weinberg, A. (2010). The manifestation of gender microaggressions. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 193–216). Wiley.

Chapin, M., McCarthy, H., Shaw, L., Bradham-Cousar, M., Chapman, R., Nosek, M., Peterson, S., Yilmaz, Z., & Ysasi, N. (2018). *Disability-related counseling competencies.* American Rehabilitation Counseling Association Task Force on Competencies for Counseling Persons with Disabilities. https://bit.ly/ARCA2018

Conover, K. J., & Israel, T. (2019). Microaggressions and social support among sexual minorities with physical disabilities. *Rehabilitation Psychology*, *64*(2), 167–178. https://doi.org/10.1037/rep0000250

Conover, K. J., Israel, T., & Nylund-Gibson, K. (2017a). Development and validation of the Ableist Microaggressions Scale. *The Counseling Psychologist*, *45*(4), 570–599. https://doi.org/10.1177/0011000017715317

Conover, K. J., Israel, T., & Nylund-Gibson, K. (2017b). *Ableist Microaggressions Scale* [Database record]. APA PsycTESTS. https://doi.org/10.1037/t64519-000

Cook, J. M., Skaistis, S. M., Borden, S., & Nair, D. (2020). Inquiring about client cultural identities: A content analysis of intake paperwork. *Journal of Mental Health Counseling*, *42*(3), 220–233. https://doi.org/10.17744/mehc.42.3.03

Dávila, B. (2015). Critical race theory, disability microaggressions, and Latina/o student experiences in special education. *Race, Ethnicity, and Education*, *18*(4), 443–468. https://doi.org/10.1080/13613324.2014.885422

Day-Vines, N. L., Cluxton-Keller, F., Agorsor, C., & Gubara, S. (2021). Strategies for broaching the subjects of race, ethnicity, and culture. *Journal of Counseling & Development*, *99*(3), 348–357. https://doi.org/10.1002/jcad.12380

Deroche, M. D., Herlihy, B., & Lyons, M. L. (2020). Counselor trainee self-perceived disability competence: Implications for training. *Counselor Education and Supervision*, *59*(3), 187–199. https://doi.org/10.1002/ceas.12183

Eisenman, L. T., Rolón-Dow, R., Freedman, B., Davison, A., & Yates, N. (2020). "Disabled or not, people just want to feel welcome": Stories of microaggressions and microaffirmations from college students with intellectual disability. *Critical Education*, *11*(17), 1–21. https://doi.org/10.14288/ce.v11i17.186499

Forrest-Bank, S. S., & Cuellar, M. J. (2018). The mediating effects of ethnic identity on the relationship between racial microaggression and psychological well-being. *Social Work Research*, *42*(1), 44–56. https://doi.org/10.1093/swr/svx023

Gonzales, L., Davidoff, K. C., Nadal, K. L., & Yanos, P. T. (2015). Microaggressions experienced by persons with mental illnesses: An exploratory study. *Psychiatric Rehabilitation Journal*, *38*(3), 234–241. https://doi.org/10.1037/prj0000096

Goyat, R., Vyas, A., & Sambamoorthi, U. (2016). Racial/ethnic disparities in disability prevalence. *Journal of Racial and Ethnic Health Disparities*, *3*(4), 635–645. https://doi.org/10.1007/s40615-015-0182-z

Heumann, J., & Joiner, K. (2021). *Being Heumann: An unrepentant memoir of a disability rights activist*. Penguin Random House.

Hunt, B., Matthews, C., Milsom, A., & Lammel, J. A. (2006). Lesbians with physical disabilities: A qualitative study of their experiences with counseling. *Journal of Counseling & Development*, *84*(2), 163–173. https://doi.org/10.1002/j.1556-6678.2006.tb00392.x

Kattari, S. K. (2019). The development and validation of the Ableist Microaggression Inventory. *Journal of Social Service Research*, *45*(3), 400–417. https://doi.org/10.1080/01488376.2018.1480565

Kattari, S. K. (2020). Ableist microaggressions and the mental health of disabled adults. *Community Mental Health Journal*, *56*(6), 1170–1179. https://doi.org/10.1007/s10597-020-00615-6

Keller, R. M., & Galgay, C. E. (2010). Microaggressive experiences of people with disabilities. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 241–268). Wiley.

Lee, E.-J., Ditchman, N., Thomas, J., & Tsen, J. (2019). Microaggressions experienced by people with multiple sclerosis in the workplace: An exploratory study using Sue's taxonomy. *Rehabilitation Psychology*, *64*(2), 179–193. https://doi.org/10.1037/rep0000269

Lett, K., Tamaian, A., & Klest, B. (2020). Impact of ableist microaggressions on university students with self-identified disabilities. *Disability & Society*, *35*(9), 1441–1456. https://doi.org/10.1080/09687599.2019.1680344

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

Olkin, R., Hayward, H., Abbene, M. S., & VanHeel, G. R. (2019). The experiences of microaggressions against women with visible and invisible disabilities. *Journal of Social Issues*, *75*(3), 757–785. https://doi.org/10.1111/josi.12342

Paul, S., Rafal, M., & Houtenville, A. (2021). *2021 annual disability statistics compendium*. University of New Hampshire, Institute on Disability. https://disabilitycompendium.org/compendium/2021-annual-disability-statistics-compendium-a

Smart, J. (2012). *Disability across the developmental life span: An introduction for the helping professions* (2nd ed.). Springer.

Sue, D. W., & Spanierman, L. B. (2022). *Microaggressions in everyday life* (2nd ed.). Wiley.

U.S. Bureau of Labor Statistics. (2023, February 23). *Persons with a disability: Labor force characteristics summary*. https://www.bls.gov/news.release/disabl.nr0.htm

Young, S. (2014). *I'm not your inspiration, thank you very much* [Video]. https://bit.ly/YoungNotyourinspiration

Using the Cultural Formulation Interview With Afro Latinx Immigrants in Counseling: A Practical Application

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Kirsis Allennys Dipre, Diana Gallardo, Susan F. Branco, Ladylanis Grullon Cepeda

Afro Latinx immigrants are an underserved population in the United States and within counseling specifically. The counseling profession has been slow to address the unique needs of this population despite the increased visibility of this group in recent years. Consistent with the codes of ethics from the American Counseling Association and the National Board for Certified Counselors and the Multicultural and Social Justice Counseling Competencies (MSJCC), counselors must continue to expand their repertoire and use empirically supported tools to address these mandates and increase cultural responsiveness in clinical practice. Despite its alignment with the MSJCC, the counseling literature demonstrates that the Cultural Formulation Interview is an underutilized, empirically supported tool. The authors describe how counselors may use the Cultural Formulation Interview in their clinical practice with Afro Latinx immigrants while operating from a multicultural and social justice–oriented framework.

Keywords: **Afro Latinx, immigrants, clinical practice, Cultural Formulation Interview, MSJCC**

According to data from the 2020 Census, there are about 62.1 million Hispanics in the United States (U.S. Census Bureau, 2021). Of those, about 6 million identify as Afro-Latinos, accounting for about 2% of all adults and about 12% of all Latinx adults in the country (Gonzales-Barrera, 2022). Considering the Afro Latinx population is increasingly gaining visibility in the United States, there is a growing need for counselors to become well-versed in working with this population. Afro Latinxs have been found to be impacted by multiple systems of oppression because of their intersecting identities (Araujo-Dawson & Quiros, 2014; Hatzenbuehler et al., 2017; Lipscomb & Stevenson, 2022), which can have a detrimental impact on their sense of identity, mental health, and overall functioning as they cope with multiple demands not often acknowledged in the counseling literature (Adames et al., 2016; Newby & Dowling, 2007). The lack of recognition of the compounded impact of being a Black Latinx person in a racialized country, where Black and Latinx communities continue to be perceived as homogeneous groups and subjected to racism and xenophobia, contributes to these difficulties. When immigration status is considered in addition to these highly stigmatized identities, well-being can be drastically impacted as Afro Latinx immigrants are left to negotiate group membership and boundaries within communities that often reject them based on their intersectional identities (Newby & Dowling, 2007).

Current paradigms of intervention for working with multiply marginalized populations within the Latinx pan-ethnic label remain unidimensional, limiting both counselors' understanding of clients and their ability to help clients understand their unique experiences and how these impact their well-being (Adames et al., 2016; López et al., 2018). When working with this population, it is imperative for counselors to pay close attention to the intersection of identities, oppression, and mental health; embrace a socioecological perspective; and work to balance individual counseling with social justice,

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Kirsis Allennys Dipre, PhD, NCC, is a core faculty member at The Family Institute at Northwestern University. Diana Gallardo, PhD, NCC, is an assistant professor at Northeastern Illinois University. Susan F. Branco, PhD, LPC, LCPC, is an associate professor at Palo Alto University. Ladylanis Grullon Cepeda, MA, LPC-A, is a doctoral student at Walden University. Correspondence may be addressed to Kirsis A. Dipre, 618 Library Place, Evanston, IL 60201, kdipre@family-institute.org.

as envisioned by the Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2016). We assert that the evidence-based Cultural Formulation Interview (CFI) is an underutilized intervention tool to support counseling practitioners' and trainees' MSJCC responsiveness when working with Afro Latinx immigrants in the United States. In this manuscript, we describe the CFI; highlight its alignment with the MSJCC; and demonstrate how the CFI may be used with Afro Latinx populations, an underserved and minoritized group.

Counseling Latinx Populations

In the United States, counseling practice with Latinx populations has primarily emphasized the role of cultural values (Ayón et al., 2020; Mancini & Farina, 2021). Cultural values are the customs, beliefs, and guiding principles held in common by a cultural group that often help shape worldview and the perceptions of individuals of that culture (Ratts et al., 2016; Sue et al., 2022). Culture plays an important role in the presentation of illness and the experience of mental disturbance (Jones-Smith, 2018). Therefore, it is imperative for counselors to attend to cultural elements throughout the counseling process. This emphasis on the role of cultural values has made significant contributions to the Latinx mental health literature by providing a foundation for counselors and counselors-in-training (CITs). But there continues to be a lack of emphasis placed on interventions that explicitly consider the role of within-group differences among this diverse ethnic population (Adames et al., 2018; Barragán et al., 2020). Scholars and practitioners have relied on cultural values and categorized the discrimination Latinx individuals and communities experience from ethnic-, language-, and immigration-related factors, while glossing over racial stressors (López et al., 2018).

In a racially charged environment, like that of the United States, culture is often used as a proxy for race across health settings, including mental health settings. Among this population, this has been done through a reliance on the socialization of Latinx people not to identify themselves racially, and instead, use country of origin or immigrant generation to reflect their experiences (López et al., 2018; Telzer & Vazquez Garcia, 2009). With this focus, racialized experiences of Latinx individuals are lost—including the impact of skin color and other phenotypical characteristics on Latinxs and their mental health. Skin color, for instance, is a critical component of identity within the Latinx community because of its historical roots in African, Indigenous, and European cultures (Araujo-Dawson, 2015). This history has contributed to a wide range of skin tones within the population, from very light skin with European features to very dark skin with Indigenous or African features (Telzer & Vazquez Garcia, 2009). A preference for Whiteness within the Latinx community manifests itself through various forms of oppressive systems, such as colorism and anti-Blackness, both of which are associated with within-group discrimination and adverse mental health outcomes among Latinx populations (Araujo-Dawson, 2015; Ortiz & Telles, 2012).

In addition to the within-group differences that are often overlooked in the Latinx mental health literature, Latinx populations are also impacted by immigration demands. Demands such as personal processes like acculturation and resultant acculturative stress may arise because of the pressures of the host country (Ayón et al., 2020; Driscoll & Torres, 2020). Structural barriers put in place by governments and society at large contribute to the stress experienced by Latinx immigrants. These stressors may have adverse impacts on immigrants' health and mental health (Ayón et al., 2020). For example, researchers suggest that immigrants are already experiencing day-to-day feelings of hopelessness and intense fear of being surveilled by immigration officials. Anti-immigration policies further exploit these feelings, which might significantly impact immigrants' long-term mental health (Rhodes et al., 2015; Stacciarini et al., 2015).

Afro Latinx Identity and Multiple Marginalization

Black and darker-skinned Latinos/as may experience higher levels of psychosocial stressors, which can erode the individual's health through psychological and physiological responses and health behaviors (Capielo Rosario et al., 2019; Cuevas et al., 2016). Greater perceived discrimination based on ethnoracial appearance has been consistently associated with higher stress levels, anxiety, and depression (Ayers et al., 2013; Mena et al., 2020; Ramos et al., 2003). Additionally, the literature demonstrates that Black and darker-skinned Latinos have worse mental and physical health outcomes than White and lighter-skinned Latinos, noticeably resembling the non-Latino Black differences from non-Latino White populations (Cuevas et al., 2016).

Although the Afro Latinx immigrant population is directly impacted by the multiple marginalized social positions that they occupy in the United States, few mental health efforts have been launched to attend to this population explicitly. In the past 20 years, no scholars have explicitly addressed the Afro Latinx immigrant population in the mental health literature, with most researchers addressing the intersection of several marginalized and privileged identities such as ethnic and binary gender identities (López et al., 2018; Ramos et al., 2003); undocumented legal status, immigrant status, and ethnic identity (Ornelas et al., 2020); and legal status, women, and ethnic identities (Ramos-Sánchez, 2020). Adames et al. (2018) drew attention to Afro Latinx queer immigrants through the lens of intersectionality, indicating a shift in the field as it pertains to addressing the mental health needs of the Latinx population. Because of the impact of occupying multiple marginalized positions in the United States, as is the case of Afro Latinx immigrants, more clinical practice recommendations, such as the utility of the CFI, are warranted.

The MSJCC and CFI

The MSJCC is conceptualized as a map that includes four main components: (a) quadrants of counselor–client interaction; (b) developmental domains of multicultural and social justice competency; (c) aspirational competencies of attitudes and beliefs, knowledge, skills, and action within each domain; and (d) ecological layers of counselor advocacy. The latter component is aimed at highlighting the fluidity and intersectionality of identities—experiences of marginalization that counselors must be aware of (Singh, Appling, & Trepal, 2020). Viewing the MSJCC within the context of the *isms* that exist within society, which lead to the marginalization of specific groups of people, is essential.

In their editorial review of developments in multicultural and social justice counseling, Lee and Moh (2020) noted that a critical step in realizing multicultural and social justice competence in the counseling profession is through the generation of andragogical practices that effectively promote their development. To do so, counselor educators must rely on empirically supported tools and theories for fostering the development of multicultural competency. With this aim, counselor educators have relied primarily on varying andragogical approaches (Hilert & Tirado, 2019; Killian & Floren, 2020), theories (Zeleke et al., 2018), and models (Cook et al., 2016), with some scholars directly integrating the MSJCC to work with specific populations (Carrola & Brown, 2018; Washington & Henfield, 2019). Zeleke and colleagues (2018) examined the usefulness of self-regulated learning strategies. Killian and Floren (2020) compared the effectiveness of different pedagogical approaches (i.e., didactic, experiential, and community service learning), while Hilert and Tirado (2019) examined contemplative pedagogy in teaching counseling trainees multicultural and social justice competencies. Similar to the examination of contemplative andragogy, Cook et al. (2016) used the professional development school model. These approaches significantly contributed to counselor education by generating knowledge that continues to move the counseling profession forward to centering multicultural responsivity.

Cultural Formulation Interview

The CFI was first included in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) to guide clinicians on how to conduct a cultural assessment in routine mental health settings (Aggarwal et al., 2015; DeSilva et al., 2018). Table 1 reflects the three versions of the CFI counselors may use with clients and their families. Each version of the CFI aligns with the four core elements of the MSJCC. A crucial prerequisite for conducting a cultural assessment, in tandem with use of the CFI, involves counselor receptiveness and capacity to engage in ongoing self-awareness (Ratts et al., 2016). The CFI helps counselors to culturally conceptualize the client's presenting problem within systems of culture, oppression, and support. In so doing, the counselor may incorporate the client's salient intersecting and marginalized identities into their clinical portrait while also maintaining attentiveness to their own personal and professional biases.

Table 1

The Cultural Formulation Interview

CFI Version	Applicability	Core Components
Core interview	To use upon intake with a client	16 semi-structured questions within 4 cultural domains: 1) Problem formulation 2) Perceptions of problem 3) Coping & help-seeking factors 4) Past coping & help-seeking factors
Informant interview	To use with client's family members or significant others after initial intake (with client permission)	17 semi-structured questions within 4 Cultural domains: 1) Problem formulation 2) Perceptions of problem 3) Coping & help-seeking factors 4) Past coping & help-seeking factors
Supplemental modules	To explore subtopics of core domains in more detail	12 supplemental modules: 1) The explanatory model 2) Level of functioning 3) Social network 4) Psychosocial stressors 5) Spirituality, religion, and moral traditions 6) Cultural identity 7) Coping and help seeking 8) Clinician-parent relationship 9) School-age children and adolescents 10) Older adults 11) Immigrants and refugees 12) Caregivers

The CFI, a semi-structured instrument, includes instructions and open-ended questions for clinicians to use. Because of the increasing empirical support for how culture influences each aspect of mental health care (Barragán et al., 2020; Cariello et al., 2020; Driscoll & Torres, 2020), the CFI is ideally utilized during the initial evaluation of any client (DeSilva et al., 2018; Sue et al., 2022); however, the CFI can also be incorporated throughout the counseling process (Ramírez Stege & Yarris, 2017). Although the CFI is the most widely used cultural assessment tool throughout the world (DeSilva et al., 2018; Lindberg et al., 2021), there is a disconnect within counselor education wherein little emphasis exists on training counseling students to properly use this tool despite the profession's mandate to use evidence-based instruments and interventions.

The CFI consists of three components: the core interview, the informant interview, and the supplemental modules (APA, 2013). The core interview totals 16 open-ended questions consisting of four domains: 1) cultural definition of the problem to include the client's view of their presenting problem; 2) the client's cultural perceptions of cause, context, and support to clarify what the client and their support group consider the origin of the problem to be and identify the connection between the problem and the client's cultural identities; 3) cultural factors that affect past self-coping and help-seeking strategies; and 4) cultural factors that affect current help-seeking, including the client's preferences for future care and concerns about the counselor–client relationship (APA, 2013; DeSilva et al., 2018). The counselor is encouraged to consider and assess how the client's varying identities influence each domain. Simultaneously, counselors must collaborate with the client to identify the salience and intersection of their specific identities (Aggarwal et al., 2016; Ramírez Stege & Yarris, 2017).

The informant version of the interview consists of the four domains in the core CFI and gathers information related to the client and their presenting problem from the perspective of caregivers and other relevant stakeholders (Aggarwal et al., 2015; APA, 2013). The supplementary modules expand on specific subtopics stemming from the four domains in the core and informant components of the CFI. The modules are designed to help counselors conduct a more comprehensive cultural assessment while focusing on specific needs based on identities and resources (Aggarwal et al., 2015; DeSilva et al., 2018). These modules are 1) the explanatory model; 2) level of functioning; 3) social network; 4) psychosocial stressors; 5) spirituality, religion, and moral traditions; 6) cultural identity; 7) coping and help seeking; 8) clinician–parent relationship; 9) school-age children and adolescents; 10) older adults; 11) immigrants and refugees; and 12) caregivers (APA, 2013).

Aggarwal et al. (2016) noted the most common barrier to implementation of the CFI was the perceived lack of conceptual relevance between intervention and problem, while Jones-Smith (2018) highlighted the CFI's lack of consideration of the embeddedness of the client in their traditional culture. In considering these limitations, researchers have indicated that information obtained from the CFI should be integrated with other clinical material to achieve the aims of the clinical assessment, including culturally valid diagnosis, social history, treatment planning, and patient engagement and satisfaction (DeSilva et al., 2018; Mills et al., 2017). Jarvis et al.'s (2020) review of CFI research reported that the CFI has been shown to clinically enhance the counselor–client relationship and increases counselor cultural sensitivity. They also noted that even mental health providers with limited CFI training demonstrated improved cultural responsivity with clients. Of relevance to Afro Latinx immigrant clients, Jarvis et al. (2020) found research supportive of the CFI's success with Latinx-identifying clients. Nonetheless, Jarvis et al. indicated that the CFI may not be an ideal assessment for clients experiencing symptoms of psychosis, suicidal ideation, aggression, or cognitive impairment. Though research is mixed, the CFI provides an innovative way to help practicing counselors and CITs become more culturally responsive (Sue et al., 2022). Next, we consider how the CFI may be specifically applicable to clients who identify as Afro Latinx.

Application of the CFI

The CFI offers an empirically supported instrument for treatment planning and conducting a culturally appropriate assessment and has been shown to increase counselor cultural sensitivity (Jarvis et al., 2020). The following case study demonstrates how the CFI can be applied with a client who identifies as Afro Latinx. After the case study, we provide a description of the domains of the MSJCC, inherent within the CFI, as they relate to counselors working with Afro Latinx immigrants.

Case Study

Martin is a 33-year-old, dark-skinned Afro Latinx immigrant from Mexico who is seeking counseling for the first time for what he describes as intense nervousness. Martin has noticed that he began experiencing muscle tension, excessive sweating, and increased agitation in the months following his relocation to the United States. Martin relocated about 14 months ago because of his job; he works as an engineer for a well-known firm in the city. Allison is the intern counselor assigned to Martin. Allison identifies as a queer White woman born in the United States. Allison first learned about the CFI during her assessment course. Her university and site supervisors both encouraged CITs to use the CFI as a supplement to the intake session to promote cultural responsivity. In their counseling intake session, Martin describes feeling incompetent at his job, as others often question his decisions. Martin reports that he never experienced the current symptoms before and is confused and scared. Martin responds with hesitancy, although he is willing to engage in the CFI questions.

Cultural Definition of the Problem

After reviewing the confidentiality limitations and the risks and benefits of counseling, Allison explains that she will ask Martin questions from the CFI to better understand him and his situation. After Martin reports experiencing concerns about his job without offering more details, Allison asks, "Sometimes people have different ways of describing their problem to their family, friends, or others in the community. How would you describe your problem to them?" Martin thinks for a moment then shares, "I would tell them that I thought I finally made it—I have a good job, I am working full time, I earn enough to take care of myself and help my family. But now strange things are happening with me. I get sweaty out of nowhere for no reason. I feel sore in my body. I cannot seem to calm down. I never felt this way before."

Cultural Perceptions of Cause, Context, and Support

Following the CFI protocol, Allison asks a causation question: "What do you think is causing this problem for you?" Martin again pauses for a moment and responds, "I miss my friends and other things, but my family is here, so I do not understand why this is happening. Like I said, I was finally able to get the engineering position and it pays really well. I work with a lot of people who are really skilled engineers. So, I am not really sure what is going on." Allison internally notes Martin's comment about missing home and decides to return to the topic later. Allison elects to probe a bit more about the new position: "Say more about your new job. It sounds like it is something you worked hard to achieve." Martin reports, "Like I said, I really like the new position and I try really hard to do my best. I show up early and stay late. I wear a suit and tie everyday even though other people don't. I guess people are trying to help me because they ask me a lot of questions about what I am doing, if I understand things, and when I will be done."

Allison states, "There seems to be a lot of attention on you and you're not used to that," before transitioning to a CFI question about supports: "Is there anything that makes the sudden sweatiness, body soreness, or trouble calming down better—such as support from family, friends, or others?"

Martin quickly responds, "My brothers and sisters are here, and I live with my sister's family for now. They are great to be around and help me understand how things work in the U.S. Also, I get to hang out with my nieces and nephews a lot after work, playing video games or going food shopping. I really like eating together with them as a family too. I don't have the sudden sweating thing with them, and I feel *tranquilo* [calm] around my family."

Allison continues to the CFI module about the role of cultural identity and explains, "Sometimes, aspects of people's background or identity can make their problem better or worse. By background and identity, I'm referring to the communities you belong to, the languages you speak, country of origin, race, ethnicity, gender, sexual orientation, faith, religion, that kind of thing. For you, what are the most important aspects of your background or identity?"

Martin takes a moment to consider and responds, "I mean . . . being a Mexican man is really important to me but also, I have no choice about my skin color and people at my job know I'm an immigrant, which I think is why they treat me differently." Allison notes this and adds, "I remember you just said you missed some of your friends and family who are still at 'home.' Tell me more about that too, please." Martin smiles and his face lights up as he explains he recently immigrated from Mexico where his parents, other siblings, and other extended family members still reside. "Yes, like I was saying, I miss home because, back there, I wasn't treated differently. We had a common language, so speaking Spanish felt more comfortable than it does now. Even though I speak English, I feel so much pressure to speak properly or act more like my coworkers. There were no hidden expectations—here I feel like, because I'm not from here, I look darker, and I speak Spanish, I have to fit a mold that I'm not sure exists." Next, Allison responds, "I hear you saying there are cultural differences and an unspoken expectation about your cultural background that are impacting you and how you're understanding the situation. Can you tell me more about what you're referring to specifically?" Again, Martin takes a minute to think and responds, "I think the pressure I feel to fit into a box—because of my darker skin, because I'm Mexican, because I'm a Spanish-speaker—causes confusion for me since I've never experienced this and I think it causes confusion for my coworkers too, and then people respond to me in ways that make me question my reality. When I started this new job, my coworkers wouldn't stop asking me why I spoke Spanish if I was Black, and I didn't know how to respond. Like, I never really thought about being Black. In Mexico we don't talk about race, and here it seems this is the only important part of a person. I don't understand it, and I feel trapped because either I have no choice on how they perceive me, or they make assumptions simply based on my skin color."

Cultural Factors Affecting Self-Coping and Past Help Seeking

Allison summarizes Martin's responses and moves to the CFI self-coping strategies: "What have you done on your own to help you manage those things that happen with your body?" Martin reports that when the feelings happen at work, he goes to the restroom to splash cold water on his face. He also might get a glass of water. Sometimes he goes outside to get fresh air. Once, according to Martin, when it was really bad, he called his sister. Later that day, his sister recommended he contact their primary care physician. The physician ruled out any medical origins to Martin's symptoms and referred Martin to the counseling center where Allison interns.

Because Allison knows Martin never experienced these symptoms before and had already sought medical help, she continues with a modified CFI question on past help seeking: "Martin, you shared this is the first time you experienced this problem; however, I'm wondering if there were other kinds of help you have found to be useful when dealing with difficult situations?" Martin indicates he typically sought help from his siblings first, much like he does now, and secondarily sought guidance from his parents. In this instance, Martin did not want to worry his parents, so he has not informed them of what is happening. Martin also reports finding some comfort in prayer at mass.

Allison continues with a CFI question about barriers to help seeking: "It sounds like not wanting to worry your parents is getting in the way of accessing their support. Are there other things getting in the way of getting help right now?" Martin responds, "It may be hard for me to find a time to meet every week because I do not want my work to start getting messed up. Also, I do not want anyone to know I am coming here because they will think I am crazy."

Cultural Factors Affecting Current Help Seeking

Allison moves to the final section of the CFI and states, "You told me that calling your sister was helpful when the sudden sweatiness and uncalm feelings come up. Is there anything you can think of that I can provide you with to help in those moments?" Martin thinks a bit and replies, "I think directions on how to get it to stop would be really important because I do not want people at work to notice. As it is they ask me a lot of questions about what I am doing, and the out-of-nowhere sweating and discomfort makes that worse."

After providing brief psychoeducation and explaining potential strategies to address his symptoms, Allison moves to the final CFI question, which attends to the counselor and client relationship. She states, "The counseling relationship is unique because the counselor and client can be very different at times. Like you and I are from different places and look different, too. And because of that, we may not necessarily understand each other immediately. Is this something that worries you?" Martin thinks about this and responds, "Well, you are not a man, and you are not from Mexico. So, I am not sure if you will understand. Also, English is something I am pretty good at, but I am still working on it. Do you speak Spanish in case I have to say things in Spanish?"

Counselor Self-Awareness

The MSJCC (Ratts et al., 2016) and the CFI call for culturally responsive counselors to seek intrapersonal self-awareness and understanding regarding their own social statuses, identities, and worldview (Singh, Nassar, et al., 2020). It is particularly important for counselors working with Afro Latinx immigrants to explore and understand these constructs in relation to their role in the counseling profession, society at large, and in the counseling relationship. As an example, Allison can consider the extent to which her privileged and marginalized identities pertaining to race, ethnicity, and nationality position her in relation to Martin. More specifically, Allison needs to explore how her values and beliefs about these identities influence her views of Martin. Allison can utilize self-reflection to address questions like (a) What are my thoughts, beliefs, and feelings about immigrants who have different ethnic and racial identities than me? (b) What are my thoughts, beliefs, and feelings about immigrants who have similar ethnic and racial identities to mine? and (c) What are my thoughts, beliefs, and feelings about people who are immigrants, regardless of their other identities? These questions will support Allison in developing a greater sense of self-awareness and will encourage openness to understanding Martin's experiences and worldviews. The CFI helped Allison gain a greater understanding of the systems of oppression that may be actively impacting Martin and his well-being while challenging her bias toward individualistic conceptualizations of clients.

Client Worldview

Although client worldview is different for everyone regarding culture and lived experiences, being an Afro descendant and an immigrant in the United States comes with unique and ubiquitous challenges. Afro Latinx immigrants have been found to have lower socioeconomic status, lower income, and overall fewer resources than lighter-skinned immigrants entering the United States (Cuevas et al., 2016). In addition to having fewer economic and social resources available to them, the shared experience of migration as a Black person in the United States may predispose clients with these intersecting identities to experience mistrust toward health care workers and others working for government institutions in general (Mancini & Farina, 2021). As a result, they may be reluctant to seek help from licensed professionals or even engage in health-promoting behaviors. Although it is important for counselors working with this population to engage in cultural encounters that allow clients to define their own experiences of living in the United States as a Black Latinx person, it is also important for the counselor to understand that institutionalized beliefs about Black people and immigrants in the United States can represent significant challenges for the counseling process and clients' growth. As such, the CFI supports the counselor in developing respect for the client's worldview, understanding the ways in which this worldview aligns—or does not align—with their own worldview, and accepting the client as they are to engage in a nonjudgmental and growth-promoting working alliance.

In the case study, Allison used the CFI to examine key elements of the client's worldview, particularly as it related to the cultural definition of the problem and perceptions of the causes and context. For example, the client's concealment of his help-seeking behaviors from some family and friends may be a key point of entry for the counselor's interventions. Through a closer examination of Martin's concealment, Allison may gain a greater understanding of her client's worldview while simultaneously challenging her own biases regarding her beliefs. At the intrapersonal and interpersonal intervention levels, Allison can seek additional awareness and knowledge about the migration experiences of Black Latinx populations through research, supervision, and consultation. At the institutional and community intervention levels, Allison could advocate to increase the awareness of her coworkers and the larger counseling field regarding this population, including specific needs and barriers to consider when working with Afro Latinx immigrants.

Counseling Relationship

Counselors need to develop an appreciation of the unique aspects of the counseling relationship by building on the gained awareness and understanding of themselves and their clients in addition to considering the unique status of their clients and how they are impacted by membership in marginalized and privileged groups—which in turn impacts how the client relates to others and the counselor (Ratts et al., 2016; Singh, Appling, & Trepal, 2020). With this gained awareness of the client's worldview and lived experiences, counselors must authentically engage with their Afro Latinx clients and demonstrate unconditional acceptance of the clients and what they bring into the counseling relationship. Because of the unique social statuses of counselor (who may experience a high degree of privilege) and client (who may experience a level of oppression based on the intersection of identities—race x ethnicity x immigration status), the client–counselor relationship requires significant attention from both parties involved. As the counselor is expected to have an awareness of the dynamics of power and privilege both within and outside the counseling environment, it is the counselor's responsibility to initiate the discourse regarding these dynamics with the clients.

Allison is guided by the awareness of the levels of privilege and marginalization present in the counseling space as emphasized by the MSJCC and put into practice with the CFI. Allison moved beyond this level of awareness by assessing cultural factors affecting current help seeking. The use of the CFI assisted Allison in building the client–counselor relationship but also empowered Martin to collaborate in the direction of their treatment. It should be noted how the CFI instrument in and of itself encapsulates the concept of broaching in counseling, whereby a counselor discusses "those racial, ethnic, and cultural issues that are relevant to a client's presenting concerns" (Day-Vines et al., 2021, p. 348).

Counseling Advocacy and Interventions

In the scenario presented above, Martin's responses illuminated areas in which his counselor could directly engage in advocacy at the individual, intrapersonal, interpersonal, institutional, community, public policy, and global/international ecological levels. At the individual and intrapersonal levels, Allison could continue to strengthen their awareness of possible treatment approaches for this specific client in addition to continuing to develop their self-awareness, particularly around social identities, privilege, and oppression. At the interpersonal level, Allison could make intentional use of the gained knowledge and increased awareness in the counseling process to foster client growth and improvement. At the institutional and community levels, Allison could look for local and national organizations to potentially connect the client to, thereby increasing their community support and network. Allison may also contact the same organizations and seek professional involvement with the goal of advocating with and for Afro Latinx immigrants in the United States. This advocacy may also take the form of presenting webinars and at professional conferences on this particular population.

Implications

As the case study demonstrates, when working with Afro Latinx immigrants, there are multiple ways counselors can integrate the CFI into their counseling practice. Based on their social locations in the United States and considering the sociopolitical climate, Afro Latinx immigrants are likely to experience increased psychological distress (Araujo-Dawson, 2015; Ramos et al., 2003). We illustrated an integration of the CFI to counseling practice as a means to assist counselors and CITs in developing their multicultural responsiveness and further providing culturally sensitive and appropriate services to Afro Latinx immigrants. It must be emphasized that careful explanation of the purpose of the CFI, its confidentiality, and the client's complete control over the information shared is necessary. Multiple recommendations for counselor educators, CITs, and practicing counselors exist.

Counselor Educators

Counselor educators should actively strive toward preparing CITs to be effective and culturally sensitive when working with a wide range of populations. The CFI may be introduced in a variety of Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015) common core areas: counseling and helping relationships, assessment and testing, social and cultural diversity, and practicum and internship. Counselor educators can disseminate the CFI with small and large group skills practice via role plays and case conceptualization to expose CITs to the instrument. In addition, counselor educators may collaborate with site supervisors to incorporate the CFI in their standard intake practices. With this collaboration, CITs would receive additional support and training as they learn to use the CFI with clients to strengthen their culturally responsive assessment and counseling skills.

The case study featured a client who identified as an Afro Latinx immigrant. We encourage counselor educators to facilitate discussions regarding the challenges that Afro Latinx immigrants may face in their lives and highlight the CFI as a tool to develop case conceptualization through an intersectional lens. Through direct emphasis on Afro Latinx immigrant clients, counselor educators can assist their students in strengthening their development as culturally responsive counselors.

Counselors-in-Training

CITs can apply the CFI to conceptualize their clients' presenting problems through a comprehensive and in-depth foundation offered by the MSJCC framework. The CFI questions offer opportunities for CITs to reflect on their client's privileged and/or marginalized statuses and their salient identities, as well as client strengths-based help-seeking strategies. In turn, CITs are challenged to reflect upon their own positionalities and biases. Through continued practice using the CFI both in classroom and clinical settings, CITs can develop and strengthen their counseling competencies in a more intentional and MSJCC-aligned manner. In the case study, Allison, a CIT, had the opportunity to consult with her site supervisor or use the intake session as a case presentation. Both opportunities would provide her with additional feedback on how to effectively use the CFI in her work with this client and other clients with marginalized identities.

Practicing Counselors

Similar to CITs, practicing counselors may integrate the CFI in their assessment efforts either at intake or throughout the counseling process. Though culture remains an important point of emphasis in the counseling of Latinx individuals, counselors must also consider the stressors involved during the migration process, as the experiences of being an immigrant vary based on the type and cause of migration (Jones-Smith, 2018). Similarly, counselors should also explore with the client any preference concerning skin color in the client's family, as this preference may affect the assessment, diagnosis, and treatment of the client (Paniagua, 2013). In the case presented above, the CFI provided key points of entry for the counselor to broach the client's understanding of his presenting problem through his lived experiences of being a Black, Spanish-speaking immigrant in the racialized United States. In allowing for this type of information to be expressed by the client, through the use of the CFI, the counselor would be better prepared to attend to the client's needs in a more effective and MSJCC-aligned manner.

Conclusion

According to the MSJCC, it is imperative that counselor educators continue to incorporate empirically supported interventions and tools, like the CFI, in their teaching of CITs (Ratts et al., 2016). Using these interventions helps counselors to increase their multicultural responsiveness both through gaining knowledge and awareness and by becoming advocates. As it stands, the counseling profession is in continued need of intentional training of students to adequately use this tool and increase cultural sensitivity. To expand counselors' roles as advocates and to integrate multiculturalism and social justice counseling competency into practice, as articulated by the MSJCC, we must reach for additional theories and tools that help us conceptualize privilege, oppression, power, and advocacy within the counseling relationship (Singh, Appling, & Trepal, 2020).

The CFI provides a powerful tool for the enhancement of clinical training and practice in counseling and counselor education. Counselor educators who teach their students to use the CFI in their practice will be equipping them with an empirically supported tool for enhancing their work with multiculturally diverse clients, as exemplified by the case study highlighted in this article. In addition, the CFI offers a viable opportunity for enhanced clinical training that could be translated into culturally responsive clinical practice. Considering the usefulness of the CFI and the lack of attention this tool has received in counselor education, it is crucial to expand our repertoire and make use of all available avenues for increasing the quality of counseling training.

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References

Adames, H. Y., Chavez-Dueñas, N. Y., & Organista, K. C. (2016). Skin color matters in Latino/a communities: Identifying, understanding, and addressing Mestizaje racial ideologies in clinical practice. *Professional Psychology: Research and Practice*, *47*(1), 46–55. https://doi.org/10.1037/pro0000062

Adames, H. Y., Chavez-Dueñas, N. Y., Sharma, S., & La Roche, M. J. (2018). Intersectionality in psychotherapy: The experiences of an AfroLatinx queer immigrant. *Psychotherapy*, *55*(1), 73–79. https://doi.org/10.1037/pst0000152

Aggarwal, N. K., Desilva, R., Nicasio, A. V., Boiler, M., & Lewis-Fernández, R. (2015). Does the Cultural Formulation Interview for the fifth revision of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) affect medical communication? A qualitative exploratory study from the New York site. *Ethnicity & Health*, *20*(1), 1–28. https://doi.org/10.1080/13557858.2013.857762

Aggarwal, N. K., Lam, P., Castillo, E. G., Weiss, M. G., Diaz, E., Alarcón, R. D., van Dijk, R., Rohlof, H., Ndetei, D. M., Scalco, M., Aguilar-Gaxiola, S., Bassiri, K., Deshpande, S., Groen, S., Jadhav, S., Kirmayer, L. J., Paralikar, V., Westermeyer, J., Santos, F. . . . & Lewis-Fernández, R. (2016). How do clinicians prefer cultural competence training? Findings from the DSM-5 Cultural Formulation Interview field trial. *Academic Psychiatry*, *40*(4), 584–591. https://doi.org/10.1007/s40596-015-0429-3

American Psychiatric Association. (2013). Cultural formulation. In *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Araujo-Dawson, B. (2015). Understanding the complexities of skin color, perceptions of race, and discrimination among Cubans, Dominicans, and Puerto Ricans. *Hispanic Journal of Behavioral Sciences*, *37*(2), 243–256. https://doi.org/10.1177/0739986314560850

Araujo-Dawson, B., & Quiros, L. (2014). The effects of racial socialization on the racial and ethnic identity development of Latinas. *Journal of Latina/o Psychology*, *2*(4), 200–213. https://doi.org/10.1037/lat0000024

Ayers, S. L., Kulis, S., & Marsiglia, F. F. (2013). The impact of ethnoracial appearance on substance use in Mexican heritage adolescents in the Southwest United States. *Hispanic Journal of Behavioral Sciences*, *35*(2), 227–240. https://doi.org/10.1177/0739986312467940

Ayón, C., Nieri, T., & Gurrola, M. (2020). Latinx immigrant health and mental health. *Encyclopedia of Social Work*. https://oxfordre.com/socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1299

Barragán, A., Yamada, A.-M., Gilreath, T. D., & Lizano, E. L. (2020). Protective and risk factors associated with comorbid mental health disorders and psychological distress among Latinx subgroups. *Journal of Human Behavior in the Social Environment*, *30*(5), 635–648. https://doi.org/10.1080/10911359.2020.1734515

Capielo Rosario, C., Adames, H. Y., Chavez-Dueñas, N. Y., & Renteria, R. (2019). Acculturation profiles of Central Florida Puerto Ricans: Examining the influence of skin color, perceived ethnic-racial discrimination, and neighborhood ethnic-racial composition. *Journal of Cross-Cultural Psychology*, *50*(4), 556–576. https://doi.org/10.1177/0022022119835979

Cariello, A. N., Perrin, P. B., Williams, C. D., Espinoza, G. A., Morlett-Paredes, A., Moreno, O. A., & Trujillo, M. A. (2020). Moderating influence of enculturation on the relations between minority stressors and physical health via anxiety in Latinx immigrants. *Cultural Diversity and Ethnic Minority Psychology*, *26*(3), 356–366. https://doi.org/10.1037/cdp0000308

Carrola, P. A., & Brown, C. H. (2018). Integrating the Multicultural and Social Justice Counseling Competencies in correctional counseling. *Journal of Counselor Leadership and Advocacy*, *5*(2), 109–121. https://doi.org/10.1080/2326716X.2018.1452077

Cook, A. L., Krell, M. M., Hayden, L. A., Gracia, R., & Denitzio, K. (2016). Fieldwork using the professional development schools model: Developing a social justice orientation and multicultural competency. *Journal of Multicultural Counseling and Development*, *44*(3), 176–188. https://doi.org/10.1002/jmcd.12045

Cuevas, A. G., Araujo-Dawson, B., & Williams, D. R. (2016). Race and skin color in Latino health: An analytic review. *American Journal of Public Health*, *106*(12), 2131–2136. https://doi.org/10.2105/AJPH.2016.303452

Day-Vines, N. L., Cluxton-Keller, F., Agorsor, C., & Gubara, S. (2021). Strategies for broaching the subjects of race, ethnicity, and culture. *Journal of Counseling & Development*, *99*(3), 348–357. https://doi.org/10.1002/jcad.12380

DeSilva, R., Aggarwal, N. K., & Lewis-Fernández, R. (2018). The *DSM-5* Cultural Formulation Interview: Bridging barriers toward a clinically integrated cultural assessment in psychiatry. *Psychiatric Annals, 48*(3), 154–159. https://doi.org/10.3928/00485713-20180214-01

Driscoll, M. W., & Torres, L. (2020). The protective roles of Latinx intercultural competence and acculturation on acculturative stress and depression: A brief longitudinal study. *Journal of Latinx Psychology, 8*(2), 161–177. https://doi.org/10.1037/lat0000138

Gonzalez-Barrera, A. (2022, May 2). *About 6 million U.S. adults identify as Afro-Latino*. Pew Research Center. https://pewrsr.ch/3OdUBEE

Hatzenbuehler, M. L., Prins, S. J., Flake, M., Philbin, M., Frazer, M. S., Hagen, D., & Hirsch, J. (2017). Immigration policies and mental health morbidity among Latinos: A state-level analysis. *Social Science & Medicine, 174*, 169–178. https://doi.org/10.1016/j.socscimed.2016.11.040

Hilert, A. J., & Tirado, C. (2019). Teaching multicultural counseling with mindfulness: A contemplative pedagogy approach. *International Journal for the Advancement of Counselling, 41*(4), 469–480. https://doi.org/10.1007/s10447-018-9363-x

Jarvis, G. E., Kirmayer, L. J., Gómez-Carrillo, A., Aggarwal, N. K., & Lewis-Fernández, R. (2020). Update on the Cultural Formulation Interview. *Focus, 18*(1), 40–46. https://doi.org/10.1176/appi.focus.20190037

Jones-Smith, E. (2018). *Culturally diverse counseling: Theory and practice*. SAGE.

Killian, T., & Floren, M. (2020). Exploring the relationship between pedagogy and counselor trainees' multicultural and social justice competence. *Journal of Counseling & Development, 98*(3), 295–307. https://doi.org/10.1002/jcad.12324

Lee, D. L., & Moh, Y. (2020). New developments in multicultural and social justice counseling competence training. *Journal of Multicultural Counseling and Development, 48*(3), 134–136. https://doi.org/10.1002/jmcd.12172

Lindberg, L. G., Johansen, K. S., Kristiansen, M., Skammeritz, S., & Carlsson, J. (2021). Negotiating engagement, worthiness of care and cultural identities through intersubjective recognition: Migrant patient perspectives on the Cultural Formulation Interview in Danish mental healthcare. *Culture, Medicine, and Psychiatry, 45*(4), 629–654. https://doi.org/10.1007/s11013-020-09694-2

Lipscomb, A. E., & Stevenson, V. (2022). Exploring self-perception and mental health wellness among racialized Afro-Latinos in the United States. *Journal of Sociology and Social Work, 10*(2), 1–8. http://jsswnet.com/journals/jssw/Vol_10_No_2_December_2022/1.pdf

López, N., Vargas, E., Juarez, M., Cacari-Stone, L., & Bettez, S. (2018). What's your "street race"? Leveraging multidimensional measures of race and intersectionality for examining physical and mental health status among Latinxs. *Sociology of Race and Ethnicity, 4*(1), 49–66. https://doi.org/10.1177/2332649217708798

Mancini, M. A., & Farina, A. S. J. (2021). Co-morbid mental health issues in a clinical sample of Latinx adults: Implications for integrated behavioral health treatment. *Journal of Ethnic & Cultural Diversity in Social Work, 30*(4), 326–340. https://doi.org/10.1080/15313204.2019.1702132

Mena, J. A., Soto, J. A., Wei, W., Kaplan, S. E., & Salazar, S. (2020). Does centrality moderate the relation between skin tone satisfaction and psychological adjustment for Latinx Blacks and non-Latinx Blacks? *Race and Social Problems, 12*(3), 219–232. https://doi.org/10.1007/s12552-020-09284-2

Mills, S., Xiao, A. Q., Wolitzky-Taylor, K., Lim, R., & Lu, F. G. (2017). Training on the DSM-5 Cultural Formulation Interview improves cultural competence in general psychiatry residents: A pilot study. *Transcultural Psychiatry, 54*(2), 179–191. https://doi.org/10.1177/1363461517700812

Newby, C. A., & Dowling, J. A. (2007). Black and Hispanic: The racial identification of Afro-Cuban immigrants in the Southwest. *Sociological Perspectives, 50*(3), 343–366. https://doi.org/10.1525/sop.2007.50.3.343

Ornelas, I. J., Yamanis, T. J., & Ruiz, R. A. (2020). The health of undocumented Latinx immigrants: What we know and future directions. *Annual Review of Public Health, 41*(1), 289–308. https://doi.org/10.1146/annurev-publhealth-040119-094211

Ortiz, V., & Telles, E. (2012). Racial identity and racial treatment of Mexican Americans. *Race and Social Problems, 4*(1), 41–56. https://doi.org/10.1007/s12552-012-9064-8

Paniagua, F. A. (2013). *Assessing and treating culturally diverse clients: A practical guide* (4th ed). SAGE.

Ramírez Stege, A. M., & Yarris, K. E. (2017). Culture in *la clínica*: Evaluating the utility of the Cultural Formulation Interview (CFI) in a Mexican outpatient setting. *Transcultural Psychiatry, 54*(4), 466–487. https://doi.org/10.1177/1363461517716051

Ramos, B., Jaccard, J., & Guilamo-Ramos, V. (2003). Dual ethnicity and depressive symptoms: Implications of being Black and Latino in the United States. *Hispanic Journal of Behavioral Sciences*, *25*(2), 147–173. https://doi.org/10.1177/0739986303025002002

Ramos-Sánchez, L. (2020). The psychological impact of immigration status on undocumented Latinx women: Recommendations for mental health providers. *Peace and Conflict: Journal of Peace Psychology*, *26*(2), 149–161. https://doi.org/10.1037/pac0000417

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

Rhodes, S. D., Mann, L., Simán, F. M., Song, E., Alonzo, J., Downs, M., Lawlor, E., Martinez, O., Sun, C. J., O'Brien, M. C., Reboussin, B. A., & Hall, M. A. (2015). The impact of local immigration enforcement policies on the health of immigrant Hispanics/Latinos in the United States. *American Journal of Public Health*, *105*(2), 329–337. https://doi.org/10.2105/AJPH.2014.302218

Singh, A. A., Appling, B., & Trepal, H. (2020). Using the Multicultural and Social Justice Counseling Competencies to decolonize counseling practice: The important roles of theory, power, and action. *Journal of Counseling & Development*, *98*(3), 261–271. https://doi.org/10.1002/jcad.12321

Singh, A. A., Nassar, S. C., Arredondo, P., & Toporek, R. (2020). The past guides the future: Implementing the Multicultural and Social Justice Counseling Competencies. *Journal of Counseling & Development*, *98*(3), 238–252. https://doi.org/10.1002/jcad.12319

Stacciarini, J.-M. R., Smith, R. F., Wiens, B., Pérez, A., Locke, B., & LaFlam, M. (2015). I didn't ask to come to this country . . . I was a child: The mental health implications of growing up undocumented. *Journal of Immigrant and Minority Health*, *17*(4), 1225–1230. https://doi.org/10.1007/s10903-014-0063-2

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2022). *Counseling the culturally diverse: Theory and practice* (9th ed). Wiley.

Telzer, E. H., & Vazquez Garcia, H. A. (2009). Skin color and self-perceptions of immigrant and U.S.-born Latinas: The moderating role of racial socialization and ethnic identity. *Hispanic Journal of Behavioral Sciences*, *31*(3), 357–374. https://doi.org/10.1177/0739986309336913

U.S. Census Bureau. (2021). *The Hispanic population in the United States: 2021*. U.S. Department of Commerce. https://www.census.gov/data/tables/2021/demo/hispanic-origin/2021-cps.html

Washington, A. R., & Henfield, M. S. (2019). What do the AMCD Multicultural and Social Justice Counseling Competencies mean in the context of Black Lives Matter? *Journal of Multicultural Counseling and Development*, *47*(3), 148–160. https://doi.org/10.1002/jmcd.12138

Zeleke, W. A., Karayiğit, C., & Myers-Brooks, K. (2018). Using self-regulated learning strategies to develop students' multicultural counseling competency. *Journal of Multicultural Counseling and Development*, *46*(1), 40–57. https://doi.org/10.1002/jmcd.12091

Diondre Also Has Bad Days: Cannabis Use and the Criminalization of Black Youth

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Rommel Johnson

Black, school-aged youth may experience socioeconomic, psychological, and emotional difficulties that affect their mental health, leading to maladaptive ways of coping, such as cannabis use. Instead of getting treatment and support to help them manage their stressors in positive ways, Black youth often receive punitive school practices, including referrals to the juvenile justice system. Counselors who work with school-aged youth are likely to encounter many Black youth and can thus either be instrumental to their psychological development or inadvertently impede their well-being with over-pathologization and criminalization of their cannabis use. In this article, the author reflects on a particular experience he had working with a Black youth and how it influenced his cultural competency and development as a counselor. The author also discusses the socioeconomic landscape and psychological experience of Black youth and their rationale for cannabis use. The article concludes with implications for professional counselors.

Keywords: **Black youth, cannabis use, criminalization, school-aged youth, cultural competency**

Even though people of all races use drugs at similar rates, drug enforcement in the United States overly targets low-income communities and people of color in general (Camplain et al., 2020; Centers for Disease Control and Prevention [CDC], 2019). A growing body of research further suggests that the enforcement of cannabis laws not only disproportionately affects marginalized communities, but that those laws particularly affect Black adolescents and young adults, who, in comparison to their White counterparts, often experience more cannabis possession arrests (Ammerman et al., 2015; Bunting et al., 2013; Tran et al., 2020). Hence, for many Black youth who use cannabis, especially those who live in low-income communities, the intersection of race and low socioeconomic status (SES) becomes a prelude to systematic stigmatization and over-pathologization, resulting in the criminalization of their cannabis use.

The two monolithic societal institutions most complicit in the criminalization of Black youth's cannabis use include the school/educational system and the juvenile justice system (JJS; Bacher-Hicks et al., 2021; Blitzman, 2021; Sheehan et al., 2021). Because of their scope of influence, power, and authority over all youth in the United States, the systematic decisions and practices endorsed within these institutions in response to Black youth's use of cannabis can often lead to deleterious and enduring consequences that can adversely impact their mental health. Professional counselors who work with school-aged youth will likely be Black youth's first encounter with the counseling profession. Therefore, these counselors' engagement with Black youth will likely set the stage for their perception of behavioral health professionals. These counselors can assume a position of active, resolute defense and support of Black youth to bring an understanding to these systems about their ecology and rationale for cannabis use and foster proactive, helpful, and supportive strategies that nurture positive coping and healthy habits. Furthermore, these counselors can challenge the status quo and effect systematic change to combat the paradigms that stigmatize and pathologize Black youth who use cannabis.

Rommel Johnson, PhD, NCC, LPC, CRC, CAADC, is an assistant professor at The University of Texas Rio Grande Valley. Correspondence may be addressed to Rommel Johnson, 1201 W University School of Rehabilitation Services and Counseling, Edinburg, TX 78539, rommel.johnson@utrgv.edu.

Alternatively, even inadvertently, counselors working in these systems may impede the well-being of Black youth by becoming complicit in these systems and endorsing the pathologization of Black youth and the criminalization of their cannabis use. For instance, counselors may have inherent biases about Black youth, their community, and why they use cannabis. Furthermore, counselors may have views about substance use that prejudice their thinking and approach to working with this population. Even when counselors can bracket their biases (Kocet & Herlihy, 2014), they may fail to address the structural barriers or systems that maintain a posture of criminalizing and dehumanizing Black youth.

Therefore, the purpose of this article is to describe the ecological context of Black youth, particularly in low-SES communities; their reasons for using cannabis; and the response of the school and criminal justice systems to this use. This article also discusses how counselors working in these systems or with Black school-aged youth can be efficacious advocates, promote healthy coping habits, and address systemic barriers that are harmful to Black youth's mental health. To illustrate these issues, I will begin by sharing an anecdote of one of my experiences as an early-career mental health counselor who was part of a multidisciplinary team primarily working with school-aged youth. I hope that this article will make counselors more aware of their biases, particularly regarding cannabis use among Black youth, and that they will work to minimize bias and meet this population's needs effectively.

Personal Anecdote

Very early in my career as a mental health counselor, I had an epiphany about the profession and my unwitting complicity in pathologizing and criminalizing Black youth who used cannabis. I was part of an interagency collaborative team that included the public school system, a community mental health organization, a case management team, and the JJS. Our goal was to help so-called *troubled teens* make better choices and graduate from high school. Referrals to our team usually came from high school teachers, administrators, or the JJS. All the referred youth were enrolled in a public school system. We covered several counties whose demographics included mostly White, Black, and a few Hispanic students.

I was in the position for about 6 months when I noticed a behavior pattern. I must say before I describe this behavior that I had developed relationships with this interdisciplinary team, and they were good people who meant well. However, the approach the team took, including myself, with the White students was different than that used with the Black students. Most of the time, the youth were referred for the same reasons: They were caught smoking, possessing, or being under the influence of cannabis on school grounds. I remember the case of two youths specifically, whom I will refer to as Diondre and Johnny. Johnny was a White teen who lived in a town not too far from Diondre. This town is predominantly White, and Johnny's family would be considered upper middle class. Diondre came from the other side of town, an area that is predominantly Black, which was considered "the ghetto." Diondre's family was considered working class.

As the team simultaneously worked with these two youths, a pattern emerged. The approach with Johnny was very restorative, and there was an inherent belief that Johnny was not "this kind of person," that he was just going through a tough phase, and that we needed to help him bounce back. Team members would say of Johnny, "He's a good kid," "You know, 'boys will be boys,'" and, "He's just experimenting. . . . When I was his age, I did too. I just didn't get caught." Coming out of those meetings, Johnny might have thought of himself: "I'm a good kid. I'm just having a bad day, and this is not really me. I have worth, and people believe that I will eventually turn things around."

In contrast, meetings with Diondre were very combative; there was always a more solemn tone, and sometimes even an aggressive one, used with him. Team members would say about Diondre, "He's acting like a thug," "I think he's in a gang. Is there a father figure in the house?" "We need to get him some mentoring," and "You know, his mom has never attended one of the intervention meetings; she probably doesn't care—you know these parents." At meetings, Diondre would hear statements such as "If you don't stop doing this, you're gonna be in juvie" and "Diondre, you need to shape up. Life is hard, but you gotta toughen up." Coming out of those meetings, Diondre might have thought of himself: "I'm a bad seed, inherently flawed and destined to be locked up. I can't have a bad day. It's always like this. I don't learn. My mom doesn't care about me, and people don't believe I'm worth the trouble."

Because I was the only Black male on the team, I was assigned to "speak some sense" into him—"Have a man-to-man talk with him," as one team member said. I recall during my first meeting with Diondre that he was slumping in the chair, and I caught his eyes—it is an image that is indelibly imprinted on my mind. Diondre sat in the chair defeated, exuding hopelessness and sadness. Looking over at me, before I could get a word out, Diondre mumbled with a sigh, "Man, you don't even know me." His facial expression, his dispirited disposition, and his words shocked me. Immediately, I recognized that yes, it was true: I did not know him. I did not care to know his story, his experience, or his world. I had made assumptions about him and his cannabis use, just like the others on my team.

I realized I had been complicit in the system by criminalizing a young man for his cannabis use and never once finding out what was underneath it. I had never given him the benefit of redemption as I did with Johnny. Now I had learned that, yes, Diondre was redeemable, and like Johnny, he could have bad days. I experienced his life changing as I worked through my biases about him, his community, and his cannabis use, which was something to which I could not relate. Although I had taken a course in multicultural counseling and addiction, I was so steeped in my biases and "cultural superiority" that it impaired my ability to effectively work with a population different from mine. I had become complicit with the system; until my epiphany, I did not advocate for change. I share this story and this article especially for new or emerging counselors who may work in programs or institutions that serve Black youth as a reality check and way of reassessing their roles and fiduciary duties to the clients they serve.

Cannabis Use and Mental Health Among Black Youth

Cannabis is the most frequently used illicit substance by adolescents in the United States (Miech et al., 2017). For instance, in 2019, 37% of U.S. high school students reported past cannabis use, and 22% reported use in the past 30 days (C. M. Jones et al., 2020). Moreover, teenage cannabis use is at its highest level in 30 years, and today's teens are more likely to use cannabis than tobacco (C. M. Jones et al., 2020). Despite this rise in teen use and the laissez-faire, pro-recreational support of cannabis use by the majority of U.S. adults (Van Green, 2022), researchers have well elucidated the dangers of cannabis use on the developing brains of teenagers and youth.

Several studies have, for example, found that consistent or heavy use of cannabis is likely to have permanent effects on adolescents, including long-lasting impairment of cognition, brain structure, and brain function associated with a potentially irreversible decline in intelligence quotient (Batalla et al., 2013; Jackson et al., 2016; Szczepanski & Knight, 2014). Furthermore, long-term use of marijuana during adolescence is also associated with increased incidence and worsened course of psychotic, mood, anxiety, and substance use disorders (Levine et al., 2017). Additionally, the American Academy of Child and Adolescent Psychiatry (AACAP; 2023) asserted that short-term cannabis use can lead to, among other things, problems with memory and concentration, school difficulties, increased aggression, and worsening of underlying mental health conditions. Given these potential harms, it behooves parents and community and government leaders to develop programs and services that can discourage or otherwise lessen the use of cannabis among all youth.

Although many programs and services have been proffered and continue to be developed to address cannabis use among youth, punitive methods that disproportionately affect Black youth continue to be the most dominant approach (Volkow, 2021). Black youth tend to be penalized more frequently and to a greater degree when compared to their White counterparts (Ammerman et al., 2015). Instead of being assessed for treatment and support to help them manage stressors or cope with traumas or other emerging mental health challenges, Black youth disproportionately receive school disciplinary actions ranging from detention to suspension as well as referrals to the JJS (Sheehan et al., 2021), a process that has been aptly referred to as *the school-to-prison pipeline* (Bacher-Hicks et al., 2021; Blitzman, 2021).

Ecology of Black Youth

Several studies that examined racial differences in motives for cannabis use have found that Black adolescents and emerging adults tend to use cannabis for three main reasons: coping, emotional enhancement, and social motives (Buckner et al., 2016; Patrick et al., 2011; Terry-McElrath et al., 2009). Therefore, counselors must seek to understand the environmental context of Black youth, particularly those who live in low-SES communities, to address their cannabis use competently and ethically. Bronfenbrenner's (1995) ecological systems theory can help counselors understand the ecological context in which Black youth's development occurs and, by extension, potentially why they use cannabis.

According to Bronfenbrenner (1995), complex interactions between individuals and their environments shape human development. Bronfenbrenner's model consists of five interrelated systems: microsystem, mesosystem, ecosystem, macrosystem, and chronosystem. Examining these various systems will help counselors deal with their biases and increase their knowledge so they can forge culturally responsive approaches in managing cannabis use. Although numerous aspects are implicated in Black youth's ecological systems, Black youth are frequently more vulnerable to socioeconomic and psychosocial factors that affect their mental health (American Psychological Association, 2017), often leading to maladaptive coping strategies such as cannabis use. A few of these factors are discussed below.

Black youth are more likely to live in impoverished neighborhoods with limited access to quality education, health care, and recreational resources (Sanders et al., 2023). Additionally, Black youth encounter higher rates of unemployment and underemployment compared to their White counterparts (Ren, 2022). These factors sustain their rationale for using cannabis to cope with stressors (Andrews et al., 2015; Mrug et al., 2016).

Black Youth and Mental Health

Another important factor to consider in the ecology of Black youth is their poor mental health status resulting from their social context. Black youth are more likely than their White counterparts to be overrepresented in environments where adverse childhood experiences occur, such as low-income neighborhoods and the foster care system (Bernard et al., 2020). Black children are more likely than White children to be exposed to frightening or threatening experiences (Morsy & Rothstein, 2019). Twice as many Black children compared to White children have lost caregivers to COVID-19 (Treglia et al., 2023), and they have also experienced vicarious racism and trauma in witnessing the widely televised murders of Black people (J. C. Williams et al., 2019).

These environmental stressors, along with psychological factors, including depression, post-traumatic stress, suicide, racism, and substance-using peers, exacerbate Black youth's vulnerability to worsened mental health problems, including depression and suicide. According to the AAKOMA Project, Black youth experience significant anxiety related to decision-making and worrying about bad events happening (Breland-Noble, 2023). King et al. (2022) explained that depression symptomatology can be one of the driving forces behind cannabis use for coping in Black youth and can thus result in more frequent cannabis use. Not only are Black youth experiencing severe challenges associated with SES, education, housing, and mental health, but suicide rates among Black youth have increased sharply (Lindsey et al., 2019; Stone et al., 2023).

Race-Based Trauma

Black youth, particularly in urban environments, report high incidences of exposure to interpersonal trauma (Henderson, 2017). Relatedly, racial trauma due to systemic racism, including discriminatory practices, racial profiling, and unequal access to opportunities, is a critical factor that negatively affects Black youth's mental well-being (J. C. Williams et al., 2019). Constant exposure to racial discrimination can lead to feelings of hopelessness, anxiety, and depression (Mouzon & McLean, 2017). Saleem et al. (2020) explained that racial trauma can significantly contribute to high rates of trauma among Black youth. Schools are often one of the first sites where Black youth experience racial trauma and its physical, psychological, and spiritual consequences (Marie & Watson, 2020).

Suicide

According to data from the CDC, from 2018 to 2021, the largest increase in suicides among people 10–24 years old was Black individuals, with an increase of 37%. This rise in suicide among Black youth has been increasing for over two decades (Stone et al., 2023). Furthermore, between 1991 and 2017, suicide attempts among Black adolescents increased by 73%, while attempts among White youth decreased, according to an analysis of more than 198,000 high school students nationwide (Lindsey et al., 2019).

Furthermore, according to AACAP, suicide rates among Black youth have risen faster than in any other racial/ethnic group over the past two decades, with suicide rates in Black males 10–19 years old increasing by 60% (AACAP, 2023). Additionally, early adolescent Black youth are twice as likely to die by suicide as compared to their White counterparts (AACAP, 2023). Even among the youngest children—ages 5–12—research has found that Black youth in this age category were approximately twice as likely to die by suicide than their White counterparts (Stone et al., 2023).

According to The Trevor Project (2020), 44% of Black LGBTQ youth seriously considered suicide in the past 12 months, including 59% of Black transgender and nonbinary youth. Furthermore, 17% of Black LGBTQ youth attempted suicide in the past 12 months, including more than one in four Black transgender and nonbinary youth. Nearly twice as many Black LGBTQ youth ages 13–17 attempted suicide in the past 12 months compared to Black LGBTQ youth ages 18–24 (The Trevor Project, 2020).

Despite these clear indicators of underlying issues, instead of being perceived as youth with potential cannabis use disorders trying to cope with a myriad of emotional, psychological, and socioeconomic challenges, Black youth who use cannabis are often perceived as pathologically deficient (McElrath et al., 2016) and deserving of punitive treatment approaches such as being referred to the criminal justice system. Hence, the JJS has become the de facto "drug treatment" system for Black youth with substance use disorders (SUDs) in the United States (M. E. Johnson et al., 2022).

Confronting Biases: My Journey of Self-Exploration

Existing biases, stereotypes, and misinformation may lead counselors to assume that Black youth use cannabis more frequently than their White peers, which further justifies pathologization of their cannabis use, just as I did when working on the interdisciplinary team. My and the team's prejudices against Diondre's cannabis use caused us to see him and people in his community as *pathological* users of drugs, unlike Johnny, who was only experimenting and would get over it. These biases were likely, in part, informed by research, which continues to find that Black youth report a greater likelihood of cannabis use than their White counterparts (R. M. Johnson et al., 2019; Lanza et al., 2015; Wu et al., 2016).

As I embarked on a journey of deep self-reflection after my epiphanic moment with Diondre, one of the things I realized was that science and research have historically not only failed the Black community, but they have also been weaponized against it in all domains, especially behavioral health science (Scharff et al., 2010). I thus had to confront an epistemological assumption that helped me understand research differently. Although research articles were limited in describing the complexity of cannabis use within the Black community and Black youth, I came to understand the role of these and other research limitations in the perpetuation of bias and stereotypes.

As explained by Connelly (2013) and Puhan et al. (2012), despite the primary goal of presenting limitations being to provide meaningful information to the reader, too often, limitations in medical education articles are overlooked or reduced to simplistic and minimally relevant themes. Whether clearly communicated by researchers or neglected by practitioners, overlooking limitations and other aspects—such as sample size, population, and other methodological or analytic procedures—can reinforce very harmful beliefs that influence our practice of counseling. Research had informed me and others on the team that Black youth used cannabis more than White youth, but questioning research, particularly research limitations, had opened my eyes to a reality that contradicted what I believed.

I came to realize, as explained by Unger (2012), that much of the research on racial or cultural differences in cannabis use tends to categorize racial groups into broad umbrella designations (e.g., White, Hispanic, Black, Asian) without considering the extensive heterogeneity of people within these categories. Social, biological, cultural, and other factors may contribute to the heterogeneity of risk for substance use by non-racial characteristics, but these factors are not often examined (Unger, 2012).

Lee et al. (2021) examined the complexity of youth's cannabis use across racial, ethnic, and cultural backgrounds. A total of 68,263 adolescents between the ages of 12 and 17 were divided into seven subgroups by race/ethnicity (White, Hispanic, Black, Asian, Native American, Native Hawaiian/Pacific Islander, and mixed race). Lee et al. then examined cannabis-specific risk and protective factors, including perceived availability of cannabis, adolescents' perceived risk of cannabis use, and perceived disapproval of parents, peers, and close friends. Past-month, past-year, and lifetime cannabis use were used as cannabis use outcomes to examine the associations with risk and protective factors as well as with race/ethnicity.

Lee et al.'s (2021) study found that 1) the perceived availability of cannabis was associated with higher use, 2) lower disapproval of cannabis use perceptions and lower cannabis risk perceptions were also associated with greater cannabis use, and 3) disapproval of one's parent(s)/peer(s)/friend(s) was inversely related to past-month, past-year, and lifetime cannabis use. These findings suggest there is substantial heterogeneity of cannabis risk, protective factors, and cannabis use across race and ethnicity among U.S. adolescents when other sociological and cultural factors are considered, as Unger (2012) previously emphasized. So, it is not that Black youth use cannabis more than White youth, but rather that Black youth, particularly in low-SES communities, may experience more risk factors that better account for or motivate cannabis use than their race.

Black Youth, the War on Drugs, and Cannabis Use

The American JJS is characterized by an overrepresentation of Black youth, including Black children at young ages (e.g., Abrams et al., 2021; Puzzanchera, 2021; Puzzanchera et al., 2022). Although Black Americans make up only 15% of all youth, 41% of youth in custody in the United States are Black (Puzzanchera, 2021). Furthermore, according to the Sentencing Project, Black youth are more likely to be in custody than White youth in every state but Hawaii (Rovner, 2023).

In 2017, the Sentencing Project reported that Black youth in the United States disproportionately enter the JJS at significantly higher rates than their White peers. Black youth are more than four times as likely to be detained or committed to juvenile facilities as their White peers (Rovner, 2023). This influx of Black youth in the criminal justice system has been called the school-to-prison pipeline, a phenomenon wherein students are pushed out of public schools and into the JJS, often causing irreparable harm (Hemez et al., 2020).

The school-to-prison pipeline often includes policies such as zero-tolerance discipline, school-based arrests, disciplinary alternative schools, and secured detention (Hemez et al., 2020; Welsh & Little, 2018). Black students are often subject to harsher disciplinary actions at school than White students are, and those punishments can damage students' perceptions of their school and negatively affect their academic success years later (Del Toro & Wang, 2023). Although Black students make up 16% of public school enrollment, they account for 42% of all students who have been suspended multiple times. Black males have led the country in suspensions, expulsions, and school arrests (Green et al., 2020), while Black students with disabilities are the most likely to receive out-of-school suspensions (Harper, 2021).

The JJS is ill equipped to provide support for Black youth who use cannabis for coping. Research indicates that youth in the JJS are grossly under-assessed for SUDs, and many are never referred for SUD treatment, even when current substance use and associated problems are reported (M. E. Johnson et al., 2022). Black youth are sometimes assessed as having behavioral problems rather than having a mental health or substance use issue (AACAP, 2022). Black youth who do receive diagnoses are often misdiagnosed or are over-diagnosed, including with very severe disorders that exaggerate legitimate mental health symptoms (Rutgers University, 2019; Schwartz & Blankenship, 2014).

Given this complexity of their ecological developmental context, it is incumbent upon counselors who work with Black youth, especially in collaboration with or within the JJS, to engage with them ethically, competently, and empathetically instead of becoming complicit with systems that perpetuate racialized systematic barriers that can lead to disastrous outcomes for Black youth. Having a correct understanding of the origin and intent of drug laws in America can help counselors dismantle their prejudices, biases, and assumptions against Black youth.

As mentioned in the anecdote, although I am a Black man, I did not grow up in the United States and therefore lacked significant understanding of certain aspects of U.S. history, which impacted my working with Diondre. For instance, I was aware of slavery, Jim Crow, and racism toward Black people, but was very much ignorant of the composite of laws embodied in the war on drugs and how it originated as a way to demonize Black and Brown people. My journey in understanding Diondre's context led me to the realization that from their inception, most drug laws in the United States were aimed at demonizing Blacks for the purpose of incarceration.

According to Baum (2016), President Nixon's domestic policy advisor John Ehrlichman revealed this very motive in a 1994 interview, in which he stated that the war on drugs had begun as a racially motivated crusade to criminalize Black Americans and the antiwar left:

> The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. . . . You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or blacks, but by getting the public to associate the hippies with marijuana and blacks with heroin. And then criminalizing them both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night in the evening news. Did we know we were lying about the drugs? Of course we did. (LoBianco, 2016, paras. 2–3)

Understanding that policies enshrined in the war on drugs originated with a malicious animus against Black bodies made me realize that a system was in place that continued to propagate the dehumanization of Black people through unwitting yet complicit participants, including me. This knowledge increased my awareness of what I was doing and laid bare my biases and how they influenced my work with Diondre.

Counseling Implications

Although counselors can impede and be complicit in perpetuating systems that are deleterious for Black youth who use cannabis, they can also be crucial allies in supporting their needs. First, counselors need to educate themselves about how addiction occurs. Some counselors may hold on to debunked theories about addiction, such as the choice theory, which erroneously posits that addiction is a choice (Heyman, 2009), or the moral theory, which posits that addiction entails a moral failing (Kennett & McConnell, 2013; Pickard, 2017). Both of these views blame the person with an addiction for their problems, justifying judgmental behaviors toward them, such as my initial approach to working with Diondre. But these views are not consistent with current research and best practices.

Many researchers and government agencies have increasingly come to understand addiction as a brain disease that affects every demographic and that treatment rather than punishment is a much more effective approach in helping people with SUDs (CDC, 2023; Goldstein & Volkow, 2011; R. Johnson, 2021; National Institute on Drug Abuse [NIDA], 2020). Counselors who understand addiction as a disease can provide insight and understanding about the plight of Black youth who use cannabis to cope and can create an environment of empathy, healing, and capacity rather than punishment.

Second, counselors need to understand that many of the drug laws in the United States were not developed based on sound scientific research and a clear understanding of how addiction happens. Rather, they were built on racist ideologies that demonized Black Americans and other racial and ethnic minorities (Flowe, 2021; Hickman, 2000; Waxman, 2019; E. H. Williams, 1914). Combined with flawed addiction theories (e.g., the aforementioned moral model and choice theory), drug laws were designed to penalize instead of treat people battling addiction, especially racial and cultural minorities (Flowe, 2021; Kennett & McConnell, 2013; Pickard, 2017; University of Georgia School of Law, 2022). Counselors should reflect upon what they learned about drugs and both the historic and present regulation of drugs in the United States.

Third, counselors need to increase their level of self-awareness. As Ratts et al. (2015) explained in the Multicultural and Social Justice Counseling Competencies (MSJCC), "Privileged and marginalized counselors develop self-awareness, so that they may explore their attitudes and beliefs, develop knowledge, skills, and actions relative to their self-awareness and worldview" (p. 5). Developing self-awareness is very hard, because it requires a level of vulnerability and honest self-reflection that can often be brutal. Doing the work reflects a deep exploration of one's self, values, beliefs, and assumptions and can bring out a lot of shame, causing one to be trepid and shrink from vital acts of self-exploration. Nevertheless, this work is essential if we are to be honest with ourselves and develop cultural humility.

Moreover, doing the work in my experience has resulted in such an unparalleled and profound groundedness that I have no regrets doing it. This practice of self-exploration has not always been easy, but it has truly transformed my existence as a human being, making me a better person. After my epiphany with Diondre, I explored my *isms.* I remember that one of my *aha* moments was realizing that, although I was a Black man working with Black youth, I was both a victim and a perpetrator of internalized racism (Hall, 2010). Scholars have referred to this phenomenon of Black-on-Black racism in many ways, such as *colorism* (Clark, 2007; Fears, 1998; M. M. Williams, 2011), *internalized racism* (Hall, 2010), and *double consciousness* (Du Bois, 1897). Deep reflection caused me to realize that, even as a Black man in the United States, I had adopted negative messages about individuals in my own race, and these influenced my understanding of my clients' issues and my provision of clinical services.

Both Johnny and Diondre were caught using cannabis, but my and my team's disposition toward them differed. The assumption was that Diondre's use was pathological somehow and required a *heavy hand*, while Johnny's use was exploratory and required a *gentle nudge* in the right direction. Race was the delineating factor, and me being Black did not ensure support for Diondre because of my negative internalizations. Although all forms of racism are harmful, internalized racism is especially toxic, as it is a rejection of self and a tacit acceptance of oppression. Self-exploration as a result of my experience with Diondre not only benefited him, but it helped me grow in my acceptance of my humanity in areas I was unaware that I was neglecting.

This allowed me to be more open to other perspectives and human experiences. I became genuinely interested in Diondre as a person. I visited his community, his church, and his home; I spent time with him and his friends at the park. I met his pastor, who had known him since he was an infant. I saw him playing the drums at his church. I met his uncle, who affirmed that "he gon' be a good quarterback." I met his father, who, although he did not live in the same home with Diondre and his mother, was nonetheless invested in his son's life. I met his cousins who introduced him to cannabis and experienced the verbal chastising of them by their aunt, Diondre's mom. I listened to her talk about her aspirations for her firstborn child and only son. He was a person who was loved. He had challenges, but he also had numerous resources of which I was not aware.

More than 15 years later, I continue to do the work. I assume that I have *isms* that might interfere with the therapeutic process. With my person-centered orientation, I explore elements of culture and identity of my clients; I open a door to explore our differences. The cultural formulation adopted by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders*, (5th ed., text rev.; 2022) is helpful in achieving this. I do it with everyone, even if they appear to be similar to me. Even with clients with whom I only have a few sessions, I find a way to bring up or broach apparent and hidden cultural differences. Broaching is the process by which counselors bring up cultural characteristics of the client and the counselor and invite clients to explore the relevance of those characteristics (Day-Vines et al., 2007). Broaching is very important because it preemptively communicates to the client that their *whole person* is welcomed into the therapeutic space.

We may only have a few minutes in session to do this work, so I would start by saying something like, "Hey, I know that we are both males, but, for instance, I identify as a cisgendered male. What about you? How do you identify? And what concerns do you have about our similarities or differences?" Doing this allows the client to be seen and sets a tone for our interactions. Even when clients brush this off during our initial session, I have experienced instances in which they bring up things later and were thankful for me broaching; they had made note of it, and it made them feel safe with me. I remember exploring cultural differences with Diondre and, through that process, exploring what it meant to be a Black male in his community. We had profound conversations about identifying as a thug or nerd, which his cousins teased him about. Diondre even opened up and began to explore his sexual orientation, something he did not feel safe doing with anyone in his community for fear of being judged. I continue to practice broaching and highly recommend it.

The fourth action counselors can take to be allies for Black youth who use cannabis calls for moving beyond self-exploration and understanding Black youth's culture to a commitment to dismantle systemic barriers. The fourth developmental domain of the MSJCC specifies that social action should be employed in six areas, which include, among others, institutional, community, and public-policy levels, to build multicultural counseling competency (Ratts et al., 2015). Structural racism includes the ways in which societal structures and institutions establish and perpetuate policies, practices, and social norms that reify racial hierarchies, including differential access to material conditions and opportunities based on race (Gee & Ford, 2011). Alvarez et al. (2022) emphasized that system transformations can occur at the client level, at the provider level, and at the organizational and community levels. Getting to know myself and my *isms* and gaining an in-depth perspective of Diondre, his family, and his community allowed me to gain insight into their ecological context and the systems they had to deal with, including the multidisciplinary team I was working with. I was not always successful, but I was very committed to pushing for equitable policies. Counselors within schools, the mental health industry at large, and the JJS have an opportunity to advocate for equitable treatment so that clients such as Diondre can have the same expectations for restoration and redemption despite their ecological contexts.

Conclusion

Over the past 15 years of experience as a professional counselor, I have come to value the experiences that have shaped me into the person I am today. Not that I am free from defects as a person and as a clinician, but I am *becoming*. Becoming a multiculturally competent counselor requires that we constantly look at ourselves and the systems within which we are employed. As our country becomes more polarized and people retreat into silos of ideology, political dogma, religiosity, and otherizing, as counselors we must resist. I am convinced more than ever that we need to maintain a stance that consistently heralds a message of love, compassion, empathy, and humanization.

To do this, we must commit to doing the work—the ongoing and at times painful, awkward, and vulnerable work of intentional self-reflection, advocacy, and action. Black youth, like other marginalized youth and adults, have suffered much and for a long time. In us they should find refuge, warmth, and a safe space to cry, to laugh, and to question themselves, their cultural identity, their gender identity, their faith, and more. Through us, they can learn to develop ways to cope with all that they experience without causing deleterious consequences to themselves. By doing the work, we can realize that, just like Johnny, Diondre can have bad days, and with a little help and support, maybe his bad days or maladaptive coping will not lead to life-altering punitive consequences.

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References

Abrams, L. S., Mizel, M. L., & Barnert, E. S. (2021). The criminalization of young children and overrepresentation of Black youth in the juvenile justice system. *Race and Social Problems*, *13*(1), 73–84. https://doi.org/10.1007/s12552-021-09314-7

Alvarez, K., Cervantes, P. E., Nelson, K. L., Seag, D. E. M., Horwitz, S. M., & Hoagwood, K. E. (2022). Review: Structural racism, children's mental health service systems, and recommendations for policy and practice change. *Journal of the American Academy of Child & Adolescent Psychiatry*, *61*(9), 1087–1105. https://doi.org/10.1016/j.jaac.2021.12.006

American Academy of Child and Adolescent Psychiatry. (2022, March). *AACAP policy statement on increased suicide among Black youth in the U.S.* https://bit.ly/3up0RCw

American Academy of Child and Adolescent Psychiatry. (2023, September). *Marijuana and teens.* https://bit.ly/3OvnaNP

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

American Psychological Association. (2017). *Ethnic and racial minorities & socioeconomic status.* https://www.apa.org/pi/ses/resources/publications/minorities

Ammerman, S., Ryan, S., & Adelman, W. P. (2015). The impact of marijuana policies on youth: Clinical, research, and legal update. *Pediatrics*, *135*(3), 769–785. https://doi.org/10.1542/peds.2014-4147

Andrews, A. R., III, Jobe-Shields, L., López, C. M., Metzger, I. W., de Arellano, M. A. R., Saunders, B., & Kilpatrick, D. G. (2015). Polyvictimization, income, and ethnic differences in trauma-related mental health during adolescence. *Social Psychiatry and Psychiatric Epidemiology*, *50*(8), 1223–1234. https://doi.org/10.1007/s00127-015-1077-3

Bacher-Hicks, A., Billings, S. B., & Deming, D. J. (2021). Proving the school-to-prison pipeline. *Education Next*, *21*(4), 52–57. https://www.educationnext.org/proving-school-to-prison-pipeline-stricter-middle-schools-raise-risk-of-adult-arrests/

Batalla, A., Bhattacharyya, S., Yücel, M., Fusar-Poli, P., Crippa, J. A., Nogué, S., Torrens, M., Pujol, J., Farré, M., & Martin-Santos, R. (2013). Structural and functional imaging studies in chronic cannabis users: A systematic review of adolescent and adult findings. *PLoS ONE*, *8*(2), e55821. https://doi.org/10.1371/journal.pone.0055821

Baum, D. (2016, March 31). *Legalize it all: How to win the war on drugs*. Harper's Magazine. https://harpers.org/archive/2016/04/legalize-it-all/

Bernard, D. L., Calhoun, C. D., Banks, D. E., Halliday, C. A., Hughes-Halbert, C., & Danielson, C. K. (2020). Making the "C-ACE" for a culturally-informed adverse childhood experiences framework to understand the pervasive mental health impact of racism on Black youth. *Journal of Child and Adolescent Trauma*, *14*(2), 233–247. https://doi.org/10.1007/s40653-020-00319-9

Blitzman, J. (2021, October 12). *Shutting down the school-to-prison pipeline*. American Bar Association. https://bit.ly/42r9M2T

Breland-Noble, A. (2023, November 30). *State of mental health for youth of color 2022*. The AAKOMA Project. www.aakomaproject.org/somhyoc-fullreport

Bronfenbrenner, U. (1995). Developmental ecology through space and time: A future perspective. In P. Moen, G. H. Elder, Jr., & K. Lüscher (Eds.), *Examining lives in context: Perspectives on the ecology of human development* (pp. 619–647). American Psychological Association. https://doi.org/10.1037/10176-018

Buckner, J. D., Shah, S. M., Dean, K. E., & Zvolensky, M. J. (2016). Cannabis use frequency and use-related impairment among African-American and White users: The impact of cannabis use motives. *Ethnicity & Health*, *21*(3), 318–331. https://doi.org/10.1080/13557858.2015.1065311

Bunting, W. C., Garcia, L., & Edwards, E. (2013, June). *The war on marijuana in Black and White*. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2819708

Camplain, R., Camplain, C., Trotter, R. T., II, Pro, G., Sabo, S., Eaves, E., Peoples, M., & Baldwin, J. A. (2020). Racial/ethnic differences in drug- and alcohol-related arrest outcomes in a southwest county from 2009 to 2018. *American Journal of Public Health*, *110*(S1), S85–S92. https://doi.org/10.2105/ajph.2019.305409

Centers for Disease Control and Prevention. (2019). Table 20: Use of selected substances in the past month among persons aged 12 years and over, by age, sex, and race and Hispanic origin: United States, selected years 2002–2018. https://www.cdc.gov/nchs/data/hus/2019/020-508.pdf

Centers for Disease Control and Prevention. (2023, July 25). *Stigma reduction: Understanding addiction to support recovery*. https://bit.ly/3SINhmW

Clark, W. A. V. (2007). Race, class, and place: Evaluating mobility outcomes for African Americans. *Urban Affairs Review*, *42*(3), 295–314. https://doi.org/10.1177/1078087406292531

Connelly, L. M. (2013). Limitation section. *Medsurg Nursing*, *22*(5), 325, 336.

Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M. J. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development*, *85*(4), 401–409. https://doi.org/10.1002/j.1556-6678.2007.tb00608.x

Del Toro, J., & Wang, M.-T. (2023). Vicarious severe school discipline predicts racial disparities among non-disciplined Black and White American adolescents. *Child Development*, *94*(6), 1762–1778. https://doi.org/10.1111/cdev.13958

Du Bois, W. E. B. (1897, August). Strivings of the Negro people. *The Atlantic Monthly*. https://www.theatlantic.com/magazine/archive/1897/08/strivings-of-the-negro-people/305446/

Fears, L. M. (1998). Colorism of Black women in news editorial photos. *The Western Journal of Black Studies*, *22*(1), 30–36.

Flowe, D. (2021). "Drug-mad Negroes": African Americans, drug use, and the law in progressive era New York City. *The Journal of the Gilded Age and Progressive Era*, *20*(4), 503–522. https://doi.org/10.1017/S1537781421000384

Gee, G. C., & Ford, C. L. (2011). Structural racism and health inequities: Old issues, new directions. *Du Bois Review: Social Science Research on Race*, *8*(1), 115–132. https://doi.org/10.1017/S1742058X11000130

Goldstein, R. Z., & Volkow, N. D. (2011). Dysfunction of the prefrontal cortex in addiction: Neuroimaging findings and clinical implications. *Nature Reviews Neurosciences*, *12*(11), 652–669. https://doi.org/10.1038/nrn3119

Green, E. L., Walker, M., & Shapiro, E. (2020, October). A battle for the souls of Black girls. *The New York Times*. https://www.nytimes.com/2020/10/01/us/politics/black-girls-school-discipline.html

Hall, M. L. (2010). Re-constituting place and space: Culture and communication in the construction of a Jamaican transnational identity. *Howard Journal of Communications*, *21*(2), 119–140. https://doi.org/10.1080/10646171003727425

Harper, S. R. (2021). Black people vs. educational culprits engaged in our systemic mass incarceration in the United States of America. *Peabody Journal of Education*, *96*(5), 582–587. https://doi.org/10.1080/0161956x.2021.1991700

Hemez, P., Brent, J. J., & Mowen, T. J. (2020, July). Exploring the school-to-prison pipeline: How school suspensions influence incarceration during young adulthood. *Youth Violence and Juvenile Justice*, *18*(3), 235–255. https://doi.org/10.1177/1541204019880945

Henderson, Z. (2017). In their own words: How Black teens define trauma. *Journal of Child & Adolescent Trauma*, *12*(1), 141–151. https://doi.org/10.1007/s40653-017-0168-6

Heyman, G. M. (2009). *Addiction: A disorder of choice*. Harvard University Press.

Hickman, T. A. (2000). Drugs and race in American culture: Orientalism in the turn-of-the-century discourse of narcotic addiction. *American Studies*, *41*(1), 71–91. https://www.jstor.org/stable/40643117

Jackson, N. J., Isen, J. D., Khoddam, R., Irons, D., Tuvblad, C., Iacono, W. G., McGue, M., Raine, A., & Baker, L. A. (2016). Impact of adolescent marijuana use on intelligence: Results from two longitudinal twin studies. *Proceedings of the National Academy of Sciences of the United States of America, 113*(5), E500–508. https://doi.org/10.1073/pnas.1516648113

Johnson, M. E., Lloyd, S. L., Bristol, S. C., Elliott, A. L., & Cottler, L. B. (2022). Black girls and referrals: Racial and gender disparities in self-reported referral to substance use disorder assessment among justice-involved children. *Substance Abuse Treatment, Prevention, and Policy*, *17*(1). https://doi.org/10.1186/s13011-022-00462-6

Johnson, R. (2021). Drug laws and policy. In E. Blanco, R. Johnson, F. Mercado, & C. Ortega (Eds.), *Substance use and addiction: How did we get here and how do we recover?* Great River Learning.

Johnson, R. M., Fleming, C. B., Cambron, C., Dean, L. T., Brighthaupt, S.-C., & Guttmannova, K. (2019). Race/ethnicity differences in trends of marijuana, cigarette, and alcohol use among 8th, 10th, and 12th graders in Washington State, 2004–2016. *Prevention Science*, *20*(2), 194–204. https://doi.org/10.1007/s11121-018-0899-0

Jones, C. M., Clayton, H. B., Deputy, N. P., Roehler, D. R., Ko, J. Y., Esser, M. B., Brookmeyer, K. A., & Hertz, M. F. (2020). Prescription opioid misuse and use of alcohol and other substances among high school students—Youth Risk Behavior Survey, United States, 2019. *Morbidity and Mortality Weekly Report*, *69*, 38–46. https://doi.org/10.15585/mmwr.su6901a5

Kennett, J., & McConnell, D. (2013). Explaining addiction: How far does the reward account of motivation take us? *Inquiry*, *56*(5), 470–489. https://doi.org/10.1080/0020174X.2013.806133

King, V. L., Mrug, S., & Windle, M. (2022). Predictors of motives for marijuana use in African American adolescents and emerging adults. *Journal of Ethnicity in Substance Abuse*, *21*(1), 3–21. https://doi.org/10.1080/15332640.2020.1747038

Kocet, M. M., & Herlihy, B. J. (2014). Addressing value-based conflicts within the counseling relationship: A decision-making model. *Journal of Counseling & Development*, *92*(2), 180–186. https://doi.org/10.1002/j.1556-6676.2014.00146.x

Lanza, S. T., Vasilenko, S. A., Dziak, J. J., & Butera, N. M. (2015). Trends among U.S. high school seniors in recent marijuana use and associations with other substances: 1976–2013. *Journal of Adolescent Health*, *57*(2), 198–204. https://doi.org/10.1016/j.jadohealth.2015.04.006

Lee, M. H., Kim-Godwin, Y. S., & Hur, H. (2021). Race/ethnicity differences in risk and protective factors for marijuana use among U.S. adolescents. *BMC Public Health*, *21*(1), 1167. https://doi.org/10.1186/s12889-021-11159-z

Levine, A., Clemenza, K., Rynn, M., & Lieberman, J. (2017). Evidence for the risks and consequences of adolescent cannabis exposure. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(3), 214–225. https://doi.org/10.1016/j.jaac.2016.12.014

Lindsey, M. A., Sheftall, A. H., Xiao, Y., & Joe, S. (2019). Trends of suicidal behaviors among high school students in the United States: 1991–2017. *Pediatrics*, *144*(5). https://doi.org/10.1542/peds.2019-1187

LoBianco, T. (2016, March). Report: Aide says Nixon's war on drugs targeted blacks, hippies. *CNN*. www.cnn.com/2016/03/23/politics/john-ehrlichman-richard-nixon-drug-war-blacks-hippie/index.html

Marie, T., & Watson, K. (2020). Remembering an apocalyptic education: Revealing life beneath the waves of Black being. *Root Work Journal*, *1*(1), 14–48. https://doi.org/10.47106/4rwj.11.02181931

McElrath, K., Taylor, A., & Tran, K. K. (2016). Black–White disparities in criminal justice referrals to drug treatment: Addressing treatment need or expanding the diagnostic net? *Behavioral Science*, *6*(4), 21. https://doi.org/10.3390/bs6040021

Miech, R. A., Johnston, L. D., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E., & Patrick, M. E. (2017). *Monitoring the Future national survey results on drug use, 1975–2016: Volume I, secondary school students*. University of Michigan Institute for Social Research. https://hdl.handle.net/2027.42/139711

Morsy, L., & Rothstein, R. (2019, May). *Toxic stress and children's outcomes: African American children growing up poor are at greater risk of disrupted physiological functioning and depressed academic achievement*. Economic Policy Institute. https://bit.ly/3HHz5nM

Mouzon, D. M., & McLean, J. S. (2017). Internalized racism and mental health among African-Americans, US-born Caribbean Blacks, and foreign-born Caribbean Blacks. *Ethnicity & Health*, *22*(1), 36–48. https://doi.org/10.1080/13557858.2016.1196652

Mrug, S., King, V., & Windle, M. (2016). Brief report: Explaining differences in depressive symptoms between African American and European American adolescents. *Journal of Adolescence*, *46*(1), 25–29. https://doi.org/10.1016/j.adolescence.2015.10.017

National Institute on Drug Abuse. (2020, July). Drugs, brains, and behavior: The science of addiction: Drug misuse and addiction. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction

Patrick, M. E., Schulenberg, J. E., O'Malley, P. M., Maggs, J. L., Kloska, D. D., Johnston, L. D., & Bachman, J. G. (2011). Age-related changes in reasons for using alcohol and marijuana from ages 18 to 30 in a national sample. *Psychology of Addictive Behaviors*, *25*(2), 330–339. https://doi.org/10.1037/a0022445

Pickard, H. (2017). Responsibility without blame for addiction. *Neuroethics*, *10*, 169–180. https://doi.org/10.1007/s12152-016-9295-2

Puhan, M. A., Akl, E. A., Bryant, D., Xie, F., Apolone, G., & ter Riet, G. (2012). Discussing study limitations in reports of biomedical studies—the need for more transparency. *Health and Quality of Life Outcomes*, *10*(1), 23. https://doi.org/10.1186/1477-7525-10-23

Puzzanchera, C. (2021). Juvenile arrests, 2019. *Juvenile Justice Statistics.* Bulletin. U.S. Department of Justice, OJP, National Institute of Justice. https://nij.ojp.gov/library/publications/juvenile-arrests-2019

Puzzanchera, C., Hockenberry, S., & Sickmund, M. (2022, December). *Youth and the juvenile justice system: 2022 national report.* National Center for Juvenile Justice. https://ojjdp.ojp.gov/publications/2022-national-report.pdf

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2015). 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

Ren, C. (2022). Cohort, signaling, and early-career dynamics: The hidden significance of class in Black-White earnings inequality. *Social Science Research*, *106*. https://doi.org/10.1016/j.ssresearch.2022.102710

Rovner, J. (2023, December 12). *Black disparities in youth incarceration.* The Sentencing Project. https://www.sentencingproject.org/fact-sheet/black-disparities-in-youth-incarceration/

Rutgers University. (2019, March 21). African Americans more likely to be misdiagnosed with schizophrenia, study finds. *ScienceDaily*. https://sciencedaily.com/releases/2019/03/190321130300.htm

Saleem, F. T., Anderson, R. E., & Williams, M. (2020). Addressing the "myth" of racial trauma: Developmental and ecological considerations for youth of color. *Clinical Child and Family Psychology Review*, *23*, 1–14. https://doi.org/10.1007/s10567-019-00304-1

Sanders, M., Winston, J., & Rochester, S. E. (2023). Most Black children live in neighborhoods that lack amenities associated with child well-being. *Child Trends*. https://www.childtrends.org/blog/most-black-children-live-in-neighborhoods-that-lack-amenities-associated-with-child-well-being

Scharff, D. P., Mathews, K. J., Jackson, P., Hoffsuemmer, J., Martin, E., & Edwards, D. (2010). More than Tuskegee: Understanding mistrust about research participation. *Journal of Health Care for the Poor and Underserved*, *21*(3), 879–897. https://doi.org/10.1353/hpu.0.0323

Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World Journal of Psychiatry*, *4*(4), 133–140.

Sheehan, B. E., Grucza, R. A., & Plunk, A. D. (2021, October). Association of racial disparity of cannabis possession arrests among adults and youths with statewide cannabis decriminalization and legalization. *JAMA Health Forum*, *2*(10). https://doi.org/10.1001/jamahealthforum.2021.3435

Stone, D. M., Mack, K. A., & Qualters, J. (2023). Notes from the field: Recent changes in suicide rates, by race and ethnicity and age group—United States, 2021. *Morbidity and Mortality Weekly Report*, *72*(6), 160–162. https://doi.org/10.15585/mmwr.mm7206a4

Szczepanski, S. M., & Knight, R. T. (2014). Insights into human behavior from lesions to the prefrontal cortex. *Neuron*, *83*(5), 1002–1018. https://doi.org/10.1016/j.neuron.2014.08.011

Terry-McElrath, Y. M., O'Malley, P. M., & Johnston, L. D. (2009). Reasons for drug use among American youth by consumption level, gender, and race/ethnicity: 1976–2005. *Journal of Drug Issues*, *39*(3), 677–713. https://doi.org/10.1177/002204260903900310

Tran, N. K., Goldstein, N. D., Purtle, J., Massey, P. M., Lankenau, S. E., Suder, J. S., & Tabb, L. P. (2020). The heterogeneous effect of marijuana decriminalization policy on arrest rates in Philadelphia, Pennsylvania, 2009–2018. *Drug and Alcohol Dependence*, *212*, 108058. https://doi.org/10.1016/j.drugalcdep.2020.108058

Treglia, D., Cutuli, J. J., Arasteh, K., & Bridgeland, J. (2023). Parental and other caregiver loss due to COVID-19 in the United States: Prevalence by race, state, relationship, and child age. *Journal of Community Health*, *48*, 390–397. https://doi.org/10.1007/s10900-022-01160-x

The Trevor Project. (2020). *The Trevor Project National Survey 2020*. https://www.thetrevorproject.org/survey-2020/?section=Introduction

Unger, J. B. (2012). The most critical unresolved issues associated with race, ethnicity, culture, and substance use. *Substance Use & Misuse*, *47*(4), 390–395. https://doi.org/10.3109/10826084.2011.638017

University of Georgia School of Law. (2022). Survey of marijuana law in the United States: History of marijuana regulation in the United States. https://libguides.law.uga.edu/c.php?g=522835&p=3575350

Van Green, T. (2022, November 22). *Americans overwhelmingly say marijuana should be legal for medical or recreational use*. Pew Research Center. https://www.pewresearch.org/short-reads/2022/11/22/americans-overwhelmingly-say-marijuana-should-be-legal-for-medical-or-recreational-use/

Volkow, N. D. (2021, August 9). *Punishing drug use heightens the stigma of addiction*. National Institute on Drug Abuse. https://nida.nih.gov/about-nida/noras-blog/2021/08/punishing-drug-use-heightens-stigma-addiction

Volkow, N. D., Swanson, J. M., Evins, A. E., DeLisi, L. E., Meier, M. H., Gonzalez, R., Bloomfield, M. A. P., Curran, H. V., & Baler, R. (2016). Effects of cannabis use on human behavior, including cognition, motivation, and psychosis: A review. *JAMA Psychiatry*, *73*(3), 292–297. https://doi.org/10.1001/jamapsychiatry.2015.3278

Waxman, O. B. (2019, April 20). The surprising link between U.S. marijuana law and the history of immigration. *Time*. https://time.com/5572691/420-marijuana-mexican-immigration/

Welsh, R. O., & Little, S. (2018). Caste and control in schools: A systematic review of the pathways, rates, and correlates of exclusion due to school discipline. *Children and Youth Services Review*, *94*, 315–339. https://doi.org/10.1016/j.childyouth.2018.09.031

Williams, E. H. (1914, February 8). Negro cocaine "fiends" are a new southern menace; murder and insanity increasing among lower class Blacks because they have taken to "niffing" since deprived of whisky by prohibition. *The New York Times*. https://www.nytimes.com/1914/02/08/archives/negro-cocaine-fiends-are-a-new-southern-menace-murder-and-insanity.html

Williams, J. C., Holloway, T. D., & Ross, D. A. (2019). Witnessing modern America: Violence and racial trauma. *Biological Psychiatry*, *86*(11), e41–e42. https://doi.org/10.1016/j.biopsych.2019.09.025

Williams, M. M. (2011). *Colorism in the Spanish Caribbean: Legacies of race and racism in Dominican and Puerto Rican literature.* University of Denver, Denver, CO: Electronic Theses and Dissertations. 709. https://digitalcommons.du.edu/etd/709

Wu, L.-T., Zhu, H., & Swartz, M. S. (2016). Trends in cannabis use disorders among racial/ethnic population groups in the United States. *Drug and Alcohol Dependence*, *165*, 181–190. https://doi.org/10.1016/j.drugalcdep.2016.06.002

Utilizing Collective Wisdom: Ceremony-Assisted Treatment for Native and Non-Native Clients

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Julie Smith-Yliniemi, Krista M. Malott, JoAnne Riegert, Susan F. Branco

Faith and Indigenous healing ceremonies offer spiritually oriented interventions that maintain client wellness or mitigate client existential, biopsychosocial, or spiritual distress. Mental health practitioners of all identities may ethically apply ceremony-assisted treatments with Native and non-Native populations. Three such interventions are described in this article, drawn from Indigenous traditions as practiced personally and professionally by the first and third authors. Directives for use, including populations appropriate for application, adaptations, ethical considerations, and culturally responsive competency considerations, are included.

Keywords: **Indigenous, healing ceremonies, ceremony-assisted treatments, Native, culturally responsive**

Across time and cultures, humans have engaged in rituals as a means for fostering healing, resilience, grounding, and connection to something larger than oneself, to ultimately create and sustain meaning and health in life (Dallas et al., 2020; Ingerman, 2018). A ritual or ceremony entails enacting a sequence of behaviors or ideas relating to symbols and meanings (La Fontaine, 1985). Healing ceremonies are spiritually oriented rituals that seek to return a person to wellness or to maintain one's physical, spiritual, or emotional health, particularly in the face of perceived threats or losses (Crouch, 2016; Kumar et al., 2023). Such traditions often stem from religious, cultural, or ethnic roots and are commonly performed to signify celebrations or other important events (Kumar et al., 2023). These acts also offer spiritual coping as a means to address difficult existential, biopsychosocial, or spiritual situations (Crouch, 2016; Mathew, 2021); to elicit healing narratives or conversations regarding trauma; and to honor feelings of frustration, fear, anxiety, and guilt (Crouch, 2016).

Indigenous healing and ceremonial practices are part of community wellness and healing traditions for Native tribes across the North American continent (Causadias et al., 2022; Saiz et al., 2021). Such practices are passed down by the generations, despite having been forced underground for a period when the U.S. government outlawed Native American cultural practices (Irwin, 1997). Indeed, colonizers have sought to suppress and erase the Indigenous knowledge and practices of colonized communities around the world throughout history.

Scholars have recently recognized the efforts of Indigenous communities across North America to reclaim the many traditional practices to which they had been denied access because of the violence of colonization (McCormick, 2021). This healing movement is embodied in the United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2008), emphasizing the rights of Indigenous people to maintain their cultural, spiritual, and health traditions and practices (Kumar et al., 2023; McCormick, 2021). In turn, ceremony-assisted treatments can be used by and with persons

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Julie Smith-Yliniemi, PhD, NCC, LPCC, is an assistant professor and Director of Community Engaged Research at the University of North Dakota. Krista M. Malott, PhD, LPC, is a full professor at Villanova University. JoAnne Riegert, PhD, LPCC, is a mental health professional from the White Earth Indian Reservation. Susan F. Branco, PhD, NCC, BC-TMH, LPC, LCPC, ACE, is an associate professor at Palo Alto University. Correspondence may be addressed to Julie Smith-Yliniemi, 1301 N Columbia Rd, Suite E-2, Grand Forks, ND 58202, julie.smithyliniemi@und.edu.

of all Indigenous roots to enact healing and sustain wellness and survivance (e.g., resistance and thriving in the face of oppression; Vizenor, 1993).

Because of the efficacious nature of healing rituals, mental health practitioners of all identities have sought to apply traditional practices with Indigenous clientele and in addressing a variety of symptoms of client distress (McCormick, 2021). Non-Native American mental health practitioners have drawn upon Indigenous rituals such as smudging and drumming to address myriad forms of presenting distress across tribal groups (Blackett & Payne, 2005). Examples of issues addressed through such rituals include chronic pain (Greensky et al., 2014), distress from discrimination and colonization (Lu & Yuen, 2012; West-Olatunji et al., 2008), and substance use (Spillane et al., 2021).

In light of the universal practice around making meaning through ritual, certain Indigenous interventions may also be considered for adaptation with non-Native clientele, albeit with caution and an ethical mindset (Rathod et al., 2019). Currently, however, there are limited guidelines around the ethical implementation of ceremony-assisted interventions for non-Native practitioners, particularly for work with non-Native clientele. Such guidelines are essential to mitigate harmful acts of appropriation born from colonization and the continued exploitation of Indigenous communities and their practices on the North American continent (Meade et al., 2022).

Consequently, considering the importance and power of ritual and ceremony as a healing and wellness practice, we offer recommendations for non-Native and Native practitioners to ethically explore and incorporate ceremony-assisted interventions into practice with Native and non-Native clientele. We provide an overview of relevant provisions of the American Counseling Association's *ACA Code of Ethics* (ACA; 2014) and, through examples, outline how practitioners can implement ceremony-assisted treatments while avoiding cultural appropriation.

Next, we present three ceremony-assisted treatments, including smudging, drumming, and a letting-go ceremony. Such traditions stem from Indigenous origins and are applied by authors Smith-Yliniemi and Riegert in both professional and personal settings. Suggestions for use, including appropriate populations and areas of distress, are included. We address ethical considerations in promoting respectful and culturally sensitive use of each practice, to share traditions with broader populations while seeking to maintain the cultural integrity of said practices.

Regarding language use in this article, we will interchangeably apply the terms Native, Native American, Indian, and Indigenous to refer to persons who are indigenous to Turtle Island (i.e., the lands recognized by the dominant normative population as North America). Reference will be made to *Creator*, to indicate a universal reference by Indigenous communities of a spiritual presence greater than oneself. In addition, drawing from the preferred naming conventions of tribal communities, the terms Ojibwe and Anishinaabe will be used interchangeably in referring to Smith-Yliniemi's and Riegert's origins. However, we recognize that Indigenous people on Turtle Island are a diverse group of tribes or nations with their own languages, traditions, cultures, and naming conventions (National Museum of the American Indian, n.d.). Consequently, different tribes or Indigenous communities may choose different terminologies and for unique reasons, and many will likely take differing stances from those put forth in this article.

Practitioner Positionality

As the authors, we collectively identify as counselor educators. We each approach the directives in this article with multiple intersecting identities and critical lenses with which we seek to understand and make meaning of the world and our work. We attempt to embody cultural humility, responsiveness, and antiracist and decolonizing frameworks. We recognize that counseling as a practice has historically applied a pathologizing and therefore harmful lens toward clientele and, in particular, toward communities whose identities have been minoritized by dominant normative systems (Malott et al., 2023). Hence, to counter this deficit-based narrative, we ascribe to a strengths-based perspective and recommend practitioners do likewise (White et al., 2020). We encourage Native American practitioners seeking to "remember what they already know" about Indigenous practices as they return to their ancestral roots. In light of these points, we will transparently and authentically share the identities and frameworks we bring to this work.

Julie Smith-Yliniemi identifies as an Anishinaabe ikwe, an Indigenous woman, who grew up on a Native American reservation in the Midwest. Additional heritage includes Scandinavian descent. Intersectionalities include being a mother, wife, daughter, cisgender, temporarily able-bodied, and a person who engages in her traditional Native American ceremonial practices. Her personal and professional lens is grounded in humanistic and relational–cultural theories.

Krista M. Malott identifies with multiple intersecting identities that profoundly shape her lens, some of which include being White, U.S.–born, cisgender, female, temporarily able-bodied, spiritually agnostic, and a member of a transracially adoptive family. She principally assumes humanist, systemic, antiracist, and intersectional lenses, which shape her worldviews and her approach to her work.

JoAnne Riegert identifies as an Anishinaabe ikwe who lives and works on a Native American Indian reservation in a rural community. Her ancestral heritage also includes French Canadian and German descent. Her familial roles include being a grandmother, mother, sister, daughter, niece, and aunt. She is steeped in the Native American community and her worldview originates from this perspective. Her theoretical foundation incorporates restorative justice practices and relational-cultural theory.

Susan F. Branco identifies as a Latina, South American–born, transracial adoptee, cisgender female, able-bodied, descendent of the Guahibo tribe, and connected to the Anishinaabe culture through marriage. She is an active member of the adoptee community and is working to reculturate and reclaim her lost cultural and Indigenous heritage. Her clinical and scholarly work revolve around relational-cultural and liberation theories.

Ethical Application and Considerations

For the purpose of this article, we approach the concept of adaptation with a collectivist perspective, whereby we eschew an ownership concept of healing practices by any one cultural group. Consequently, as counselor educators and mental health practitioners, we collectively suggest that some Indigenous ritual or ceremonial healing practices may also be adapted for clients of non-Native identities, and by practitioners of all cultural identities, albeit while keeping certain points in mind—for example, if undertaken with respect and sensitivity, awareness, and guidance, and with the understanding that every person has origins to some tract of land and a spiritual connection to earth and self. This perspective is not true, of course, for all Native interventions, and not all Indigenous people will adhere to this stance. Attending to ethical guidelines can reduce the risk of appropriation, whereby cultural knowledge is used without proper and respectful acknowledgement to the cultural creators (Lalonde, 2021). Ethical guidelines may also increase cultural appreciation, adaptation, and acknowledgement, along with respectful attribution to the creators of certain interventions without stereotyping (Han, 2019; Hiratsuka et al., 2018; Meade et al., 2022).

To further attend to issues of ethics and harm in drawing on Indigenous healing ceremonies, non-Native counselors may refer to Meade et al.'s *Checklist for Counselor Practitioners* (2022). Meade and colleagues (2022) cited the need for practitioners to acquire cultural knowledge to more ethically implement ceremony-assisted practices, beginning with researching the "origins of the clinical intervention" (p. 103). We encourage practitioners to consider relevant ethical standards (ACA, 2014) as a starting point in the journey to Indigenous practice implementation and adaptation. We will denote suggested ethical standards after each ceremony-assisted treatment description.

Ceremony-Assisted Treatments

In the following sections we describe three specific healing rituals premised on Indigenous ceremonial treatments as means for supporting clients in healing or in sustaining wellness in a private (i.e., individual client) setting: smudging, drumming, and a letting-go ceremony. We detail when and how (and with whom) such practices could optimally be applied. A case example is used to illustrate application of each ritual with clients, with directives for the cultural adaptation of each. Considering the right and essential need for Indigenous peoples to protect their lands, traditions, and ceremonies (Drissi, 2023; United Nations, 2008), each ritual includes directives according to ethical use of its application, including consideration around appropriation and reverence for land and material use, when applicable.

Smudging

Smudging is an act of burning a traditional medicinal plant with the purpose of cleansing the body, mind, or spirit; renewing energy within and around individuals in a particular space or with a certain object; or calling for help in opening oneself to a new experience (Borden & Coyote, 1991). Some people incorporate smudging into their daily lives, while others apply it as needed. For instance, if a person is in the presence of someone who is giving off negativity or energy that is not welcoming, they may leave and smudge themselves to cleanse themselves of the negativity. At other times, if a person receives a gift or buys something new, they smudge that object in order to cleanse it. Cleansing a space to bring positive energy is also a common use of smudging. Hence, if someone moves into a new or different home, or is using a specific space for a ceremony, they might walk around the space, smudging it.

Smudging may invoke positive energy for a specific event. For instance, both in-person or virtual meetings can be started with a smudge. Smith-Yliniemi smudges each morning as a way to start her day positively. A counselor could begin sessions with a smudge, if the client desires to do so, along with personalizing or adapting the ceremony according to the client's expressed needs or wants.

Smudging is a ceremonial process with a purpose, a beginning, and an end, with different teachings according to different tribal or community norms. Examples of smudging materials include cedar, sage, and sweetgrass. Those materials can be purchased or found in nature. In Smith-Yliniemi's Anishinaabe community, sage is used, and it is gathered within a natural setting, with the act of gathering as part of the ceremonial process. Grown in the wild, sage differs according to the ecosystem in which it resides. Smith-Yliniemi's community typically picks sage annually during the summer months when it is grown and ready, typically found in ditches and usually in patches. The person picking the sage will offer tobacco to Mother Earth and to the sage plant prior to picking it, to give thanks.

Traditional tobacco has been used for spiritual and medicinal purposes within communities for generations. It is central to culture, spirituality, and healing (National Native Network, n.d.). To offer tobacco, a person takes a pinch of loose-leaf tobacco from a bag or jar and places it in the palm of their left hand. The left hand is typically used because it is closest to our hearts. One then closes their hand with the tobacco secured in the fist and prays to Mother Earth and gives gratitude for the healing medicine offered by sage; they also ask the sage to help all who smudge with it. After the prayer, the tobacco in the left hand is gently placed next to the sage plants intended for harvest.

One of the Anishinaabe Original Instructions from Creator is to take only what one needs, so that there is enough for others. Individuals typically pick enough sage for those who are unable to do so, such as elders or those affected by an impairment. The sage is cut or picked from the stem of the plant, leaving the root intact; in this way the sage is able to regrow each year. Once picked, the sage is hung upside down to dry, a process that can take several weeks depending on the heat and humidity. It is then bundled and stored in a dry place to be used throughout the year.

Although smudging can be used at any time of the day, it is often done in the morning. To smudge, a small amount of sage is taken off the bundle and rolled into a small ball. It is usually placed in a shell or a special bowl and then lit with matches. The teaching Smith-Yliniemi received is that, when smudging, the smoke from the burning sage is initially taken into the hands and placed over the heart while asking Creator to open one's heart to the experience they are about to have, as a new beginning. That beginning may entail the opening of the day, a counseling session, an event related to a life transition, or something else. In this way, a person asks for help to open their heart to a new experience.

Next, the smoke from the sage is smudged (fanned or wafted) toward the throat area while asking Creator to help with one's words—to formulate loving and respectful words and thoughts and to know when to use them thoughtfully. Hence, one smudges the throat to reduce impulsivity and increase thoughtfulness and deliberation in speaking. Next, the ears are smudged while asking Creator to help the person hear what they are meant to hear, as so much of what one hears can cause undue worry. Hence, smudging the ears allows others' words not meant to be heard to dissipate. In this way, Creator helps people to better hear only that which promotes learning and growth or the calming of our minds.

Next, the eyes are smudged while asking Creator to help one see what they are meant to see, including the best in others—knowing that all persons have flaws and wounds from living in a world full of chaos and worry. Additionally, the person asks to look beyond the physical, to use a lens that Creator intends. Seeing in this way allows one to live in a more peaceful manner. The person then smudges their head while asking Creator to help them with healthy thoughts and the ability to welcome a positive mindset. Consequently, through this ceremony, a person seeks spiritual and physical healing through the cleansing of any negative feelings, thoughts, or energies. They ask Creator to help them to be present and open to a more positive, healthy, and compassionate way of being toward themselves and others.

Counselors or clients of any identity can smudge if it is something they feel called to do and it makes them (or their clients) feel better. As the process is used by Indigenous communities around the world, anyone can have their own smudging routine. Some groups use smudging in association with ceremonies, as a means to feel connected to something they have lost, such as their culture and ways of being, or to address loss from war, genocide, intergenerational trauma, or colonialism. Smudging can be used as a precursor to a "welcome home" ceremony for Native American clients who were adopted and do not know their culture well or urban Indians lacking direct connection to their reservation or tribe. The ritual serves as an opening process that clears the space of any negative energy before enacting that ceremony. Smudging in this way brings in positive energy and allows attendees to be fully present and with open spirits, hearts, and minds. In turn, the welcome home ceremony acts as a coming-together process that helps individuals feel a part of their cultural community, as a symbolic rebirth of their connection to their culture.

Smudging can cleanse one's mind, body, and spirit, bringing the person to the here and now, and therefore it can help with depression, trauma, anxiety, or substance abuse. In turn, researchers have cited smudging to have significant meaning for individuals in regard to myriad issues, from physical health issues (Greensky et al., 2014) to mental health recovery (Spillane et al., 2021) to connecting employees to one another and to their work setting through the ritual itself (McPhee et al., 2017).

Ethical Considerations

In considering the ethics of applying smudging with clients, there are several points to keep in mind. First, for non-Indigenous practitioners, it is essential that ethical standard C.2.a. Boundaries of Competence (ACA, 2014) is considered. This states that practitioners, at minimum, read about and, ideally, receive training or experience with the practice of smudging. Such services could be advertised as one intervention available to specific populations, similar to the way other modalities are advertised (e.g., via the practitioner's website, written materials, and verbally). Mentions of smudging should include its traditional origins and meaning, in order to educate potential clients about the nature of the intervention. Potential areas of learning include understanding the historical roots and practices of smudging, recognizing the impact of colonialism and contemporary culture on the practice (McCormick, 2021), and attending to personal bias and values per standard A.4.b. Personal Values (ACA, 2014).

In addressing issues of cultural appropriation, practitioners should avoid use of the intervention solely for profit, aligned with standard A.4.a. Avoiding Harm (ACA, 2014). When using the intervention, they should clearly credit the source and origins of the practice for their clients. Regarding materials, they should also be mindful to avoid taking more sage than necessary, to allow others access to the plant. Ideally, counselors would consult, learn, and draw from local cultural protocol and original persons/elders/tribes of their area. They would also keep in mind that what is acceptable in one community is not the same in others, and that although some Indigenous persons believe that Indigenous medicines are there to help people of any and all identities, others believe such practices should be maintained as sacred and exclusive to their community. Hence, one should seek out protocols and perspectives in their local community, aligned with ethical standard C.2.e. Consultations on Ethical Obligations (ACA, 2014).

Finally, if smudging with clients whose ancestors may have used the practice, such as African Americans, it is important to gauge their cultural awareness regarding their identities. Perhaps encourage research around ancestral African ceremonial practices or research such histories collaboratively. Explore their perspectives and emotions around what is discovered; what has been lost to colonialism, enslavement, genocide, and other historical traumas; and how they wish to proceed with smudging as a practice in collaboration with the counselor. A decolonizing counseling framework could be drawn upon for processing deep-seated trauma and corresponding emotions stemming from colonization impacts (Millner et al., 2021). In so doing, counselors will attend to ethical standard A.2.c. Developmental and Cultural Sensitivity (ACA, 2014).

Adaptation Possibilities

As an intervention, smudging is suitable for adaptation. If not using sage, counselors can still engage in the act of cleansing a space. Some clients may be interested in burning a different herbal medicine that is meaningful to them. Some may be interested in using incense or oils to cleanse themselves or the space they are in. Adaptations, in turn, can be made in collaboration with each client, to honor their own cultural norms and practices.

Smudging: A Case Example

Kiah, a 15-year-old Indigenous youth, sought out her school counselor, who was non-Indigenous. The client had been struggling with identity issues since hearing that there was going to be a school-sponsored powwow at the end of the school year. Some of her friends asked her if she would be dancing, as they knew she was Native American. However, she moved from the reservation to the city over 10 years ago and didn't know much about her culture or dancing. As a result, she was feeling disconnected and anxious about who she was as a Native American.

In an effort to support Kiah, the school counselor researched and read articles regarding Native American identity and also reached out to the school district's Native American education director in order to glean ideas on how to effectively work with the student. The director advised the counselor to engage Kiah in an activity that included her memories of living on the reservation while asking her what she may want to reconnect to.

During this activity, Kiah remembered her grandmother having a shell on her kitchen table, a distinct smell, and feelings of calmness in her home. Working collaboratively, the student and counselor recalled that her grandmother would engage in the ceremonial practice of smudging each day, and Kiah realized this was something she would like to do in reconnecting to her culture. The Native American education director shared the smudging teaching with the student and helped procure sage from a local Native American–owned shop. The student relearned this ceremonial practice and planned to regularly practice the new ritual as a way to stay grounded in and connected to her identity.

Drumming

The goals of drumming are to find rhythm in one's life again; to help people celebrate, grieve, and heal; and to feel connected to Mother Earth as one was once connected to their mother's womb (Rojiani et al., 2022). Many Indigenous people believe that drumming represents the heartbeat of Mother Earth. The act of drumming connects the drummer with the earth. It is a practice that is both intimate and ceremonial. Drumming has been shown to enact multiple positive outcomes in clients, with examples including positive identity development (Rojiani et al., 2022); stress reduction and empowerment (Maschi et al., 2013); coping with societal oppression (McKinley, 2023); and anxiety reduction, decreased self-stigma, and the improvement of mood (Mungas & Silverman, 2014; Rowe et al., 2023).

Drums can be made from different animal hides; in the Midwest region, they are often made with deer hides. Drums can be made or bought, with kits accessible online. Drumming music can come from any origin. Oftentimes, Indigenous songs originate from someone's dream and then are gifted to a person or group. One example is that of an elder who once dreamt a specific song for a women's ceremony, and then gifted the song to Smith-Yliniemi and Riegert. The elder sang the song to them, and it was their responsibility to learn the song and sing it at that certain monthly ceremony from then on, which has been done for the past decade. The drum is considered a sacred living object, as an animal gave their life so that humans could benefit and heal. Consequently, caring for a drum should occur regularly and is considered a ritualistic ceremonial experience, whereby the keeper has the responsibility to acknowledge its life and treat it with great respect and honor.

The act of drumming includes tapping the instrument with a drumstick or hand. One or multiple individuals can drum. Drumming can be used in ceremonies. In some communities, behavioral health departments offer ceremonies to community members as a way to heal and connect with their Indigenous roots. As an example of the use of drumming in counseling, when Smith-Yliniemi engaged in group trauma therapy with adolescents, she would use drumming as a way to connect members. They would begin with a smudge and then one person would choose a song and either drum and sing individually or ask the group to join if they happen to know the song.

Individuals of all identities can drum, as the practice is not exclusively Indigenous (e.g., there are music therapy degrees that incorporate drumming for all). Anyone can drum, as it comes from within; one doesn't have to be a musician or take lessons. Drumming can be used with myriad client issues, including depression, oppression, anxiety, affect regulation, substance use, and identity strengthening. As noted in the prior paragraph, drumming can connect members of a group to enhance social interest (Sperry et al., 2021) or create a sense of belonging and humanization (Craddock et al., 2022).

Ethical Considerations

In considering the ethics of applying drumming with clients, there are several points to keep in mind. First, like the above directives with smudging, for non-Indigenous practitioners, it is essential that practitioners adhere to standard C.2.a. Boundaries of Competence (ACA, 2014) and read about, research, and study—and ideally receive training or experience with—the practice of drumming. Potential areas of learning include understanding the historical roots and practices of drumming, recognizing the impact of colonialism and contemporary culture on the practice (Quarshie, 2023), and use of drumming in contemporary healing practices (Rojiani et al., 2022; Rowe et al., 2023), all of which support adherence to standard C.2.b. New Specialty Areas of Practice (ACA, 2014). In addition, counselors can describe the practice, meaning, and impacts of drumming both in advertising and verbally with clients.

Adaptation Possibilities

When drumming with clients whose ancestors may have used the practice, such as African Americans, similar to the suggestions for smudging, it is important to explore their awareness of their identities and roots, encourage research around their ancestors' ceremonial practices, or research such histories collaboratively. Explore their perspectives and emotions around what is discovered; what has been lost to colonialism, enslavement, genocide, and other historical traumas; and how they wish to proceed with drumming as a practice in collaboration with the counselor.

Drumming: A Case Example

Zane, a non-Indigenous, African American client sought counseling because of feeling depressed following several failed romantic relationships. Zane explained to the counselor that he had a recent "aha" moment when he realized he kept breaking up with his partners because he didn't know who he was. His insight came after watching a movie on African American history and realizing he wasn't sure of who he was, where he was from, or any cultural practices of his African American ancestors. Zane asked, "How am I supposed to know what I want in others when I don't even know myself"?

The counselor explored with Zane what parts of the movie called him to his "aha" moment. He explained that it was a part in which African ceremonies were taking place and that the drumming had immediately brought him to tears. Throughout the next few sessions Zane and his counselor explored his African roots, and he ordered a drum kit so that he could make his own drum. Zane also reached out to a local African organization and began attending a bimonthly community event that promotes African culture and song. Over time and across the counseling sessions, Zane's mood appeared to significantly improve. He began to discuss additional ways of researching his identity and to also consider the implication of these explorations on his dating choices going forward.

Letting-Go Ceremony

A letting-go ceremony is a ritual that allows a person to process and/or release thoughts, emotions, or memories around beliefs or experiences in order to bring about healing and a sense of peace and to make room for new ways of being or engaging in the world (McCormick, 2021). It is often believed that one cannot simply talk their way through a trauma, but that they must spiritually and physically release it as well. Using tobacco ties is one traditional way to release a trauma, as a symbol of letting go, freeing oneself from the human experience, and returning the trauma back into the earth. It is a metaphor for no longer having to carry a certain burden.

Tobacco is considered a sacred medicine that represents the earth and is used for myriad purposes in Indigenous communities (National Native Network, n.d.). A tobacco tie can be created by placing a small amount of tobacco on a cloth and folding or tying the corners to create a small ball or sachet. It can be connected to a chain of ties, as well. The ties are released or given to the earth or sky, through laying them near the roots of a tree or placing them in a fire.

The process itself can be ceremonial, implemented with fasting or praying. The idea is an offering to the spirit world meant to impact the here and now in the physical world and to release some of the pain associated with an event (Wilson & Restoule, 2010). When the client and counselor practice the ceremony together, both are able to let go of part of the pain. The collective connection of healing helps to ease some of the traumatic experience.

In an example of using tobacco ties in group counseling, Smith-Yliniemi would often invite a medicine person to be part of the closure process for trauma groups. The medicine person would instruct group members to make a tobacco tie for each trauma they wanted to release from their bodies and their lives. These ties would then be used in a sweat lodge ceremony in the final session of a 10–12 week group.

The idea of symbolically “giving over/letting go” or releasing something as a means for healing is a universal act and therefore can be drawn upon and applied by counselors and clients of any identity. However, the ceremony would look different according to the client’s identity and wishes. Letting go allows one to release thoughts or beliefs that keep them held to the past—hence, it allows people to stay more focused in the present moment, which could apply to many topics. Common letting-go issues include grief, traumas, and depression, as well as negative and harmful thoughts, feelings, habits, and experiences. Ultimately, we could not think of any issue that necessarily would not benefit from a spiritual and/or physical ceremonial process of “letting go.” The client, of course, must be amenable to the idea of letting go; hence, the counselor should collaboratively determine client readiness for letting go and explore client reluctance, if it does arise, as a natural part of the process.

Ethical Considerations

Individuals of any identity can engage in letting-go ceremonies, and likely the best practice is to initially draw upon clients’ own cultural practices specific to letting go in line with standard E.5.b. Cultural Sensitivity (ACA, 2014). However, if they are unaware of any such practice in their own community, counselors may adapt a letting-go ceremony as described here to meet the client’s need. Because letting-go ceremonies can be particularly emotionally laden for both the client and counselor, we encourage counselors to monitor their own wellness and to be mindful of counselor impairment, as noted in ACA ethical standard C.2.g. Impairment (2014).

Adaptation Possibilities

If a person does not use tobacco as part of the letting-go ceremony, other elements of nature can be used instead. For example, a person can use a stone. A stone/rock is known as a "grandfather" in many Indigenous cultures. They have been on the earth the longest and have helped humans for many generations, carrying wisdom and strength. As a symbol of letting go, a person could find and hold a grandfather (rock) in their hand, releasing their pain from the human experience back into the earth through the rock, symbolizing that we do not have to carry the pain within us, but that we can release it to Mother Nature, who serves as a caregiver to us all.

Letting-Go Ceremony: A Case Example

Lisa, a non-Indigenous client, came to counseling to address the trauma of losing an unborn child. During the sessions, the counselor and Lisa explored the impact of this trauma. Together, they decided to engage in a letting-go ceremony as a means for healing. As a first step, the counselor gave credit to the origins of the letting-go ceremony and explained to the client how and from whom the intervention was learned.

In preparation for the ceremony, the counselor obtained the necessary items, while also tending to their own emotions to ensure that the ceremony was delivered in a healthy and therapeutic way. The counselor prepared the meeting space to ensure that it was free of distractions. A blanket was laid on the floor with a sacred altar or centerpiece, on which both the counselor and Lisa placed items that were meaningful to them. Elements of the natural world were also part of the altar—examples of potential elements include a stone, tree leaves, a small dish of water, and even an electric candle to represent fire.

In addition, objects that represented other important people in the client's life could be present, such as a small picture or an item that belongs to a significant person. That object signifies that one does not carry the challenges in their lives alone, that there are other humans who helped to guide one along the way. In this case, the centerpiece objects were selected collaboratively by the counselor and Lisa with the intention of providing support during the letting-go ceremony.

Next, the counselor offered a small piece of cloth (4" by 4" square) to Lisa, while keeping a piece of the material for themself. In this cloth, Lisa and the counselor placed dried herbs and natural earth medicines brought specifically for the ceremony. They then tied their individual bundles of herbs with a small string and held them in their left hands, which are closest to the human heart. Importantly, only a small amount of dried medicine (one teaspoon) was used for the cloth tie.

Next, a song was played. (Other options include reading a poem or offering several moments of silence.) The counselor explained to Lisa that the particular moment was spent intentionally in sending any energy from the traumatic experience into the tied cloth. After some time passed and the client signaled that they felt ready, the counselor brought the session to a close. The altar was disassembled while both participants continued to hold their ties.

At the end of the session, the counselor explained that the cloth tie that held the medicine and the energy from the ceremony can be placed on the earth, left at the base of a tree, placed in the woods, or even put near a body of water. The implication and healing properties of the ceremony were that the energy and emotions from the loss are now part of the tie and part of the earth, so that Lisa did not have to carry them all individually. The counselor also explained that a letting-go ceremony was not a one-time practice, and that throughout Lisa's life, she now had the knowledge to practice letting go as needed.

Competency and Cultural Responsivity Considerations

We have identified methods by which practicing counselors can begin to implement ceremony-assisted treatments. Suggestions for obtaining more information about ceremony-assisted experiences include reaching out to and collaborating with one's local Indigenous community and seeking out a knowledge expert. It is important to offer a gift to the person who is sharing their knowledge. Gift giving in this way aligns with the spirit of the 2014 ACA *Code of Ethics* preamble, which asserts the importance of honoring and "embracing a multicultural approach in support of the worth, dignity, potential and uniqueness of people within their social and cultural contexts" (p. 2). ACA ethical standard A.10.f. Receiving Gifts may also be relevant for giving gifts to those from whom one learns. Making a gift to recognize the importance of honoring cultural norms around gifting is certainly in keeping with the reasons and values behind this standard. Gift giving in this instance could entail any tangible item given with thoughtful consideration from one's heart to the heart of the person from whom they seek wisdom. Examples include plants from the earth (dried or fresh), an object with a meaningful phrase, something useful (such as towels/blankets), or a handmade item. The gift item itself is not as important as the intention behind it—as an expression of love and respect and the sharing of gratitude for the opportunity to be open and learn from wisdom keepers. The experience of earnestly seeking, listening, and developing deeper understanding creates an opportunity for the growth of cultural humility (Tham & Solomon, 2023). Additionally, practitioners are building cultural responsivity as they adopt customs and traditions with awareness of the cultural origins.

Once knowledge of the healing ceremony is learned, practitioners should also offer the earth a gift of natural essence (a stone, small berry, dried herb, or small amount of water), as the counselor now holds this wisdom and has a responsibility to honor the earth and the person who gifted it to them. This connection and reciprocity between the natural and human world are a continual exchange of gratitude. It is essential that practitioners give due credit to the contributors of newly learned practices and traditions (Meade et al., 2022). In service delivery, sincerity is honored while using our own language and understanding.

In considering competency, ethical standard C.2.b. New Specialty Areas of Practice cites the need for counselors to take steps to ensure competence in applying new techniques, and always with the lens of "protecting others from possible harm" (p. 8). Additionally, counselor commitment to ongoing learning is emphasized in ethical standard C.2.f. Continuing Education (ACA, 2014). Hence, learning should not be considered as a singular universal practice; rather, practitioners should seek to learn in the moment from the knowledge keeper and engage in ongoing consultation, learning, and interaction with the wisdom holders. Continual practitioner reflection and the eliciting of client feedback—to determine the meaningfulness and impact of such interventions—is also essential to determining counselor effectiveness. These steps align with ethical standard C.2.d. Monitor Effectiveness (ACA, 2014), stating the importance of counselor action in monitoring the effectiveness of the work they do.

Conclusion

Ceremony-assisted treatments are powerful sources of healing and health for clientele. Ritual is essential for all humans, as a means for healing and for the maintenance of one's physical, spiritual, and emotional health (Hewson et al., 2014)—albeit in ways that are uniquely shaped by personal culture and experiences (McCormick, 2021). We hope that the interventions included in this article can be used to enhance client mental health and health care needs.

Essential directives noted in this article include the importance of consulting with Indigenous healers within (or in approximation to) readers' own contexts, to consider the ethical application of Indigenous-origin healing practices. We suggest seeking out and receiving education around such interventions, their histories, and the communities from which they originate to gain further understanding and respect for the practices. Those working in school systems may want to work collaboratively with an Indigenous education director in the ethical provision of ceremony-based interventions in their setting or to advocate for hiring such professionals for settings that lack an expert. Readers can also refer to the Association for Multicultural Counseling and Development's Native American Concerns Group as a resource for Native counselors as well as for professionals counseling Native populations.

We reiterate that the perspectives around the use of and appropriation of Indigenous practices differ within and across Indigenous communities. Meade et al.'s (2022) *Checklist for Counselor Practitioners* reminds practitioners to remain vigilant to their own intersecting identities and to adhere to ethical practices in order to avoid harmful cultural appropriation. We attend to several of these recommendations by acknowledging and sharing our intersecting identities and offering guidance on ethically adapting the interventions to all clients.

Finally, going forward, when sharing these healing teachings, we encourage readers to maintain an awareness of the deep roots of these practices—stretching back and beyond seven generations—as a way to honor the ancestors who came before us and who have persisted in the face of great tragedy. We recognize the oral traditions that have allowed these teachings to be passed across the generations and ask readers to mindfully and respectfully pass on such teachings (orally or in writing) for seven generations more. In this way, future communities will know the healing practices that have aided Indigenous people for thousands of years, and they can adapt such practices in ways that heal and bring balance and wholeness to each unique community. Ultimately, we hope that counselor awareness of such factors will ensure that these teachings are shared in a mindful, loving, and honorable way.

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References

American Counseling Association. (2014). *ACA code of ethics*. https://www.counseling.org/resources/aca-code-of-ethics.pdf

Blackett, P. S., & Payne, H. L. (2005). Health rhythms: A preliminary inquiry into group-drumming as experienced by participants on a structured day services programme for substance-misusers. *Drugs: Education, Prevention and Policy*, *12*(6), 477–491. https://doi.org/10.1080/09687630500342881

Borden, A., & Coyote, S. (2007, April 25). *Smudging ceremony*. http://www.snowwowl.com/nainfosmudging.htm

Causadias, J. M., Alcalá, L., Morris, K. S., Yaylaci, F. T., & Zhang, N. (2022). Future directions on BIPOC youth mental health: The importance of cultural rituals in the COVID-19 pandemic. *Journal of Clinical Child & Adolescent Psychology*, *51*(4), 577–592. https://doi.org/10.1080/15374416.2022.2084744

Craddock, L., Kells, M., Morgan, L., & Shah-Beckley, I. (2022). Drumming, singing and ceremony within a psychologically informed planned environment for women on the offender personality disorder pathway. *The Journal of Forensic Practice*, *24*(2), 123–137. https://doi.org/10.1108/JFP-05-2021-0026

Crouch, M. A. (2016). A breath of fresh air: A family ceremony. *Families, Systems, & Health*, *34*(1), 64–66. https://doi.org/10.1037/fsh0000167

Dallas, T., Baroutsa, N. M., & Dein, S. (2020). The power of the divine: Religion, rituals, and healing in Greece. *Mental Health, Religion & Culture*, *23*(8), 718–732. https://doi.org/10.1080/13674676.2020.1825363

Drissi, S. (2023, September). *Indigenous peoples and the nature they protect.* UN Environment Programme. https://www.unep.org/news-and-stories/story/indigenous-peoples-and-nature-they-protect

Greensky, C., Stapleton, M. A., Walsh, K., Gibbs, L., Abrahamson, J., Finnie, D. M., Hathaway, J. C., Vickers-Douglas, K. S., Cronin, J. B., Townsend, C. O., & Hooten, W. M. (2014). A qualitative study of traditional healing practices among American Indians with chronic pain. *Pain Medicine*, *15*(10), 1795–1802. https://doi.org/10.1111/pme.12488

Han, H.-C. (2019). Moving from cultural appropriation to cultural appreciation. *Art Education*, *72*(2), 8–13. https://doi.org/10.1080/00043125.2019.1559575

Hewson, P., Rowold, J., Sichler, C., & Walter, W. (2014). Are healing ceremonies useful for enhancing quality of life? *The Journal of Alternative and Complementary Medicine*, *20*(9), 713–717. https://doi.org/10.1089/acm.2013.0248

Hiratsuka, V. Y., Parker, M. E., Sanchez, J., Riley, R., Heath, D., Chomo, J. C., Beltangady, M., & Sarche, M. (2018). Cultural adaptations of evidence-based home-visitation models in tribal communities. *Infant Mental Health Journal*, *39*(3), 265–275. https://doi.org/10.1002/imhj.21708

Ingerman, S. (2018). *The book of ceremony: Shamanic wisdom for invoking the sacred in everyday life.* Sounds True.

Irwin, L. (1997). Freedom, law, and prophecy: A brief history of Native American religious resistance. *American Indian Quarterly*, *21*(1), 35–55. https://doi.org/10.2307/1185587

Kumar, M., Guruvayoorappan, S., & Menon, S. (2023). Transgressing narrative boundaries: Exploring how indigenous faith-healing rituals from Kerala move beyond the limitations of narrative therapy. *Psychological Studies*, *68*(2), 1–10. https://doi.org/10.1007/s12646-023-00715-9

La Fontaine, J. S. (1985). *Initiation*. Penguin.

Lalonde, D. (2021). Does cultural appropriation cause harm? *Politics, Groups, and Identities*, *9*(2), 329–346. https://doi.org/10.1080/21565503.2019.1674160

Lu, L., & Yuen, F. (2012). Journey women: Art therapy in a decolonizing framework of practice. *The Arts in Psychotherapy*, *39*(3), 192–200. https://doi.org/10.1016/j.aip.2011.12.007

Maschi, T., MacMillan, T., & Viola, D. (2013). Group drumming and well-being: A promising self-care strategy for social workers. *Arts & Health*, *5*(2), 142–151. https://doi.org/10.1080/17533015.2012.748081

Mathew, L. E. (2021). Braiding western and eastern cultural rituals in bereavement: An autoethnography of healing the pain of prolonged grief. *British Journal of Guidance & Counselling*, *49*(6), 791–803. https://doi.org/10.1080/03069885.2021.1983158

McCormick, R. (2021). Indigenous North American healing. In R. Moodley & E. Lee (Eds.), *The Routledge international handbook of race, culture and mental health* (pp. 485–495). Routledge.

McKinley, C. E. (2023). "Prayer is universal": How integrative faith practices enable Indigenous peoples' persistence and resistance to transcend historical oppression. *Psychology of Religion and Spirituality*, advance online publication. https://doi.org/10.1037/rel0000497

McPhee, D., Julien, M., Miller, D., & Wright, B. (2017). Smudging, connecting, and dual identities: Case study of an aboriginal ERG. *Personnel Review*, *46*(6), 1104–1119. https://doi.org/10.1108/PR-10-2015-0270

Malott, K. M., Barraclough, S., & Yee, T. (2023). Towards decolonizing diagnosis: A critical review and suggested alternatives. *International Journal for the Advancement of Counselling*, *45*, 1–17. https://rdcu.be/c3o3O

Meade, N. A., Branco, S. F., Burt, I., White, R. K., & Hanks, A. (2022). Cultural appropriation, appreciation, and adaption: A rejoinder to "Effects of a Rite of Passage Ceremony on Veterans' Well-Being." *Journal of Counseling & Development*, *100*(1), 96–103. https://doi.org/10.1002/jcad.12400

Millner, U. C., Maru, M., Ismail, A., & Chakrabarti, U. (2021). Decolonizing mental health practice: Reconstructing an Asian-centric framework through a social justice lens. *Asian American Journal of Psychology*, *12*(4), 333–345. https://doi.org/10.1037/aap0000268

Mungas, R., & Silverman, M. J. (2014). Immediate effects of group-based wellness drumming on affective states in university students. *The Arts in Psychotherapy*, *41*(3), 287–292. https://doi.org/10.1016/j.aip.2014.04.008

National Museum of the American Indian. (n.d.). *The impact of words and tips for using appropriate terminology: Am I using the right word?* Native Knowledge 360°. https://americanindian.si.edu/nk360/resources/Impact-of-Words-and-Tips-for-Using-Appropriate-Terminology-Am-I-Using-the-Right-Word

National Native Network. (n.d.). *Traditional tobacco.* http://keepitsacred.itcmi.org/tobacco-and-tradition/traditional-tobacco-use/

Quarshie, N. O. (2023). Spiritual pawning: "Mad slaves" and mental healing in Atlantic-era West Africa. *Comparative Studies in Society and History*, *65*(3), 475–499. https://doi.org/10.1017/S0010417523000051

Rathod, S., Gega, L., Degnan, A., Pikard, J., Khan, T., Husain, N., Munshi, T., & Naeem, F. (2019). The current status of culturally adapted mental health interventions: A practice-focused review of meta-analyses. *Neuropsychiatric Disease and Treatment*, *2018*(14), 165–178. https://doi.org/10.2147/NDT.S138430

Rojiani, R., Junn, A., Wood, M., Gordon, K. L., & Sells, D. (2022). Group drumming for incarcerated men may improve community reintegration: A mixed methods pilot study. *Journal of Experimental Criminology*, *18*, 825–846. https://doi.org/10.1007/s11292-021-09460-3

Rowe, K., Pozuelo, J. R., Nickless, A., Nkosi, A. D., dos Santos, A., Kahn, K., Tollman, S., Wagner, R. G., Scerif, G., & Stein, A. (2023). The adolescent HIV executive function and drumming (AHEAD) study, a feasibility trial of a group drumming intervention amongst adolescents with HIV. *AIDS Care*, *35*(11), 1796–1814. https://doi.org/10.1080/09540121.2023.2195607

Saiz, J., Galilea, M., Molina, A. J., Salazar, M., Barsotti, T. J., Depak, C., & Paul, J. M. (2021). Spirituality and employment in recovery from severe and persistent mental illness and psychological well-being. *Healthcare*, *9*(1), 57. https://doi.org/10.3390/healthcare9010057

Sperry, J., Casteleiro, G., Rinard, A., & Cooper, P. (2021). Group drumming and the Crucial Cs: Immediate effects of an Adlerian-based group drumming intervention on mood and social interest among college students. *The Journal of Individual Psychology*, *77*(2), 225–237. https://doi.org/10.1353/jip.2021.0017

Spillane, N. S., Schick, M. R., Nalven, T., Goldstein, S. C., Kirk-Provencher, K. T., Hill, D., & Kahler, C. W. (2021). Testing the Competing Life Reinforcers model for substance use in reserve-dwelling First Nation youth. *American Journal of Orthopsychiatry*, *91*(4), 477–486. https://doi.org/10.1037/ort0000543

Tham, S. S., & Solomon, P. (2023). Practicing cultural humility will achieve recovery-oriented mental health practice and service delivery. *Administration and Policy in Mental Health and Mental Health Services Research*, 1–4. https://doi.org/10.1007/s10488-023-01307-5

United Nations. (2007). *United Nations Declaration on the Rights of Indigenous Peoples*. https://social.desa.un.org/issues/indigenous-peoples/united-nations-declaration-on-the-rights-of-indigenous-peoples

Vizenor, G. (1993). The ruins of representation: Shadow survivance and the literature of dominance. *American Indian Quarterly*, *17*(1), 7–30. https://www.jstor.org/stable/1184777

West-Olatunji, C., Shure, L., Garrett, M. T., Conwill, W., & Rivera, E. T. (2008). Rite of passage programs as effective tools for fostering resilience among low-income African American male adolescents. *The Journal of Humanistic Counseling, Education and Development*, *47*(2), 131–143. https://doi.org/10.1002/j.2161-1939.2008.tb00053.x

White, R. K., Hanks, A., Branco, S., Meade, N., & Burt, I. (2020, February 11). A collective voice: Indigenous resilience and a call for advocacy. *Counseling Today*. https://ct.counseling.org/2020/02/a-collective-voice-indigenous-resilience-and-a-call-for-advocacy

Wilson, D. D., & Restoule, J.-P. (2010). Tobacco ties: The relationship of the sacred to research. *The Canadian Journal of Native Education*, *33*(1), 29–45. https://doi.org/10.14288/cjne.v33i1.196520

Taking Action: Reflections on Forming and Facilitating a Peer-Led Social Justice Advocacy Group

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Sunanda M. Sharma, Jennifer E. Bianchini, Zeynep L. Cakmak, MaryRose Kaplan, Muninder K. Ahluwalia

According to the American Counseling Association and the Council for Accreditation of Counseling and Related Educational Programs, social justice advocacy is an ethical imperative for counselors and a training standard for counseling students. As a group of socially conscious mental health counseling students and faculty, we developed and facilitated a social justice advocacy group to learn about tangible ways to engage in social justice action. Using the S-Quad model developed by Toporek and Ahluwalia, we formed and facilitated a social justice advocacy group for our peers. This paper will serve as a reflection of our experiences engaging in the process.

Keywords: **social justice, advocacy, counseling students, S-Quad model, mental health**

When describing the motivation for her political aspirations, Georgia gubernatorial hopeful Stacey Abrams (2019) stated, "We have to have people who understand that social justice belongs to us all." This quote speaks to this group of authors who feel strongly about the importance of social justice in mental health counseling. This ethos served as the motivation to create a peer-led group to foster the development of our social justice advocacy skills. We used the S-Quad model (Toporek & Ahluwalia, 2020) to form and facilitate a social justice advocacy group for master's and doctoral counseling students at our institution.

Historically, the counseling profession has been rooted in social justice advocacy (SJA) with Frank Parsons's efforts to support White European immigrants in the United States to develop their vocational goals (Gummere, 1988; Toporek & Daniels, 2018). However, SJA has not been consistently operationalized across counselor training programs (Counselors for Social Justice [CSJ], 2020). Although ethical standards established by the American Counseling Association's *ACA Code of Ethics* (ACA; 2014) encourage counselors to advocate for clients and communities when appropriate (A.7.a, A.7.b.), and training standards established by the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015) state that SJA should be a part of counseling curriculum (2.F.2.b.), counselors have reported receiving little guidance about how to implement advocacy in practice (Field et al., 2019; Ratts & Greenleaf, 2018). As counseling students, we experienced the same concern. To address this gap in our educational experience, we created and facilitated a group based on the S-Quad model (strengths, solidarity, strategies, and sustainability) of SJA (Toporek & Ahluwalia, 2020). As a group of socially conscious mental health counseling students, our aim was to grow in our roles as professionals by learning about, teaching, and engaging in SJA. In the process, we learned about ourselves as budding counselors and educators.

Sunanda M. Sharma, MS, NCC, LPC (NJ), LPCC (OH), is a lecturer at Wright State University. Jennifer E. Bianchini, BFA, is a master's student at Montclair State University. Zeynep L. Cakmak, MA, LAC (NJ), is a mental health counselor at Montclair State University. MaryRose Kaplan, PhD, NCC, LPC, is a school counselor and adjunct professor at Montclair State University. Muninder K. Ahluwalia, PhD, is a professor at Montclair State University. Correspondence may be addressed to Sunanda M. Sharma, 3640 Colonel Glenn Hwy., Millett Hall 370, Dayton, OH 45435, sharmas1@montclair.edu.

Literature Review

In their foundational article, Vera and Speight (2003) called on the counseling profession to expand its understanding of multicultural competence; they asserted that without SJA, counselors are perpetuating the systems of oppression from which their clients are attempting to heal. Utilizing intrapsychic approaches which neglect to account for contextual factors not only perpetuates oppressive counseling practices, but it also does a disservice to those with marginalized identities (Ratts, 2009; Vera & Speight, 2003). In order to properly serve clients, counselors must step beyond the classroom, expand the original conceptualization of our roles, and explore beyond the counseling office (Ratts, 2009; Ratts & Greenleaf, 2018; Vera & Speight, 2003). Despite the increase in available resources such as the ACA Advocacy Competencies (Toporek et al., 2009) and the Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2016), the number of sociocultural forces such as racial demographics of counseling programs and reliance on theories and interventions developed for White European clients prevents social justice from being a central force in the profession (CSJ, 2020).

As mental health professionals, we are positioned to understand the impact that oppression has on health (Nadal et al., 2021), which speaks to the need for operationalizing social justice counseling and SJA so counselors may support client wellness. Counseling students require more knowledge and practice to obtain appropriate resources and tools in order to intervene and resist systemic oppression (Vera & Speight, 2003). Ratts (2009) named social justice as the "fifth force" in counseling in an attempt to concretize the relevance and importance of challenging the status quo in counseling. However, the perceived attitude of the counseling profession toward social justice is reflected in the definition of counseling. The 20/20 initiative was a movement to unify the profession and solidify professional identity by arriving at the definition of counseling. Delegates from 31 counseling-related organizations (e.g., CACREP, Chi Sigma Iota) participated in a Delphi-method study to achieve consensus on a definition; however, only 29 organizations ultimately endorsed the definition (Kaplan et al., 2014). Although the definition for counseling includes the word "empower"; it does not include the words "social justice" or "advocacy." Thus, CSJ was one organization that did not support the new definition (Kaplan et al., 2014). Despite these challenges, Ratts and Greenleaf (2018) assert that counselors must develop the advocate part of their identity, yet they note that there is more of a focus on traditional counseling skills rather than acknowledging the shifting sociopolitical climate and equipping counselors with the skills to address these concerns. The leadership and advocacy course (or the content in another course; CACREP, 2023) in CACREP-accredited counseling doctoral programs often only focuses on leadership and advocacy within and for the profession. Although CACREP (2023) standards do not dictate the courses a counseling program must offer, there continues to be limited discussion of SJA and social justice, nor are there solid instructional methods for counselor educators to use in the classroom (Chapman-Hilliard & Parker, 2022). This situation hinders students' understanding of the role systemic issues have on minoritized communities, further deterring people in those communities from seeking help.

As counselors and counseling students, we understand our responsibility to advocate for clients, but we feel unprepared to fulfill our ethical (and for many of us, moral) duty. We did not learn enough about the concrete, tangible skills that a professional counselor can utilize to challenge oppression and inequity. We were unable to locate any studies regarding peer-led SJA groups for counseling students, thus we hope to contribute something novel to the counseling literature and encourage counseling students to better understand and grow into their roles as social justice advocates. Counselors-in-training (CITs) and practicing counselors within the profession sometimes question the relevance of SJA and report feeling confused about how to implement SJA in counseling (Field et al., 2019; Ratts & Greenleaf, 2018).

hooks (1994) notes it is imperative that a student accepts responsibility for their education and becomes "an active participant, not a passive consumer" (p. 14). Thus, we engaged in this process to support our colleagues in the counseling student body and take accountability for our education.

Taking Action: Social Justice Advocacy Group

Leading organizations in the profession claim a two-pronged approach to advocacy: one prong advocating for the legitimacy of the counseling profession, and the other advocating on behalf of the clients and students whom counselors serve (Chang et al., 2012). In our educational experience, SJA on behalf of and in partnership with clients was emphasized, but tangible interventions were not discussed. Further, systemic issues and inequities were often left unaddressed. Thus, we developed this group to more concretely address the second "prong" of advocacy in counseling. First and fourth authors Sunanda M. Sharma and MaryRose Kaplan were part of the executive board of Chi Sigma Mu (Chi Sigma Iota chapter at Montclair State University) and co-founded the social justice committee. Second and third authors Jennifer E. Bianchini and Zeynep L. Cakmak were the first members of the committee who proposed ideas and facilitated events and activities related to social justice that they felt passionately about. Bianchini proposed a social justice book club ahead of a presentation that the CSI chapter organized (hosting the authors of the book *Taking Action*). The book club met three times with up to three students, from whom we received feedback to help us form the SJA group.

The following semester, fifth author Muninder K. Ahluwalia proposed restructuring the book club into an advocacy group by utilizing the *Taking Action* text as a framework to teach students about systemic SJA. CACREP (2015) standards state that multiculturalism and social justice must be discussed throughout counseling courses (2.F.2.b.); however, in our experiences, we found that social justice is addressed as an ethical and moral imperative, but curricula do not address concrete SJA skills and strategies to combat systemic oppression. The counseling program in which the first four authors are enrolled and the fifth author is a faculty member offers a social justice counseling class as an elective. However, the class is not consistently offered every semester and has only been taught by that one faculty member. Thus, our aim with this group was to provide a space for our colleagues in which we could collaboratively learn about how to enact social justice. This section will describe the S-Quad model, explain the group structure, outline the proposed learning objectives, and provide a table that outlines the curriculum of the group.

The S-Quad Framework

As a profession, mental health counseling is positioned to "buffer" against challenges with oppression and changes to the status quo (Kivel, 2020). There is an emphasis on intrapsychic interventions to combat systemic issues, rather than attempt to uproot the oppression itself (Kivel, 2020; Ratts, 2009; Toporek, 2018). Toporek (2018) noted that upon reflection of the way the profession is positioned and her privileged identities, she developed a framework through which to take social justice action despite the challenges she continues to encounter. The S-Quad model includes four Ss for social justice advocates to formulate a way to address systemic injustices: strengths, solidarity, strategy, and sustainability (Toporek & Ahluwalia, 2020).

Strengths are described as a combination of one's existing "skills, knowledge, and expertise" (Toporek & Ahluwalia, 2020, p. 27). Although strengths can be qualities one already has, both personal and professional, the authors also encourage budding advocates to reflect upon strengths that they would like to develop. *Solidarity* has multiple facets to its definition, as advocates are asked to support, honor, and respect communities they intend to engage with and to also seek support from their personal networks to remain grounded (Toporek & Ahluwalia, 2020). Solidarity is enacted through collaborative efforts and through the lens of cultural humility (Toporek & Ahluwalia, 2020). *Strategy* is the implementation of strengths and solidarity to construct a plan of action (Toporek & Ahluwalia, 2020). It is important to evaluate the efficacy, efficiency, and impact of different strategic plans to ensure they work toward the stated goal and—most importantly—benefit the community that the action is intended for (Toporek & Ahluwalia, 2020). Finally, a unique facet of the S-Quad model is the fourth "S," sustainability. *Sustainability* addresses the wellness of advocates; without it, there is a higher likelihood they may abandon their efforts. SJA can be an enriching and healing practice, but it can also be an emotionally draining pursuit, and one can feel helpless when attempting to combat the gravity and breadth of oppression (Toporek & Ahluwalia, 2020). Thus, the authors encourage budding advocates to take an inventory of the practices that replenish and nourish them in order to remain engaged in their work.

Group Structure

Sharma proposed structuring this SJA group as a biweekly, one-hour, peer-led, open (students were free to join at any point) psychoeducation group, whose grounding framework would be the S-Quad model (Toporek & Ahluwalia, 2020). Due to COVID-19 restrictions, we facilitated the group through Zoom. The objectives of the group were: to describe all components of the S-Quad model, to describe the ethical responsibility of being a social justice advocate, to create a solidarity network of fellow advocates, to increase awareness of how one's positionality impacts their advocacy work, and to apply the S-Quad model (Toporek, 2018) through the creation of a social justice action plan (Sheely-Moore & Kooyman, 2011). Initially, the intention was to divide each group session into two parts. The first part of the session would be didactic, in which we would discuss the "S" of that week and ground it in a case study. The second half of the session would offer members the chance to process the content so they can apply what they are learning to their social justice plan. Upon reflection and discussion as co-facilitators, we recognized the challenges associated with attempting to address so much content in a 60-minute session and collectively agreed to shift the group and make it akin to a flipped classroom by including pre-recorded didactic videos. This afforded members the chance to view the videos at their own pace and come to the session prepared to engage in dialogue.

In our experiences, instructors who taught our counseling theories courses recommended for us to select one theory to learn about before declaring our theoretical orientation. Similarly, we asked members to narrow down their focus for the purposes of this group to a cause within a community that they feel passionately about. The other structural component we addressed with group members was that this curriculum is cumulative but not necessarily linear; so, an application of the previous "S" is necessary to study the following "S." For example, once a group member identifies their strengths, we apply those strengths to inform what strategies they will use, but it does not necessarily mean that strengths are not revisited.

Given that this was a psychoeducation group rather than a traditional course, we did not want to use typical didactic methods to engage with this material. We intentionally paired each part of the S-Quad model with a story about an advocate from a minoritized community of whom others likely may not be aware. This demonstrated that SJA is not always done on a public stage. This narrative form of teaching (Hannam et al., 2015) allowed us to contextualize stories of advocates who are quietly resisting oppression in their respective communities. We spotlighted those stories so members could feel less intimidated by the prospect of SJA. In the interest of social justice and accessibility, the Chi Sigma Iota Counseling Honor Society's Chi Sigma Mu chapter at Montclair State University funded books for interested members so they could follow along with the activities and didactic content. After the second session, we also introduced the idea of the social justice action plan.

Table 1 shows the structure/syllabus of the group that we utilized for the semester and describes the ways in which we adapted to agreed-upon changes.

Table 1

Taking Action *Group Structure*

Week	Topic & Activity Assigned	Content/Activities
Week 1	Introducing *Taking Action* S-Quad Model	• Purpose, rationale, and structure of group • Group agreements/norms • Overview of S-Quad model (Toporek & Ahluwalia, 2020) • ADDRESSING model (Hays, 2022), a framework that explores individual identity in context • Difference between justice, charity, philanthropy
Week 2	1st S: Strengths Activity 4.2, p. 29**	• Reviewing agreed-upon group norms • Defining strengths • Case study: Arunachalam Muruganantham (“The Pad Man”) - Processing case study as a group • Introducing the social action plan
Week 3	Co-facilitators reflection meeting	• This session was initially planned to address the 2nd S in the S-Quad, but no members attended the group this day. Instead, as co-facilitators, we met to discuss the progress of the group.
Week 4*	2nd S: Solidarity Activity 5.1, p. 55	• Defining solidarity • Case study: 4 young Black women, Black Lives Matter protests - Combining strengths and solidarity - Processing case study as a group
Week 5	3rd S: Strategy Activity 6.1, p. 66	• Defining strategy • Case study: Cakmak - Strength, solidarity, and strategy - Processing case study as a group - Cakmak’s social action plan
Week 6	4th S: Sustainability Activity 7.6, p. 176	• Defining sustainability • Case study: Alexandria Ocasio Cortez - Strength, solidarity, strategy, and sustainability - Processing the importance and guilt of self-care - Processing burnout
Week 7	Final Group	• Case study - Apply ADDRESSING, S-Quad model • Feedback from members

*Marks shift to videos for the didactic portion

**All activities listed are from Ahluwalia & Toporek (2020).

Reflections

In this section, we offer our reflections on the group and extract salient collective themes that have come about through our processing. In our first session, we informed the group members that we intended to write a reflection paper, and they gave implicit consent to this writing; we did not collect data from group members for the purposes of this article. We begin by grounding the discussion of the group by acknowledging our positionality and social location and how that influenced how we approached our facilitation and planning of the group. Sharma, Bianchini, and Cakmak will provide their most salient takeaways from the forming and facilitation of the *Taking Action* group.

Positionality

Sharma identifies as a cisgender, South Asian (Indian), middle-class, able-bodied woman who is a doctoral candidate in a CACREP-accredited counseling program and a full-time lecturer in a CACREP-accredited counseling program. I bring a bicultural perspective to my counseling practice and education, and I have attended primarily White institutions (PWIs) for most of my life. As a master's and doctoral National Board for Certified Counselors Minority Fellowship Program fellow, I learned about the importance and practice of SJA. I am a practicing clinician in private practice (working mostly with White clients), and I engage in advocacy work with South Asian intimate partner violence survivors.

Bianchini identifies as a White, cisgender woman who grew up in a predominantly White community in the United States. My family has lived in the United States for several generations and the majority of my extended family identifies as part of the middle class. I do not have any disabilities and am a practicing Christian. I am a master's-level graduate student and joined Chi Sigma Iota's social justice committee in my first semester of coursework.

Cakmak identifies as a Muslim American, cisgender woman of Turkish origin. I do not have any physical disabilities, but I have been diagnosed with general anxiety disorder (GAD) and major depressive disorder (MDD). I identified as part of the upper middle class in Turkey as a child, and I am middle class as an immigrant in the United States. I have two graduate degrees, one in literature and one in counseling. I have done volunteer work with underrepresented religious and cultural communities since I was in high school.

Themes

As cocreators and coauthors, we reflected on our collective and individual experiences of facilitating our *Taking Action* group. We each completed individual reflection sheets within 48 hours of each group session to capture our takeaways, and we processed our experiences together after each group session. We reviewed our reflection sheets individually and noted themes that arose for each of us. We then collectively reviewed the sheets to determine what themes arose across our reflection sheets. We reengaged in the reflection process as we wrote this manuscript. In this section, we highlight the major themes among our experiences.

Fear

The most significant theme of our collective experience was fear. Throughout each session, fear came up under several different guises, which served as an umbrella for additional themes: judgment, self-efficacy, and humility. Fear was the main antagonist preventing us from doing social justice work before this program. Fear of not knowing the necessary information, fear of saying or doing the wrong thing, and fear of not helping enough or adequately were examples of how this feeling manifested.

However, engaging in this group helped us alleviate that fear through resources, support, and a plan of action. In the first session, we felt tentative and timid, and optimistic yet stagnant. After providing members with more information and concrete steps to create real social justice action, our fear dissipated, our passion for working as a group was ignited, and the motivation to take action began.

Judgment

In our first session, when we engaged members in a dialogue about group agreements, we noticed that there was more focus on the importance of the group serving as a judgment-free space than as a confidential one. We felt that members wanted to feel safe in the group because they feared being judged due to their self-perceived incompetence. We recognized they did not want to feel judged by others if their ideas were deemed unacceptable or incorrect. Establishing a nonjudgmental space permitted members to try, even if the outcomes were not as they hoped. We believe it allowed members to have a safe space to begin processing what they understand about SJA.

Judgment was a recurrent theme and shifted from self-judgment to judging others. Members reported feeling frustrated and upset when their peers in the program were not at the same level of advocacy awareness and action as they were. They reported feeling angry about others' ignorance. Through a shared reflection on these feelings, the group acknowledged that the judgment of others reinforces the barriers to change that we are trying to knock down. Members recognized the importance of being humble regarding other people (another theme discussed below) and empathetic to help manage feelings of judgment.

When discussing sustainability and self-care, members and facilitators shared our hesitations to implement sustainability practices, despite it being an ethical responsibility. This hesitancy revealed itself to be motivated by self-judgment of our productivity levels. It appeared that the group members would not allow themselves the breaks they needed to provide self-care because of the importance they gave to SJA. We then discussed the need to be unapologetic in our self-care as advocates and counselors.

Self-Efficacy

Related to judgment of self and others, we found self-efficacy was another significant and recurrent theme. Almost every group member expressed that they were struggling to feel like they could contribute enough to society to perform real social justice action rather than charity. Having members share similar insecurities resulted in an insightful and vulnerable conversation that helped us to feel connected and inspired. In the second session, members reported experiencing imposter syndrome, likely resulting from their low self-efficacy in social justice work. Our self-efficacy grew throughout the sessions as members received the information and tools they needed to take concrete steps in SJA. Once we clarified a reasonable idea of what was expected of them and had some direction, they felt more prepared to take action.

Humility

Lastly, the theme of humility appeared in several different iterations. The humility through humor with which we, as facilitators, approached this process helped break the ice and create a comfortable atmosphere in our initial meeting. Humility emerged in our second session when discussing the first "S" of the S-Quad model, strengths. In our reflection process, we noted that both facilitators and members appeared to be uncomfortable when sharing what they are "good" at. We, as female-identifying co-facilitators, noted the societal pressure and shame that have historically come with feelings of discomfort for behavior commonly regarded as boastful.

In the fourth session, the group discussed the importance of humility within their community. Members discussed how it was easy to humble oneself when trying to assist a community from the outside, but that it was an important lesson that we must be humble within our own communities. Members seemed to realize that their experience of their community and identity would not be the same as the next person's, highlighting the importance of intersectionality within the human experience.

Humility was next discussed in the fifth session in terms of failure. Members acknowledged the importance of possessing humility and patience regarding our work because we will generally fail more than we will succeed in our efforts to create change. If we never failed, we would never learn from our mistakes and there would be no more SJA to do. However, knowing this instills the hope to persevere, for you never know what your planted seeds of action will grow into.

Combining Themes

As facilitators, we noticed a parallel between what we were experiencing and our members' experiences. From the start of our group, we felt we needed to be more qualified to be teachers of SJA. This was our campus's first peer-led advocacy group, which meant we did not have any models to reference, and we had to rely on our own ideas, skills, and judgment. With faculty support, we went outside the confines of our curriculum because we wanted to share and engage with this content in a meaningful way. This was a large undertaking, with little training and even less confidence. Similar to what we observed in our members, we were afraid of making mistakes in the content, direction, and discussion of this group because of the weight of the topic of social justice—especially as the first group any of us attempted to create or lead. We had to adapt to constantly developing circumstances, and this felt inappropriate for us as leaders. Something we recognized much later was that we could teach and learn simultaneously; we did not need to reach a point of expertise before developing this group. Although we do not consider ourselves experts in SJA, the work we did to prepare for each session, combined with the humility with which we presented ourselves and our work, effectively allowed us to lead the group to the best of our ability.

Another source of our fear was that there was an ulterior motivation for creating this group, which was not purely social justice–oriented. We sought a sense of community, particularly given the isolating COVID-19 pandemic we were living through, and running this group gave us that community, support, and friendship. This longing for connection played into our feelings of being unqualified to do social justice work because a few of us became involved in this project out of a desire to work with friends, and not solely because we wanted to devote ourselves to social justice. However, this search for connection and participation in this SJA group gave us a passion for this work if it was not present beforehand. That feeling of connection and belonging provided us with the inner power to attempt something bigger than ourselves. The bond we authors created while facilitating this group instilled the importance of collaboration, especially when doing something new, significant, and daunting. The "S" for solidarity was also particularly salient in this case; we recognize that we could not have created or run this group alone. We needed each other to not only complete all the work required but also to hold each other accountable, support each other in times of need, and encourage each other to keep going even when our hopes dimmed. In a sense, this group and the connection to each other provided the "S" for sustainability and wellness for ourselves and our work.

While reflecting on these two sources of our fear as facilitators, we discovered our desire to make this call to the counseling profession: to strengthen the bridge between academia and counseling in practice. Applying the knowledge gained from our courses to daily practice could be less intimidating and feel more like the natural progression of our nascent counseling careers. However, once the opportunity arose to test our skills, we felt hesitant and unprepared. Creating an advocacy group is not the only venue in which this fear of practice appears. As students, we authors felt a similar fear when stepping into our practicum and internship sites. It is natural to feel afraid when seeing clients for the first time as CITs, but this fear could be lessened by academic leaders guiding students into the field before their final year of studies. If more opportunities to work with real issues affecting communities were available to students and supported by faculty, the transition between the classroom and fieldwork would feel less daunting.

Discussion

Although this project was not an empirical study, our reflective process taught us about how it feels to learn about SJA and the labor required to teach about SJA. With this knowledge, we have identified potential implications for the counseling profession and counselor education training programs. We also acknowledge the limitations of the group we formed and facilitated.

Implications

Per our experience, we believe social justice counseling—and advocacy skills more specifically—must have a more prominent place in counseling curricula. Potential solutions may include consistently operationalizing social justice counseling and SJA in counselor training programs (CSJ, 2020). Furthermore, it is imperative to have more guidance from our institutional standards such as CACREP (2023) and to have more ethical standards regarding SJA in the next iteration of the ACA *Code of Ethics*. CACREP (2023) requirements establish content that should be covered throughout all coursework, rather than specific classes; however, each program might have a different approach to operationalize these standards because they are vaguely defined (Austin & Austin, 2020). For example, in the current CACREP (2023) standards, there is more frequent mention of social justice compared to the 2016 CACREP standards; however, there is still ambiguity about how this may present in a counseling course. Standard 3.B.1 (CACREP, 2023) says that counseling curricula must state how "theories and models of multicultural counseling, social justice, and advocacy" are addressed, but there is no mention of techniques, interventions, or skills for SJA. As a point of comparison, there are specific guidelines with respect to content like group counseling which delineate time that students must spend engaged in direct experience. However, it appears that social justice and SJA are still referred to in broader terms with fewer contingencies about how they must be addressed. We recognize that out-of-class work like advocacy might be left out of the curriculum because there are many required courses and training standards filling up students' time in graduate school (Vera & Speight, 2003). However, we urge counseling leaders to consider the importance of SJA and the core role it plays in our healing work and our counseling identity.

Limitations and Future Directions

This group was developed and facilitated to encourage counseling students to develop their social justice advocate identity, but it was not an empirical study, and our collective reflections can only offer so much insight to facilitating such groups in the future. As this was an extracurricular group for which attendees took time out of their personal schedules, we do not know what motivated our peers to attend sessions that we offered. This would be important knowledge to address in future offerings of this group and to understand students' attitudes toward social justice in counseling. Another limitation of our group was our inability to reach students who are unsure of what social justice is and might not recognize it as an inherent and imperative part of mental health counseling. Practicum and other service-learning opportunities for SJA within the profession have been explored in the literature (Farrell et al., 2020; Field et al., 2019; Langellier et al., 2020), but perhaps peer encouragement can help CITs to feel more confident as advocates. Although we intentionally kept the group open for accessibility, new introductions and catching up took time away from the group plan and content. We do not have data to explicate a group like this, but we hope our master's and doctoral peers feel encouraged to start similar groups within their own programs. Finally, we wrote this article more than a year after our group ended; although we relied on our reflection sheets and notes from our experience, we are aware that there may be gaps in our recollections.

For future groups, we would be interested to complete an empirical study through an IRB in order to collect data regarding peer-led SJA groups. Screening or surveys before and after the group could not only provide valuable data, but also offer guidance for attendees even before the group starts and an opportunity for reflection after the group ends. Our decision to keep our group open led to attrition of members; thus, empirical studies might also investigate factors that contribute to student engagement. Collecting quantitative and qualitative data may provide further insight into effective strategies for describing and encouraging students to engage in concrete SJA skill development.

Conclusion

The experience of facilitating an SJA group was new, challenging, transformative, and important to our growth as CITs and budding counselor educators. As counselors, we understand our ethical duty to engage in SJA; however, we have not had adequate training in tangible strategies to utilize when advocating on behalf of our clients. The S-Quad model is an important guide that helped facilitate our understanding of how to implement SJA as mental health professionals. As co-facilitators and coauthors, we learned a great deal about ourselves as developing social justice advocates, CEs, and CITs and confronted fears parallel to those of the group members. Although SJA is a growing focus in the counseling literature, there is a great deal of research and training that must continue to occur so current and future counselors can develop their social justice advocate identities.

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References

Abrams, S. (2019, January). *3 questions to ask yourself about everything you do* [Video]. TED Talks. https://www.youtube.com/watch?v=3zJHwOwirjA

American Counseling Association. (2014). *ACA code of ethics*. https://www.counseling.org/docs/default-source/default-document-library/2014-code-of-ethics-finaladdress.pdf?sfvrsn=96b532c_8

Austin, J. T., II, & Austin, J. A. (2020). *The counselor educator's guide: Practical in-class strategies and activities*. Springer.

Chang, C. Y., Barrio Minton, C. A., Dixon, A. L., Myers, J. E., & Sweeney, T. J. (Eds.). (2012). *Professional counseling excellence through leadership and advocacy* (1st ed.). Routledge.

Chapman-Hilliard, C., & Parker, B. (2022). Embodied social justice learning: Considerations for curriculum development and training in counseling programs. *Journal for Social Action in Counseling and Psychology*, *14*(1), 77–93. https://doi.org/10.33043/JSACP.14.1.77-93

Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP standards*. https://www.cacrep.org/wp-content/uploads/2017/08/2016-Standards-with-citations.pdf

Council for Accreditation of Counseling and Related Educational Programs. (2023). *2024 CACREP standards*. https://www.cacrep.org/wp-content/uploads/2023/06/2024-Standards-Combined-Version-6.27.23.pdf

Counselors for Social Justice. (2020). A call for social justice in the American Counseling Association (ACA). *Journal for Social Action in Counseling and Psychology*, *12*(1), 2–12. https://doi.org/10.33043/JSACP.12.1.2-12

Farrell, I. C., DeDiego, A. C., & Marshall, R. C. (2020). Service learning to foster advocacy training in CACREP accredited programs. *Journal of Creativity in Mental Health*, *15*(4), 522–534. https://doi.org/10.1080/15401383.2020.1733724

Field, T. A., Ghoston, M. R., Grimes, T. O., Sturm, D. C., Kaur, M., Aninditya, A., & Toomey, M. (2019). Trainee counselor development of social justice counseling competencies. *Journal for Social Action in Counseling and Psychology*, *11*(1), 33–50. https://doi.org/10.33043/JSACP.11.1.33-50

Gummere, R. M., Jr. (1988). The counselor as prophet: Frank Parsons, 1854–1908. *Journal of Counseling & Development*, *66*(9), 402–405. https://doi.org/10.1002/j.1556-6676.1988.tb00899.x

Hannam, F. D. (2015). Teaching through narrative. *Forum on Public Policy Online*, *2015*(2).

Hays, P. A. (2022). *Addressing cultural complexities in counseling and clinical practice: An intersectional approach* (4th ed.). American Psychological Association.

hooks, b. (1994). *Teaching to transgress: Education as the practice of freedom*. Routledge.

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*(3), 366–372. https://doi.org/10.1002/j.1556-6676.2014.00164.x

Kivel, P. (2020). Social service or social change? Who benefits from your work. https://paulkivel.com/wp-content/uploads/2011/07/Social-Service-or-Social-Change-2020-Update.pdf

Langellier, K. A., Astramovich, R. L., & Horn, E. A. D. (2020). Infusing service learning into the counselor education curriculum. *The Professional Counselor*, *10*(2), 194–203. https://doi.org/10.15241/kal.10.2.194

Nadal, K. L., King, R., Sissoko, D. R. G., Floyd, N., & Hines, D. (2021). The legacies of systemic and internalized oppression: Experiences of microaggressions, imposter phenomenon, and stereotype threat on historically marginalized groups. *New Ideas in Psychology*, *63*, 1–9. https://doi.org/10.1016/j.newideapsych.2021.100895

Ratts, M. J. (2009). Social justice counseling: Toward the development of a fifth force among counseling paradigms. *The Journal of Humanistic Counseling, Education and Development*, *48*(2), 160–172. https://doi.org/10.1002/j.2161-1939.2009.tb00076.x

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

Sheely-Moore, A. I., & Kooyman, L. (2011). Infusing multicultural and social justice competencies within counseling practice: A guide for trainers. *Adultspan Journal*, *10*(2), 102–109. https://doi.org/10.1002/j.2161-0029.2011.tb00129.x

Toporek, R. L. (2018). Strength, solidarity, strategy and sustainability: A counseling psychologist's guide to social action. *The European Journal of Counselling Psychology*, *7*(1), 90–110. https://doi.org/10.5964/ejcop.v7i1.153

Toporek, R. L., & Ahluwalia, M. K. (2020). *Taking action: Creating social change through strength, solidarity, strategy and sustainability.* Cognella.

Toporek, R. L., & Daniels, J. (2018). *American Counseling Association advocacy competencies (updated 2018)*. American Counseling Association. https://www.counseling.org/docs/default-source/competencies/aca-advocacy-competencies-updated-may-2020.pdf

Toporek, R. L., Lewis, J. A., & Crethar, H. C. (2009). Promoting systemic change through the ACA advocacy competencies. *Journal of Counseling & Development*, *87*(3), 260–268. https://doi.org/10.1002/j.1556-6678.2009.tb00105.x

Vera, E. M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist*, *31*(3), 253–272. https://doi.org/10.1177/0011000003031003001

Comorbidity of Obsessive-Compulsive Disorder in Youth Diagnosed With Oppositional Defiant Disorder

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Nelson Handal, Emma Quadlander-Goff, Laura Handal Abularach, Sarah Seghrouchni, Barbara Baldwin

Understanding the overlap of symptoms between oppositional defiant disorder (ODD) and obsessive-compulsive disorder (OCD) experienced by youth is pertinent for accurate diagnosis. A quantitative, retrospective, cross-sectional design format was used to assess the relationship between ODD and OCD in addition to evaluating the difference in ODD severity and symptoms based on OCD severity. Symptoms and severity ratings of ODD and OCD were collected from youth diagnosed with ODD ($N = 179$). Fisher's exact test and a Wilcoxon signed-rank test were performed. There were significant relationships between frustration related to obsessions and compulsions and the ODD symptoms of annoyance and anger. Results suggested that OCD severity predicted an increase in scores for ODD severity and symptoms.

Keywords: **oppositional defiant disorder, obsessive-compulsive disorder, overlap of symptoms, youth, severity**

Children and adolescents who struggle with mental health disorders experience a decline in their quality of life related to psychological, physical, and social well-being (Celebre et al., 2021). The most common disorders diagnosed in childhood and adolescence are attention-deficit/hyperactivity disorder (ADHD), generalized anxiety disorder (GAD), major depressive disorder (MDD), obsessive-compulsive disorder (OCD) and other disruptive behavior disorders such as oppositional defiant disorder (ODD) and conduct disorder (CD; Ghandour et al., 2019; Perou et al., 2013). The array of disorders diagnosed in childhood and adolescence contributes to the probability of misdiagnosis or overdiagnosis (Merten et al., 2017). Moreover, approximately 7.4% of children between the ages of 3–17 are diagnosed with a behavioral problem (Centers for Disease Control and Prevention [CDC], 2021). According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013), the prevalence of OCD in the United States is 1.2%, with the majority of cases being reported before the age of 14, while the prevalence of ODD has an average estimate of 3.3%. Behavioral problems as a result of mental health issues impact a child's antisocial behaviors (Justicia-Arráez et al., 2021), further influencing performance at home and school.

Previous studies have documented the overlap of ODD with other mental disorders. For example, Garcia et al. (2009) found that approximately 12% of 4- to 8-year-old children who were diagnosed with OCD also presented with comorbid ODD. Furthermore, Thériault et al. (2014) suggested that irritability, a symptom affiliated with ODD, has been reported by individuals diagnosed with obsessive-compulsive behavior or OCD. A systematic review conducted by Stahnke (2021) revealed that OCD is commonly misunderstood by the general population as well as misdiagnosed by

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Nelson Handal, MD, DFAPA, is Founder, Chairman, and Medical Director for Dothan Behavioral Medicine Clinic and Harmonex Neuroscience Research. Emma Quadlander-Goff, PhD, NCC, LPC, is a clinical researcher at Harmonex Neuroscience Research and an assistant professor at Troy University. Laura Handal Abularach, MD, is a researcher at Harmonex Neuroscience Research and PGY-1 Psychiatry Resident at Louisiana State University. Sarah Seghrouchni, BS, is a research assistant at Alabama College of Osteopathic Medicine. Barbara Baldwin, MS, is Director of Clinical Research at Harmonex Neuroscience Research. Correspondence may be addressed to Emma Quadlander-Goff, 408 Healthwest Dr., Dothan, AL 36303, equadlander@troy.edu.

mental health professionals and primary care physicians. On the other hand, Grimmett et al. (2016) suggested that the diagnostic criterion of ODD is reflective of general child and adolescent behavior. This could result in the misdiagnosis or overdiagnosis of ODD. The interchangeable symptoms of OCD and ODD may suggest that children and adolescents are experiencing comorbidity or that they are misdiagnosed, resulting in the use of ineffective interventions and treatment for children and adolescents with OCD or ODD. The co-occurrence of ODD and OCD in youth may be attributed to the overlap of anger-related symptoms. Assessment of anger-related symptoms can provide further insight on the comorbidity of these disorders in addition to suggesting the potential for misdiagnosis.

Literature Review

Oppositional Defiant Disorder

According to Loeber et al. (2000), approximately 1%–16% of school-aged children and adolescents have been diagnosed with ODD. ODD is characterized by emotional disruptions such as anger and mood irritability in addition to behavioral issues, including argumentativeness and defiance (APA, 2013). One study suggested that ODD comprises three symptomatic components: headstrong (i.e., argumentative toward adults and defying their requests), irritable (i.e., temper dysregulation and resentfulness), and hurtful (i.e., aggression toward others; Stringaris & Goodman, 2009). ODD has demonstrated significant impairments related to emotional, social, educational, and vocational daily functioning (APA, 2013).

Pharmacological interventions that treat ODD include antipsychotics (Hood et al., 2015) and psychostimulants (Pringsheim et al., 2015). Additionally, children and adolescents diagnosed with ODD often receive therapeutic interventions such as cognitive behavioral therapy (CBT) and brief strategic family therapy (Ghosh et al., 2017). Accurate diagnosis of ODD is imperative for appropriate treatment interventions to be implemented.

Obsessive-Compulsive Disorder

OCD includes the presence of intrusive and unwanted thoughts, urges, or images that are often recurrent (obsessions) and/or repeated behaviors or mental acts that are completed as a result of obsessions (compulsions; APA, 2013). Moreover, individuals with OCD may experience intolerance of uncertainty with an emphasis on controlling their thoughts to lessen said uncertainty. A study conducted by Mancebo et al. (2008) suggested that common obsessions include contamination, catastrophic thoughts, and aligning objects to be symmetrical in addition to compulsions related to checking, repeating routine activities, and ordering or rearranging objects. Genetic, environmental, and familial factors can contribute to the severity of OCD symptoms. D. A. Geller (2006) described the average age of onset of OCD symptoms occurring between the ages of 7.5 and 12.5 years. Although the symptoms of OCD are focused on obsessions and compulsions, researchers have demonstrated that individuals with OCD experience issues with anger. For instance, Painuly et al. (2011) found that half of the participants in their study ($N = 21$) who were diagnosed with OCD reported anger attacks. Furthermore, individuals diagnosed with OCD ($N = 48$) reported increased frequency of anger along with higher anger suppression scores (Cludius et al., 2021). A third study conducted by Radomsky et al. (2007) suggested that individuals diagnosed with OCD who experience checking compulsions indicated heightened trait anger or an increased rate of anger over time. A longitudinal study that assessed children and adolescents ($N = 563$) demonstrated the developmental trajectories of ODD and obsessive-compulsive problems (OCP), which provided evidence that youth endorsed high scores of irritability and defiance in addition to increased scores of OCP (Ezpeleta et al., 2022). This study conceptualized OCP as a component of an OCD diagnosis. Hence, children may appear to have ODD when, in actuality, they may not be able to perform obsessions and compulsions, leading to irritability, defiance, and anger.

Pharmacological interventions for children and adolescents diagnosed with OCD include serotogenic medications (Nazeer et al., 2020) and selective serotonin reuptake inhibitors (Kotapati et al., 2019). Therapeutic interventions such as CBT and behavior therapy have demonstrated effectiveness in the treatment of OCD in children and adolescents (Avasthi et al., 2019). The differentiations in treatment approaches between OCD and ODD highlight the need for further research on the specific symptoms that lead to a diagnosis.

Comorbidity of ODD and OCD

Researchers have demonstrated that OCD is a highly comorbid disorder; approximately 80% of adults with OCD meet criteria for other conditions and 36.6% of children under the age of 17 with behavioral problems present with OCD (Ghandour et al., 2019). Moreover, a recent study by Ezpeleta et al. (2022) noted that ODD and obsessive-compulsive problems affect approximately 9.4% of children that are between the ages of 6 and 13. An additional study reported that one in five individuals experience depressive symptoms with OCD (Ghandour et al., 2019). However, there is inconclusive information regarding the comorbidity of ODD in association with OCD. Assessment tools such as the Child Behavior Checklist (Achenbach, 1991) can screen for comorbidity, including OCD, and the Children's Yale-Brown Obsessive Compulsive Scale (Scahill et al., 1997) can evaluate the severity of obsessions and compulsions. But a thorough inventory that assesses for comorbidities in children and adolescents and considers OCD and ODD has yet to be developed. Coskun and colleagues (2012) suggested that comprehensive evaluation could screen for comorbidities with regard to OCD in children in addition to increasing understanding of severity and age of onset, as these components can vary according to coexisting disorders.

A study conducted by Storch et al. (2010) evaluated the comorbidity of disruptive behavior disorder, including adolescents diagnosed with ODD, OCD, and CD, and reported that comorbid disruptive behavior disorder is related to greater family accommodation, less symptom resistance to obsessions, and heightened OCD severity. Moreover, the *DSM-5* suggested that males are more often diagnosed in childhood with OCD and ODD compared to females (APA, 2013). Although these two conditions are represented in distinct categories in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5-TR*; APA, 2022), clinical data and previous literature have suggested overlap. For example, one study stated that temper outbursts, which are described as behaviors such as anger outbursts, temper tantrums, and resentfulness, were two to three times more common in youth with OCD compared to those without (Krebs et al., 2013). Moreover, another study found that 53% of children diagnosed with OCD exhibited explosive anger outbursts, which were caused by perfectionism, modification to routine, or rules enforced by parents (Storch et al., 2012). Additionally, researchers have reported greater validity in OCD-diagnosed patients who exhibit increased behavioral and cognitive impulsivity (Boisseau et al., 2012). This finding has been observed and anecdotally reported by parents and teachers of youth diagnosed with OCD when compulsions cannot be acted on (Krebs et al., 2013). The influence of ODD and OCD symptoms can have lasting effects on children and adolescents, thus emphasizing the importance of mental health professionals' accurate diagnoses and the appropriate treatment of these disorders.

The pattern of uncooperative and defiant behavior toward authority figures can pose challenges in diagnosis and assessment. Factors associated with the environment, such as externalizing behaviors secondary to trauma (Beltrán et al., 2021), psychiatric conditions that include symptoms related to aggression and defiance, and hyperactivity, can be difficult to discriminate (APA, 2013; Thériault et al., 2014). This is common in ODD-diagnosed children and adolescents who often do not comply with authority figures without reason, resulting in repetitive negative behavior patterns. Similarly, youth diagnosed with OCD might respond defiantly to their obsessive thoughts when they cannot be acted upon (J. Geller, 2022). Further, children and adolescents may experience obsessive thoughts of which parents and guardians are not aware. Ezpeleta et al. (2022) reported the coexistence of the two disorders:

> The stubbornness of the oppositional child who wants to do their will and the rituals of the obsessive child who needs to do things a certain way, the low anger threshold in oppositionism and the anger attacks of the obsessive child when prevented from doing their rituals, the argumentativeness in both cases to be able to do what they want annoying others for fun or because they need to participate in the ritual, and defying rules may make the two disorders coexist. (p. 1090)

Similarly, a case study developed by Ale and Krackow (2011) described a 6-year-old boy who struggled with ritualized behaviors and avoidance that would lead to anger and aggression. The case study provided an example in which the boy feared small, round objects, and when the boy observed other children at school wearing buttons, the boy expressed his anger through name calling and kicking a peer. The distress from viewing buttons was due to an obsession that led the boy to become fearful of choking (Ale & Krackow, 2011). These explanations of anger or frustration that are an outcome of the child's inability to engage in rituals emphasize the importance of considering the misdiagnosis and comorbidity of ODD.

Study Purpose

We hypothesized that children and adolescents diagnosed with ODD would report increased OCD severity and higher ratings of symptoms related to anger, providing further insight into the overlap in symptoms of ODD and OCD. For the purpose of this study, comorbidity was defined as the presence of two or more diagnosed disorders (Basu et al., 2018). Moreover, we hypothesized that children and adolescents would endorse higher scores on symptoms related to anger and frustration because of the inability to perform obsessions and compulsions. The research questions were:

Research Question 1: What is the relationship between ODD and OCD for youth diagnosed with ODD?

Research Question 2: Is there a difference in ODD severity and symptoms between youth that scored lower on OCD severity compared to those that had high scores of OCD severity?

Method

Design

This study followed a quantitative, retrospective, cross-sectional design format that utilized a purposive sampling technique. Purposive convenience sampling allowed for intentional selection of participants who were accessible based on location. Children and adolescents diagnosed with ODD were selected for the study in order to evaluate comorbidity with OCD. This methodological approach allowed for further insight into the overlap in symptoms experienced by children and adolescents with ODD. To answer the first research question, Fisher's exact test was utilized, and to answer the second research question, a Wilcoxon signed-rank test was conducted.

Participants

The participants in this study (*N* = 179) included children and adolescents between the ages of 5 and 19 that had been referred by their parents or guardians to a mental health clinic located in the Southern region of the United States. Following the securing of IRB approval, participant documents containing diagnoses, symptoms, and severity from children and adolescents that reported to the clinic between 2017 and 2020 were retrospectively collected. Participants who were prescribed psychotropic medication or had received any other diagnosis were excluded from the study. All participants were clients at the clinic at the time of data collection. Participants gave assent through their parent or guardian's completion of an informed consent form, which indicated that diagnostic information would be used for research purposes, including future studies that would retrospectively collect participant information while keeping their identifying information confidential. Participants did not receive any reimbursement for participation in this study.

The sample used in this study included 179 children and adolescents (121 boys and 58 girls) between 5 and 19 years of age (*M* = 13.34, *SD* = 3.56) that were diagnosed with ODD. Of the sample, 14 participants (8%) were between the ages of 5 and 8, 63 participants (35%) were between the ages of 9 and 12, 55 participants (31%) were between the ages of 13 and 16, and 47 participants (26%) were between the ages of 17 and 19. The average age of the sample was 13.34 years (*SD* = 3.56).

Data Collection

Measures

CliniCom™ Psychiatric Assessment Software. The CliniCom™ Psychiatric Assessment (hereafter referred to as CliniCom) is a validated and reliable web-based tool that uses algorithms based on mental health research and *DSM-5* criteria to identify multiple psychiatric conditions (Handal et al., 2018). CliniCom is a self-guided measure that collects information including individual and family history, social history, responses to mental health questions, self-assessment of severity of symptoms, quality of life, and current and previous mental health treatments. Participants complete CliniCom at their own pace on a computer at a location of their preference (e.g., home, school). CliniCom assesses for 81 disorders and utilizes items from the Children's Yale-Brown Obsessive Compulsive Scale (Scahill et al., 1997). CliniCom has undergone psychometric investigation, indicating 78% concordance in diagnosing the same disorder in test–retest analysis, including the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989; Handal et al., 2018).

The data were retrospectively collected from participants' charts, which included a report from CliniCom. The participants completed CliniCom prior to their initial appointment with assistance from their parent or guardian. Participants received a suggested diagnosis from the assessment. Following the completion of the CliniCom assessment, semi-structured diagnostic interviews and parent questionnaires were conducted and completed. Diagnoses were verified and confirmed by a board-certified child and adolescent psychiatrist. CliniCom and the semi-structured diagnostic interviews utilized diagnostic criteria from the *DSM-5* (APA, 2013) to assess the onset, duration, frequency, and severity of mental disorders in addition to the level of impairment experienced by the client. Symptoms were conceptualized based on clinical severity, which ranges from 0–10, with 10 as the most severe presentation of the symptom and 4 or higher indicating moderate to severe symptoms. A score of 4 is the threshold to be considered positive for the symptom. The overall severity ratings for ODD and OCD are determined by the Clinical Global Impressions Scale (CGI-S). The CGI-S uses a range between 1 and 7 to indicate illness severity with 1 = *normal* to 7 = *extremely ill* (Busner & Targum, 2007).

Assessment of ODD and OCD. To determine the overlap of symptoms related to ODD and OCD for children and adolescents, the following symptoms were collected from the responses to the CliniCom items: easily annoyed, bothered, or upset by others (ODD Symptom 1), often angry or resentful (ODD Symptom 2), often spiteful or vindictive (ODD Symptom 3), and frustrated and/or angry with relation to obsessions and compulsions (OCD Symptom 1). Descriptions of symptoms can be viewed in Table 1. To respond to the ODD symptom items in the assessment, participants submitted a rating between 1 and 10. A rating of 10 represents the most severe presentation of the symptom and 4 or higher represents a moderate to severe presentation; a score of 4 is the threshold to be considered positive for the symptom. Responses to the OCD symptom item were dichotomous, wherein participants indicated "yes" or "no" if they were experiencing the symptom. OCD and ODD severity ratings for each participant were recorded.

Table 1

Description of Symptoms Collected

Disorder Term	**Description from CliniCom™ Psychiatric Assessment**
ODD Symptom 1	"Easily annoyed, bothered, or upset by others"
ODD Symptom 2	"Often angry and resentful"
ODD Symptom 3	"Often spiteful or vindictive"
OCD Symptom 1	"Frustrated and/or angry with relation to obsessions and compulsions"

Data Analysis

IBM SPSS 27 software was used for data analysis. Preliminary analysis included all clients in the sample. The Kolmogorov-Smirnov test of normality was conducted to determine the numerical distribution of variables. The test of normality showed that none of the variables were normally distributed, $p < .05$. Spearman correlation coefficients were calculated to determine significant associations between variables.

Fisher's exact tests were conducted to determine non-random associations between variables. Phi was used to calculate the effect size for the Fisher's exact test. A Wilcoxon signed-rank test was performed to analyze other variables in the sample through comparison of groups. The first group included participants who endorsed a score between 1–3 on the CGI-S for OCD severity ($n = 47$). The second group was composed of participants who reported a score between 4–7 on the CGI-S for OCD severity ($n = 132$). Correlation coefficients were calculated to determine the effect sizes for the Wilcoxon signed-rank test.

Results

The mean score for the characteristics of ODD Symptom 1 was 7.79 (*SD* = 2.39), ODD Symptom 2 was 6.09 (*SD* = 3.18), and ODD Symptom 3 was 4.58 (*SD* = 3.49). For OCD Symptom 1, 88% (*n* = 159) of participants endorsed experiencing the symptom and 12% (*n* = 20) did not endorse the symptom. The mean score for ODD severity was 6.05 (*SD* = 0.996) and OCD severity was 4.61 (*SD* = 1.92). Descriptive statistics and Spearman correlations are reported in Table 2.

Table 2

*Spearman Correlation Coefficients (*p* Values), Mean, and Standard Deviations of Variables*

Measure	*M*	*SD*	1	2	3	4	5	6
1. Age	13.34	3.56	-					
2. ODD Severity	6.05	0.996	−0.102	-				
3. OCD Severity	4.61	1.92	−0.004	.286**	-			
4. ODD Symptom 1	7.79	2.39	0.026	.246**	0.112	-		
5. ODD Symptom 2	6.09	3.18	0.025	.240**	0.172*	.645**	-	
6. ODD Symptom 3	4.58	3.49	0	.220**	0.152*	.522**	.715**	-

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

Fisher's exact test was used to determine if there was a significant association between the OCD and ODD variables. There was no statistical significance between ODD Severity and OCD Symptom 1 (two-tailed, $p = .196$) or between OCD Symptom 1 and ODD Symptom 3 (two-tailed, $p = .015$). However, there was a strong positive relationship between OCD Symptom 1 and ODD Symptom 1 ($\phi = .43$; two-tailed, $p < .001$) as well as a strong positive significant association between OCD Symptom 1 and ODD Symptom 2 ($\phi = .53$; two-tailed, $p < .001$).

A Wilcoxon signed-rank test revealed a statistically significant difference between ODD Severity and OCD Severity ($z = -8.803$, $p < .001$) with a medium effect size ($r = .60$). The median score increased from 5 to 6 when ODD Severity was considered with OCD Severity, suggesting that OCD Severity scores predicted a significant increase in ODD Severity scores. Analysis indicated a statistically significant difference between OCD Severity and ODD Symptom 1 ($z = -9.834$, $p < .001$) with a large effect size ($r = .735$), suggesting that the median score of ODD Symptom 1 increased from 8 to 9 when OCD Severity was included. ODD Symptom 1 predicted a significant increase in OCD Severity scores. The results revealed a statistically significant difference between OCD Severity and ODD Symptom 2 ($z = -5.114$, $p < .001$) with a small effect size ($r = .382$). The median score for ODD Symptom 2 increased from 5 to 7 when OCD Severity was included. Results did not reveal a statistically significant difference between OCD Severity and ODD Symptom 3 ($z = -.266$, $p = .790$). The median score remained the same (*Mdn* = 5) when OCD Severity was considered with ODD Symptom 3. Results of the Wilcoxon signed-rank test are depicted in Table 3.

Table 3

Wilcoxon Signed-Rank Test for OCD Severity

Measure	Ranks	Mean Rank	Sum of Rank	*Z*	*p*
ODD Severity	Negative Ranks	47.64	667.00	−8.083	< 0.001
	Positive Ranks	64.94	7208.00		
ODD Symptom 1	Negative Ranks	61.72	987.50	−9.834	< 0.001
	Positive Ranks	88.51	13718.50		
ODD Symptom 2	Negative Ranks	76.86	3766.00	−5.114	< 0.001
	Positive Ranks	86.28	10095.00		
ODD Symptom 3	Negative Ranks	85.56	7700.50	−0.266	0.790
	Positive Ranks	88.56	7350.50		

Discussion

The objective of the present study was to identify and assess children and adolescents for overlap in symptoms and severity of ODD and OCD to determine potential comorbidity and suggest misdiagnosis. The aim of this study was to better understand the potential for children and adolescents to be misdiagnosed with ODD rather than OCD based on the premise that OCD-diagnosed children and adolescents experience symptoms that mimic ODD, such as anger and frustration, because of the inability to perform compulsions.

According to the results of this study, there was a significant relationship between OCD Symptom 1 and ODD Symptom 1. This finding suggested that youth diagnosed with ODD demonstrated significant associations with anger/frustration related to obsessions, compulsions, and annoyance. Additionally, the results suggested a significant relationship between OCD Symptom 1 (feels very frustrated and or angry with relation to obsession and compulsions) and ODD Symptom 2 (often angry and resentful). These results are similar to the prior research conducted by Ezpeleta et al. (2022), which revealed that children with OCP and ODD experienced heightened severity with relation to irritability and defiance, which may be due to the inability to act on a compulsion or perform a ritual. Moreover, researchers have conceptualized that the inability to complete compulsions may result in defiance or temper/anger outbursts (Ale & Krackow, 2011; Krebs et al., 2013; Painuly et al., 2011). Perhaps the children and adolescents in this study were diagnosed with ODD because of the endorsement of symptoms associated with frustration and anger; however, these symptoms might be a result of the inability to complete compulsions.

Findings from this study suggested that ODD Severity, ODD Symptom 1 (easily annoyed, bothered, or upset by others), and ODD Symptom 2 (often angry and resentful) increased when OCD Severity was considered. The heightened severity and symptoms of ODD when OCD Severity was included in the analysis demonstrated the potential for comorbidity. These results are similar to the findings of Storch et al. (2010), who found that youth diagnosed with ODD and OCD (*N* = 192) reported increased OCD severity. Moreover, in a similar study, Coskun et al. (2012) found that 48% (*n* = 12) of children and adolescents who were diagnosed with OCD had comorbidity with ODD. Understanding the co-occurrence of these disorders is crucial because they have shown to be predictors of OCD in young adulthood (Bloch et al., 2009).

Implications

Clinical assessment is imperative to accurately diagnose children and adolescents who exhibit anger and frustration. The results of this study are imperative to understanding the potential for misdiagnosis and comorbidity among OCD and ODD. It is also important to note the overdiagnosis of ODD, which could contribute to the lack of consideration of OCD and misdiagnosis of ODD in children and adolescents. According to Grimmett et al. (2016), the *DSM-5* criteria for ODD appear to be too general, which may make it more of a convenient diagnosis rather than an accurate one. Moreover, Merten et al. (2017) noted that misdiagnosis and overdiagnosis of mental disorders for children and adolescents could be due to the methods implemented in evaluation, reports of symptoms by parents or guardians, and differences in perspectives of diagnostic criteria. Consequently, clients may receive a fast and inadequate evaluation for ODD without a thorough consideration of the possibility of coexisting conditions, such as OCD. Clinicians can utilize this information by thoroughly evaluating the underlying cause or origin of the anger or frustration experienced by children and adolescents in order to engage in accurate conceptualization and planning of treatment modalities. We suggest that clinicians ask their clients about their cognitive thought processes prior to experiencing anger to determine if unwanted, intrusive, or upsetting thoughts (i.e., obsessions) are occurring prior to experiencing anger. To accurately diagnose, clinicians should ask if the client is engaging in compulsions in various environments to which the repetitive behaviors can be freely acted on and if the client experiences anger and frustration in all environments. Likewise, if the client reports experiencing anger or frustration mostly in the presence of authority figures, clinicians will be better able to rule out OCD. Additionally, clinicians should consider the onset of these disorders because ODD symptoms typically appear in preschool and OCD has an average onset of 19.5 years (APA, 2013). The assessment of both mental disorders can assist in the development of preventative efforts to better support emotional regulation of youth in the school and home settings (Ezpeleta et al., 2022). Lastly, Ale and Krackow (2011) touched on the importance of clinicians providing behavioral training to parents or guardians of children diagnosed with OCD and ODD that focused on differentiating defiant behaviors and anxiety-related behaviors. The American Academy of Children and Adolescent Psychiatry (AACAP; 2023) hosts the Oppositional Defiant Disorder Resource Center and the Obsessive-Compulsive Disorder Resource Center. These resource centers include psychoeducation on mental disorders and information on medications and treatment options (AACAP, 2023). Moreover, parents or guardians can find information, prevention, and intervention through government agencies, including the U.S. Department of Health and Human Services (2023) and state departments of mental health. Lastly, parents or guardians can seek information from nonprofit organizations, including the National Federation of Families (2023), the International OCD Foundation (2023), and the Child Mind Institute (2023).

Limitations and Future Research

This study has a few limitations. First, with relation to the CliniCom, only one symptom of OCD was collected. Future studies should consider collecting more information on OCD when evaluating for overlap in symptoms. Second, the study relied on self-report data completed by the participants and their guardians, although a semi-structured diagnostic interview was completed by a board-certified psychiatrist to verify and confirm the diagnosis. Third, the sample size for the study was small, which limited the power of the data analysis, and comprised far more boys than girls, limiting the generalizability of the results. However, this gender compilation was expected as more males are diagnosed with ODD compared to females (APA, 2013; Ezpeleta et al., 2022).

Despite limitations, this study contributes further evidence of the overlap in symptoms between ODD and OCD in addition to highlighting the challenges of accurate diagnosis. The findings of this study demonstrated that further research must be conducted to understand how frustration or anger related to obsessions and compulsions may be misinterpreted as symptoms of ODD for children and adolescents.

Conclusion

This study sought to assess the associations in symptoms and severity between ODD and OCD as reported by children and adolescents. Specifically, we examined anger and frustration with relation to obsessions and compulsions to further understand the overlap in these disorders. The premise of this study was that the inability to act on obsessions and compulsions may lead to increases in anger and frustration. The inconclusive information regarding the overlap in symptoms related to anger for youth experiencing symptoms of OCD demonstrates the need for further research. Identifying the source of defiance (i.e., anger, annoyance, resentfulness) should be considered in the development of comprehensive assessments. This will further impact accurate diagnosis and treatment planning. The associations between anger or frustration related to obsessions and compulsions with the ODD symptoms of annoyance and anger/resentfulness indicate the need for further assessment regarding comorbidity and additional consideration of misdiagnosis or overdiagnosis. Furthermore, the increases in ODD symptoms and severity when OCD severity was considered further suggest that clinicians should recognize the impact of one diagnosis on another. Accurate diagnosis of these disorders is pertinent to providing effective treatment, which will influence the daily functioning of youth diagnosed with these disorders.

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

References

Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist/4-18 and the 1991 profile.* Department of Psychiatry, University of Vermont.

Ale, C. M., & Krackow, E. (2011). Concurrent treatment of early childhood OCD and ODD: A case illustration. *Clinical Case Studies*, *10*(4), 312–323. https://doi.org/10.1177/1534650111420283

American Academy of Child and Adolescent Psychiatry. (2023). *Resource centers.* https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Home.aspx

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176.appi.books.9780890425787

Avasthi, A., Sharma, A., & Grover, S. (2019). Clinical practice guidelines for the management of obsessive-compulsive disorder in children and adolescents. *Indian Journal of Psychiatry*, *61*(2), 306–316. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_554_18

Basu, D., Basu, A., & Ghosh, A. (2018). Assessment of clinical co-morbidities. *Indian Journal of Psychiatry*, *60*(4), 457–465. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_13_18

Beltrán, S., Sit, L., & Ginsburg, K. R. (2021). A call to revise the diagnosis of oppositional defiant disorder—Diagnoses are for helping, not harming. *JAMA Psychiatry*, *78*(11), 1181–1182. https://doi.org/10.1001/jamapsychiatry.2021.2127

Bloch, M. H., Craiglow, B. G., Landeros-Weisenberger, A., Dombrowski, P. A., Panza, K. E., Peterson, B. S., & Leckman, J. F. (2009). Predictors of early adult outcomes in pediatric-onset obsessive-compulsive disorder. *Pediatrics*, *124*(4), 1085–1093. https://doi.org/10.1542/peds.2009-0015

Boisseau, C. L., Thompson-Brenner, H., Caldwell-Harris, C., Pratt, E., Farchione, T., & Barlow, D. H. (2012). Behavioral and cognitive impulsivity in obsessive–compulsive disorder and eating disorders. *Psychiatry Research*, *200*(2–3), 1062–1066. https://doi.org/10.1016/j.psychres.2012.06.010

Busner, J., & Targum, S. D. (2007). The Clinical Global Impressions Scale: Applying a research tool in clinical practice. *Psychiatry*, *4*(7), 28–37. PMID: 20526405

Celebre, A., Stewart, S. L., Theall, L., & Lapshina, N. (2021). An examination of correlates of quality of life in children and youth with mental health issues. *Frontiers in Psychiatry*, *12*. https://doi.org/10.3389/fpsyt.2021.709516

Centers for Disease Control and Prevention. (2023, March 8). *Children's mental health: Data and statistics*. https://www.cdc.gov/childrensmentalhealth/data.html

Child Mind Institute. (2023, March). *Complete guide to OCD*. https://www.childmind.org/guide/parents-guide-to-ocd/

Cludius, B., Mannsfeld, A. K., Schmidt, A. F., & Jelinek, L. (2021). Anger and aggressiveness in obsessive-compulsive disorder (OCD) and the mediating role of responsibility, non-acceptance of emotions, and social desirability. *European Archives of Psychiatry and Clinical Neuroscience*, *271*, 1179–1191. https://doi.org/10.1007/s00406-020-01199-8

Coskun, M., Zoroglu, S., & Ozturk, M. (2012). Phenomenology, psychiatric comorbidity and family history in referred preschool children with obsessive-compulsive disorder. *Child and Adolescent Psychiatry and Mental Health*, *6*. https://doi.org/10.1186/1753-2000-6-36

Ezpeleta, L., Penelo, E., Navarro, J. B., de la Osa, N., & Trepat, E. (2022). Irritability, defiant and obsessive-compulsive problems development from childhood to adolescence. *Journal of Youth and Adolescence*, *51*, 1089–1105. https://doi.org/10.1007/s10964-021-01528-7

Garcia, A. M., Freeman, J. B., Himle, M. B., Berman, N. C., Ogata, A. K., Ng, J., Choate-Summers, M. L., & Leonard, H. (2009). Phenomenology of early childhood onset obsessive compulsive disorder. *Journal of Psychopathology and Behavioral Assessment*, *31*, 104–111. https://doi.org/10.1007/s10862-008-9094-0

Geller, D. A. (2006). Obsessive-compulsive and spectrum disorders in children and adolescents. *Psychiatric Clinics of North America*, *29*(2), 353–370. https://doi.org/10.1016/j.psc.2006.02.012

Geller, J. (2022, October). *What is obsessive-compulsive disorder?* American Psychiatric Association. https://www.psychiatry.org/patients-families/obsessive-compulsive-disorder/what-is-obsessive-compulsive-disorder

Ghandour, R. M., Sherman, L. J., Vladutiu, C. J., Ali, M. M., Lynch, S. E., Bitsko, R. H., & Blumberg, S. J. (2019). Prevalence and treatment of depression, anxiety, and conduct problems in US children. *The Journal of Pediatrics*, *206*, 256–267. https://doi.org/10.1016/j.jpeds.2018.09.021

Ghosh, A., Ray, A., & Basu, A. (2017). Oppositional defiant disorder: Current insight. *Psychology Research and Behavior Management*, *2017*(10), 353–367. https://doi.org/10.2147/PRBM.S120582

Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C. L., Heninger, G. R., & Charney, D. S. (1989). The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Archives of General Psychiatry*, *46*(11), 1006–1011. https://doi.org/10.1001/archpsyc.1989.01810110048007

Grimmett, M. A., Dunbar, A. S., Williams, T., Clark, C., Prioleau, B., & Miller, J. S. (2016). The process and implications of diagnosing oppositional defiant disorder in African American males. *The Professional Counselor*, *6*(2), 147–160. https://doi.org/10.15241/mg.6.2.147

Handal, N., LePage, J., Dayley, P., Baldwin, B., Roeser, A., Kay, J., Theobald, H. A., Nellamattathil, M., Drotar, S., Weir, C., Tindell, N., & Tice, K. (2018). Validation, reliability, and specificity of Clinicom™ psychiatric assessment software. *Psychiatry Research*, *265*, 334–340. https://doi.org/10.1016/j.psychres.2018.05.029

Hood, B. S., Elrod, M. G., & DeWine, D. B. (2015). Treatment of childhood oppositional defiant disorder. *Current Treatment Options in Pediatrics*, *1*, 155–167. https://doi.org/10.1007/s40746-015-0015-7

International OCD Foundation. (2023). *For parents and families.* https://kids.iocdf.org/for-parents/

Justicia-Arráez, A., Pichardo, M. C., Romero-López, M., & Alba, G. (2021). Can we manage behavioral problems through the development of children's social-emotional regulated behavior? Longitudinal study of a preschool program. *International Journal of Environmental Research Public Health*, *18*(16), 8447. https://doi.org/10.3390/ijerph18168447

Kotapati, V. P., Khan, A. M., Dar, S., Begum, G., Bachu, R., Adnan, M., Zubair, A., & Ahmed, R. A. (2019). The effectiveness of selective serotonin reuptake inhibitors for treatment of obsessive-compulsive disorder in adolescents and children: A systematic review and meta-analysis. *Frontiers in Psychiatry*, *10*(523). https://doi.org/10.3389/fpsyt.2019.00523

Krebs, G., Bolhuis, K., Heyman, I., Mataix-Cols, D., Turner, C., & Stringaris, A. (2013). Temper outbursts in pediatric obsessive-compulsive disorder and their association with depressed mood and treatment outcome. *Journal of Child Psychology and Psychiatry*, *54*(3), 313–322. https://doi.org/10.1111/j.1469-7610.2012.02605.x

Loeber, R., Burke, J. D., Lahey, B. B., Winters, A., & Zera, M. (2000). Oppositional defiant and conduct disorder: A review of the past 10 years, part I. *Journal of the American Academy of Child and Adolescent Psychiatry*, *39*(12), 1468–1484. https://doi.org/10.1097/00004583-200012000-00007

Mancebo, M. C., Garcia, A. M., Pinto, A., Freeman, J. B., Przeworski, A., Stout, R., Kane, J. S., Eisen, J. L., & Rasmussen, S. A. (2008). Juvenile-onset OCD: Clinical features in children, adolescents and adults. *Acta Psychiatrica Scandinavica*, *118*(2), 149–159. https://doi.org/10.1111/j.1600-0447.2008.01224.x

Merten, E. C., Cwik, J. C., Margraf, J., & Schneider, S. (2017). Overdiagnosis of mental disorders in children and adolescents (in developed countries). *Child and Adolescent Psychiatry and Mental Health*, *11*(5). https://doi.org/10.1186/s13034-016-0140-5

National Federation of Families. (2023). *Oppositional defiant disorder resources.* https://www.Ffcmh.org/esources-odd

Nazeer, A., Latif, F., Mondal, A., Azeem, M. W., & Greydanus, D. E. (2020). Obsessive-compulsive disorder in children and adolescents: Epidemiology, diagnosis and management. *Translational Pediatrics*, *9*(1), S76–S93. https://doi.org/10.21037/tp.2019.10.02

Painuly, N. P., Grover, S., Mattoo, S. K., & Gupta, N. (2011). Anger attacks in obsessive compulsive disorder. *Industrial Psychiatry Journal*, *20*(2), 115–119. https://doi.org/10.4103/0972-6748.102501

Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., Hedden, S. L., Crosby, A. E., Visser, S. N., Schieve, L. A., Parks, S. E., Hall, J. E., Brody, D., Simile, C. M., Thompson, W. W., Baio, J., Avenevoli, S., Kogan, M. D., & Huang, L. N. (2013). Mental health surveillance among children – United States, 2005-2011. *Morbidity and Mortality Weekly Report Supplements*, *62*(02), 1–35. PMID: 23677130

Pringsheim, T., Hirsch, L., Gardner, D., & Gorman, D. A. (2015). The pharmacological management of oppositional behaviour, conduct problems, and aggression in children and adolescents with attention-deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder: A systematic review and meta-analysis. Part 1: Psychostimulants, alpha-2 agonists, and atomoxetine. *The Canadian Journal of Psychiatry*, *60*(2), 42–51. https://doi.org/10.1177/070674371506000202

Radomsky, A. S., Ashbaugh, A. R., & Gelfand, L. A. (2007). Relationships between anger, symptoms, and cognitive factors in OCD checkers. *Behaviour Research and Therapy*, *45*(11), 2712–2725. https://doi.org/10.1016/j.brat.2007.07.009

Scahill, L., Riddle, M. A., McSwiggin-Hardin, M., Ort, S. I., King, R. A., Goodman, W. K., Cicchetti, D., & Leckman, J. F. (1997). Children's Yale-Brown Obsessive Compulsive Scale: Reliability and validity. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*(6), 844–852. https://doi.org/10.1097/00004583-199706000-00023

Stahnke, B. (2021). A systematic review of misdiagnosis in those with obsessive-compulsive disorder. *Journal of Affective Disorders Reports*, *6*, 1–7. https://doi.org/10.1016/j.jadr.2021.100231

Storch, E. A., Jones, A. M., Lack, C. W., Ale, C. M., Sulkowski, M. L., Lewin, A. B., De Nadai, A. S., & Murphy, T. K. (2012). Rage attacks in pediatric obsessive-compulsive disorder: Phenomenology and clinical correlates. *Journal of the American Academy of Child and Adolescent Psychiatry*, *51*(6), 582–592. https://doi.org/10.1016/j.jaac.2012.02.016

Storch, E. A., Lewin, A. B., Geffken, G. R., Morgan, J. R., & Murphy, T. K. (2010). The role of comorbid disruptive behavior in the clinical expression of pediatric obsessive-compulsive disorder. *Behaviour Research and Therapy*, *48*(12), 1204–1210. https://doi.org/10.1016/j.brat.2010.09.004

Stringaris, A., & Goodman, R. (2009). Longitudinal outcome of youth oppositionality: Irritable, headstrong, and hurtful behaviors have distinctive predictions. *Journal of the American Academy of Child and Adolescent Psychiatry*, *48*(4), 404–412. https://doi.org/10.1097/CHI.0b013e3181984f30

Thériault, M.-C. G., Lespérance, P., Achim, A., Tellier, G., Diab, S., Rouleau, G. A., Chouinard, S., & Richer, F. (2014). ODD irritability is associated with obsessive–compulsive behavior and not ADHD in chronic tic disorders. *Psychiatry Research*, *220*(1–2), 447–452. https://doi.org/10.1016/j.psychres.2014.07.039

U.S. Department of Health and Human Services. (2023). *Youth mental health.* https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/index.html

Bridging the Gap Between Intentions and Impact: Understanding Disability Culture to Support Disability Justice

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K. Lynn Pierce

Persistent ableism in higher education, counseling practice, and society necessitates disability justice advocacy. In this article, the author explores the historical context of disability and the importance of disability knowledge for counselors and counselor educators. In addition to discrimination and inaccessibility, able privilege and lack of representation present significant barriers to equity and empowerment of disabled people. Better awareness of disability culture and community-oriented frameworks for the collective liberation of disabled people, such as disability justice, can improve disability equity and allyship within counseling and counselor education.

Keywords: **ableism, disability justice, advocacy, allyship, counseling**

The disability rights motto, "Nothing about us without us," highlights the importance of including disabled people in decisions that affect them. However, in a society dominated by able privilege, this motto has at times translated into "Nothing at all." The absence of disabled representation and empowerment leads to a lack of understanding, empathy, and action toward improving the lived experiences of the disability community.

Over 60 million Americans live with a disability, making them the largest minority group in the United States (Centers for Disease Control and Prevention, 2023). The Americans with Disabilities Act (ADA) defines a person with a disability as "a person who has a physical or mental impairment that substantially limits one or more major life activity" (ADA National Network, 2024, para. 1). These activities include daily tasks like breathing, walking, talking, hearing, seeing, sleeping, taking care of oneself, doing manual tasks, and working. The year 2020 marked the 30th anniversary of the ADA, the major law granting protections to disabled individuals. Yet institutional ableism continues to persist in higher education, counseling practice, and public life. Disabled people face various obstacles, including unresolved barriers to physical access (including of health care and mental health services), social stigma, and insufficient funding for rehabilitation programs. Able privilege (also referred to as ability privilege or able-bodied privilege) is a viewpoint in which non-disabled bodies are considered normative (Lewis, 2022). Able privilege is pervasive in society and continues to contribute to societal stigmatization of and discrimination against disabled bodies, minds, and lives.

Positionality

The positionality of authors engaged in disability justice work is crucial for acknowledging biases and perspectives that influence the writing process. This practice also allows for transparency for readers to better understand the context this article is situated in. This is particularly important given the diversity of cultural norms within and between disability subcommunities and the differences of perception of ableism, access, and disability equity shaped by individuals' unique experiences of disability.

K. Lynn Pierce, PhD, NCC, ACS, LPC, CRC, is an assistant professor and Counselor Education and Supervision PhD Program Coordinator at Mercer University. Correspondence may be addressed to K. Lynn Pierce, Mercer University College of Professional Advancement, 2930 Flowers Rd. S., Chamblee, GA 30341, pierce_k03@mercer.edu.

I identify as a White, queer, disabled academic who aligns with crip culture. The term "crip" is a reclamation of the derogatory slang "cripple," much as "queer" has been reclaimed by the LGBTQ+ community. I integrate the principles of disability justice and bring lived experience into advocacy, clinical, and research work pertaining to the disability community. I have navigated ableism personally and professionally and am invested in critical examination of ableist systems and advancement of cross-disability liberation. I use an anti-ableist and identity-affirming ideological lens to approach disability advocacy. The use of identity-first language throughout this paper reflects this positionality and is an acknowledgement of many disability subcommunities' preference for this language.

A Brief History of Disability in the United States

Attitudes and policies surrounding the disability experience in the United States have historically imposed harsh restrictions and exclusions grounded in ableism. In the late 19th and early 20th centuries, the eugenics movement promoted the view that disability was undesirable and needed to be purged from society (Rutherford, 2022). Many proponents of eugenics were scientists, doctors, and policymakers. This contributed to forced sterilization and institutionalization of disabled people, restrictive immigration policies, and segregation in education. These policies, along with social stigma, led to disabled people being socially and economically disadvantaged and pushed to the fringes of society (RespectAbility, 2021).

In the 1970s, The Independent Living Movement and Centers for Independent Living (CILs) emerged as a civil rights campaign spearheaded by and for the disability community (Hayman, 2019). This movement pushed back against the discriminatory environments and paternalistic professionals of the time and focused on providing peer support, dignity, civil rights, and autonomy through direct service and advocacy. At this same time, the 504 protests (referring to section 504 of the Rehabilitation Act) paved the way for the civil rights work that eventually culminated in the passage of the ADA in 1990, which finally extended similar federally protected rights to disability as those that cover race and gender (Cone, n.d.).

Since 2000, disability-related activism has been most prominent online. Within this environment, community-based efforts such as the #SayTheWord movement and disability-related hashtags began to trend on social media. Many within the disability community have embraced X, formerly known as Twitter, specifically because it is free, has accessibility features, and allows for global connection and unprecedented reach to businesses and public figures, as well as other individuals and organizations within the disability community (Wilson-Beattie, 2018). Facebook and other social media groups have been important gathering places for disabled individuals to connect, obtain information about their conditions and available treatments, and find others who can relate to their experiences.

Exclusion of Disability in Education and Practice

The Rehabilitation Act of 1973 and the ADA both extended disability protections into higher education settings. However, because of the lack of protections in these settings prior to these laws, colleges and universities were already built on inaccessible foundations both physically and socially (Dolmage, 2017). This has led to a continued lack of equity for disabled people within higher education.

The National Center for Education Statistics (2018) reported that 19.4% of the undergraduate student body report having a disability, but only 11.9% at the graduate level. The Center for College Students with Disabilities reported that less than 4% of faculty members have disabilities (Grigely, 2017). This suggests barriers to recruitment and retention and/or biases that prevent disclosure of disability identity. Despite the requirements under the Rehabilitation Act and ADA to provide equitable access, providing disability-related supports is often in conflict with ableist systems within higher education. For example, very few universities and colleges embrace a holistic and affirming model to support disability inclusion on their campuses and instead use an accommodation-only–focused approach. Most colleges and universities do not have a disability cultural center or student organizations focused on disability, despite the benefits for students and the community that such a center can provide (Elmore et al., 2018).

Disability and Counselor Education

Unfortunately, there is very little research available on disability within counseling and counselor education. Disability is often absent from captured demographics in our research, including when studies focus on the experiences of diverse counselors, counselor educators, and students. There is no information currently available regarding disability representation among counselor educators or counseling leadership, and very little about the experiences of disabled individuals within the profession or even the experiences of disabled clients with professional counselors.

Counselor education programs, apart from rehabilitation-specific classes, seldom focus on disability topics. According to Feather and Carlson (2019), 36% of faculty surveyed believed their program was ineffective at addressing disability topics, while only 10.6% believed their program to be "very effective" in this content area. Faculty self-assessment of competence to teach disability-related content correlated significantly with previous work or personal experience with disability, underscoring the importance of exposure to and training about disability-related concepts being infused across core areas. Key elements related to disability competence such as accessibility, able privilege, disability culture, and disability justice are explored in the following sections.

Considering Accessibility

Accessibility is a word that is often co-opted in diversity, equity, and inclusion (DEI) spaces to mean attainability, affordability, inclusion, etc. However, *accessibility* is a concept that is legally related to the ability of disabled people to equitably interact with built environments and services. The Office for Civil Rights (OCR) defines accessibility as:

> When a person with a disability is afforded the opportunity to acquire the same information, engage in the same interactions, and enjoy the same services as a person without a disability in an equally integrated and equally effective manner, with substantially equivalent ease of use. (U.S. Department of Education, 2013, p. 3)

Physical accessibility includes factors such as ample accessible parking, pathways without stairs, clear curb cuts, even paving, wide doors and pathways, clear signage, clear spaces for wheelchairs and mobility devices, and accessible bathrooms. Accessibility of websites and other digital services is also covered under the ADA. The accessibility of learning management systems, captioning and transcripts for videos, and accessible file types are all important factors in classroom accessibility. Despite the ADA requirements, many spaces fall short, emphasizing the need for continual self-evaluation and consultation (ADA National Network, 2016).

Accessibility is often viewed only as what must be done at a minimum legally, and sometimes it is unclear within a given structure who exactly is responsible for ensuring accessibility. This often results in a reactive approach that places the burden on disabled people to experience barriers and report them. Another common approach is an accommodation mindset, in which disability is seen as so unlikely within a setting that those who need disability supports are seen as burdensome and must request them in advance. This can be contrasted with a barrier reduction or universally designed approach, in which disability would be proactively considered and planned for within a system or space. The resistance to these more equitable approaches is largely the result of lack of awareness of disability prevalence and needs, rooted in ableism and able privilege (Dolmage, 2017).

Able Privilege

Able privilege (also referred to as ability privilege or able-bodied privilege) is a viewpoint in which non-disabled bodies are considered normative. This condition lends itself to the continuation of inaccessible environments and attitudes, which, in turn, further entrenches able privilege within society. To illustrate the implications of able privilege, one may consider the day-to-day experiences of non-disabled individuals and the stark contrast with the experiences of disabled people. The simple act of opening a door without strategizing your approach or having the liberty to choose any seat at a movie theater or concert are further indicators of able privilege. If you have always been able to access materials showcasing individuals of your ability as role models or had access to mentors who mirror your ability, you have experienced able privilege. The ability to move around with the assurance that housing options will generally be accessible to you is a distinct advantage, one that disabled people, particularly those who use mobility devices or who have physical limitations often cannot take for granted. The invisibility of these privileges to those who benefit from them is precisely what fuels the cycle of able privilege, leading to a lack of representation and empowerment for disabled individuals (Dolmage, 2017).

Able privilege is a major but often neglected aspect of social inequality, mostly because disabled individuals are systematically underrepresented. This exclusion is deeply ingrained in our society, impacting policies, cultural norms, and current structures, which further magnify able privilege. “Ugly laws,” a discriminatory legislation active in certain parts of the United States through the ’70s and ’80s, literally pushed disabled people out of public view, further contributing to their erasure (Schweik, 2011). The discomfort with the disabled body being seen and acknowledged in public continues, with organizations like the Ford Foundation finding a lack of disability representation in popular media (Heumann et al., 2019). Despite increasing emphasis on diversity, equity, inclusion, and accessibility (DEIA) in counseling, the reality is that the disability community often finds itself on the outskirts of these crucial conversations because of historical inequalities that are unchallenged or a continued lack of equitable access (Dolmage, 2017).

This cycle of exclusion parallels a common physical accessibility challenge: The lack of disabled people present in a space is often used to justify a lack of priority given to accessibility. However, the inaccessibility itself is the barrier preventing disabled people from entering and remaining in these spaces in the first place. Inaccessibility precludes disabled presence and advocacy, and barriers often then stand unchallenged.

Our educational systems and programs are no exception to the impacts of the exclusion of disabled bodies and minds. Ableist ideologies are often left unchallenged and unknowingly promoted, shaping the understanding of disability at crucial developmental stages. The exposure that most people have to disabilities is also skewed, leading to the formation of harmful stereotypes and stigmas discussed further below.

Disability Culture

Disability culture encompasses a group identity with shared experiences, a history of oppression, literature, art, language, and expression. This is highlighted through various forms of art and literature and through movements advocating for disability rights and inclusion (Brown, 2015). However, the disability community boasts a rich and diverse culture that's often absent from mainstream media and popular culture.

Representation

As with other minoritized and marginalized populations, the representation of disability in mainstream media, film, and literature can have significant impacts on the societal view of disability and bias and stigma experienced by disabled individuals. Because of the various challenges in access presented by society and the taboos regarding discussions of disability, media is a primary way many people may form opinions about disability and disabled people. Unfortunately, these depictions are few and often convey misinformation and harmful tropes. In a review of 100 top movies in 2016, fewer than 3% of characters had a disability (Smith et al., 2017). Heumann and colleagues (2019) found in their examination of disability in media that most disabled characters in film fell into four stereotypes: the *Super Crips* who triumph over disability and provide the message that disability is merely a negative thing to be overcome; *Villains* who are often portrayed with disfigurement of some kind and play on fear and discomfort of disability and difference; *Victims* who are defined only by their disability and often are shown as better off dead than disabled; or *Innocent Fools* who embody negative stereotypes of those with intellectual disabilities or neurological differences. These issues with one-dimensional and negative representation in the small number of examples of disability shown on the screen are compounded by a lack of input from disabled writers, actors, or directors. Most disabled characters are played by non-disabled actors, and disability is the most underrepresented minority in the Hollywood film industry (Woodburn & Kopić, 2016).

Within the disability community, a starkly different narrative emerges, often directly hitting back at the misrepresentation and villainization of disability that is commonplace in mainstream media. For example, *Disfigured: On Fairy Tales, Disability, and Making Space* by Amanda Leduc (2020) critically analyzes the narratives ingrained in our culture around disability. Leduc particularly explores the impact of fairy tales and their modern retellings on identity development and belonging for disabled people, centering her own story and other disabled people's narratives. *Crip Camp*, a Netflix documentary, discusses the disability rights movement through the personal stories of advocates such as the late Judy Heumann (Hale & LeBrecht, 2020). Heumann's autobiography, *Being Heumann: An Unrepentant Memoir of a Disability Rights Activist* (2020), is a powerful work in the disability space along with early commentaries on empowered language and identity choice such as Nancy Mairs's essay, *On Being a Cripple* (1986).

"Crip culture" is one notable aspect of disability culture. In the anthology *Criptiques*, compiled by Caitlin Wood (2014), *crip*, slang for *cripple*, is embraced as a powerful self-descriptor, representing audacity, noncompliance, and a direct challenge to disability being pushed into the shadows. It is an example of the arts and expression of "crip culture," which draws on shared experiences of ableism, creating a community that affirms and reflects its members' originality and beauty. *Criptiques* presents a diverse set of essays embodying this revolutionary spirit and fostering discussions about disability experiences (Wood, 2014).

Social media platforms, particularly X/Twitter, have catalyzed the formation of a global disability community. Hashtags like #DisabledandCute and #AbledsAreWeird have trended, fostering discussions and highlighting the shared experiences within the disability community. "The disability revolution will be tweeted" because of the critical role social media plays in fostering community in accessible formats (Wilson-Beattie, 2018).

Emerging trends in disability spaces include the #SayTheWord movement, which seeks to reclaim the term *disability* and challenges forced person-first, euphemistic language often pressed on the disability community by able-bodied individuals, discussed further below. *Spoonie* communities are also prevalent in chronic illness and even some mental health circles. These spaces use the spoon theory by Christine Miserandino (2003), which describes how there is a set amount of energy for daily tasks that can be lowered by disability-related factors such as pain or fatigue. Spoon theory seeks to help disabled people and those close to them understand the fluctuating nature of chronic illness and better communicate about it.

Language and Empowered Expression

It is essential to understand how to talk about disabilities and disabled people in an empowering and inclusive way. *Person-first language* (e.g., "person with a disability" and "person with [condition]") emphasizes the person before the disability. While this language is used primarily in academic spaces and was mandatory until the seventh edition of the American Psychological Association style manual (APA; 2020), it is often criticized for being avoidant and contributing to perpetuating rather than confronting stigma (Collier, 2012).

Alternatively, *identity-first language* proposes that the identity of an individual should lead the conversation. This mode of language is used more commonly within disability spaces, such as "disabled individuals" or "autistic people." Some subgroups, like the Deaf and autistic communities, strongly identify with their disability factors, promoting a sense of disability pride.

Disabling language, such as "handicapped," "wheelchair-bound," or "crippled," are terms that are outdated, inaccurate, and offensive. These terms can be stigmatizing based on social and historical contexts, like referring to someone diagnosed with schizophrenia as "schizophrenic." The exception to this is in usages such as those outlined above in which some subcommunities have reclaimed words like "crippled" or find them accurate and therefore identity affirming. This highlights a trend that language and slang within the disability community often focuses on relevant factors of assistive technology or the disabilities themselves (e.g., "wheelies" for wheelchair users, "spoonies" for those who endorse spoon theory, or "potsies" for those with postural orthostatic tachycardic syndrome [POTS]), whereas out-of-group language typically rejected by disabled people is often designed to avoid using the word disability (e.g., "differently abled," "diverse-ability," or "special needs").

While person-first language is valid and should be used when it is the preference of the individual with a disability, there are many compelling arguments for normalizing and empowering identity-based language. Person-first language can be incongruent with people's self-concept and with their experience of the perception others have of them. Person-first language can perpetuate stigmatization of disability, leading to perceived hypocrisy (Collier, 2012). The language choices made by able-bodied allies often disregard the preferences of the disabled community, echoing a history of erasure and opposing the principle of "nothing about us without us." This has sometimes extended to able-bodied academics imposing their preference for person-first language on disabled people through academic standards and publishing norms. It can be argued that these restrictions historically have inhibited self-identification, language preference, and the ability to produce scholarship that accurately represents disabled people and community values. This impedes collaborative research with the disability community and reinforces a division and lack of understanding between the disability community and counselors or other medical and mental health providers.

Allyship and Disability Justice

Allyship is not an identity but a practice. Allies for the disability community must operate in solidarity with and advocate for the rights of those oppressed by systems in ways that do not reinforce the system's oppression (Brown, 2015). This involves actively listening, observing dynamics of power, focusing on impact rather than intent, leaning into discomfort, modeling inclusive language, and offering kind and constructive feedback. In this context, it's vital to understand ableism, defined as, "a system of assigning value to people's bodies and minds based on societally constructed ideas of normalcy, productivity, desirability, intelligence, excellence, and fitness" (Lewis, 2022, para. 4). Ableism devalues and discriminates against disabled people and gives preference and normative status to able-bodied people.

The Disability Justice framework (Sins Invalid, 2015) offers a comprehensive and inclusive perspective on human bodies and experiences. The Disability Justice framework was originally developed by the activist Patty Berne, a co-founder of the organization Sins Invalid, to reflect the collaborative work occurring in community spaces. Sins Invalid is a performance project that deconstructs the dehumanizing practices disabled people face and centers intersectionality and diversity of identities.

The Disability Justice framework emphasizes that every body is unique, important, and powerful. This framework understands that people are shaped by complex intersections of factors like ability, race, gender, sexuality, social class, nationality, religion, and more. Instead of isolating these factors, it insists on viewing them collectively. This viewpoint stresses that our pursuit of a fair society is rooted in these intertwined identities and points out a critical observation: Our current global system is essentially "incompatible with life" (Berne, 2015, para. 13). Disability Justice principles include "leadership of the most impacted," "interdependence," "collective access," "cross-disability solidarity," and "collective liberation" and focus strongly on intersectionality and cross-movement organizing to ensure no one is left behind or excluded (Sins Invalid, 2015, p. 1).

Although there are voices advocating for disability rights, these are predominantly from within the disability community itself, a testament to the lack of understanding and allyship from broader society. Historically, those who could have been allies—abled caregivers, academics, medical professionals, and others—have often worked against the community, whether consciously or not (Dolmage, 2017). This can be combated first by ensuring access to spaces so that disabled voices are present. Then, allies can elevate these voices while implementing a framework like disability justice to ensure that those impacted are leading and that cross-disability approaches are being implemented around equity and liberation work, in line with community priorities.

Implications for the Counseling Profession

Counselor Education and Preparation

Instructors have a critical role in supporting disabled counselors-in-training. Not only is this support mandated by law, but it also increases visibility, representation, and lived experiences of disability in the profession, thereby improving services for clients. Implementing Universal Design for Learning (UDL) can minimize the need for accommodations and provide access, engagement, and learning motivation to the widest possible audience of learners (CAST, 2018). UDL is grounded in Universal Design principles, which are architectural strategies to make physical spaces usable by the widest number of people possible. The UDL principles include strategies such as multiple means of representing information to capture various learning types and multiple means of expression to allow learners to demonstrate learning in various ways (CAST, 2018). Adopting these principles can significantly contribute to making materials and learning environments more accessible. Instructors should consider how they can better focus on curriculum, activities, and assessments that increase exposure of counseling students to disability as a common multicultural factor and client identity. In addition, it is highly advisable to approach accessibility proactively in assignments and course materials and to become comfortable with the process required to swiftly provide equitable accommodations for students when a request is made.

Where a need for access or accommodations is established for a student, an opportunity also exists to proactively advocate for and support students in ensuring accessibility and equity in their practicum and internship placements, graduate assistantships, and other duties required for or connected to their program of study. Sometimes a student’s disability and related accommodation needs are new. Even for those who have established what they need to succeed in a classroom, counseling programs with their clinical requirements are a new setting and students may not always know what they need in advance. It is therefore the responsibility of counselor educators to take a barrier reduction approach, take on the labor of researching the accessibility of approved sites and processes of accommodations specific to graduate students within their universities, and work collaboratively with the student at all stages of a program.

Counseling Practice

It is an ethical mandate that counselors become competent in working with disabled clients as addressed in the *ACA Code of Ethics* pertaining to nondiscrimination and multicultural issues (American Counseling Association, 2014). It is also important for counselors to work in ways that are respectful and promote client autonomy. This can begin with ensuring that proper etiquette is understood. Examples include speaking directly to a person, not their interpreter or attendant; not drawing attention to, commenting on, or interfering with assistive technology (including service animals); and asking questions rather than making assumptions. Working from a disability-affirming perspective is important, as well as being engaged in self-reflective work around disability bias and seeking appropriate supervision. Supervision might be with a peer to check for bias and process reactions to disability topics, or with someone with disability identity or rehabilitation training to consult on best practices around accessibility and disability-affirming approaches.

The physical counseling environment needs to be accessible according to ADA guidelines, and this should be determined based on the checklist for existing facilities and/or a professional consultant (ADA National Network, 2016). Continuing to offer telehealth as an option while still ensuring spaces are accessible helps to meet a long-standing need expressed by disabled people in ensuring access to mental health care. Websites need to meet web accessibility guidelines, and it is advisable to ensure accessible formats are available for documentation (e.g., large font and digital options). Within spaces, common triggers for various conditions should be considered. For example, fluorescent lights may trigger migraines or neurological conditions, while chemical sensitivities could be triggered by anything from bleach and other cleaning supplies to perfume, room fresheners, or lavender and other essential oils.

In working with clients, it should not be assumed a client is not disabled merely because they are not visibly disabled or have not disclosed a disability. If a client is visibly disabled or has disclosed but not elaborated, signaling openness to further discussion while respecting boundaries and client priorities is warranted. Intrusive questioning is never appropriate, and client autonomy and treatment goals should always be respected. In my own work, I think of this similarly to when I may diffuse a question regarding trauma on an intake by acknowledging the client may not yet trust me; we can come back to discuss it further at any time in our work together, and I invite them to share to their level of comfort. An example of broaching a visible or previously disclosed disability might be simply asking if there is anything that can be done to increase accessibility or comfort in the space. Another approach might be to reflect the client's own language to describe the disability, chronic illness, assistive technology, etc. and to simply ask if there is anything specific that the client would like for you to know up front that would support your work together, or whether they would like to address things as they come up.

Conclusion

Disability culture is rich and complex, asserting its place in sharp contrast to mainstream narratives with defiance. It is a culture that celebrates wholeness and intersectionality and challenges ableist norms without apology for occupying space.

By understanding how ableism in counseling and counselor education fits into the broader history of disability oppression and increasing awareness of disability culture and disability justice, the counseling profession can better serve the disability community. Normalizing conversation about disability allows us to prepare ourselves, our students, and our supervisees to work with this large and diverse population. When we act intentionally to proactively make spaces accessible, we are providing disabled people with the same rights we provide to other clients. This allows them to share their stories gradually and comfortably, without having to disclose too early or fight for their basic rights.

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References

ADA National Network. (2016). *ADA checklist for existing facilities.* https://www.adachecklist.org/doc/fullchecklist/ada-checklist.pdf

ADA National Network. (2024). *Top ADA frequently asked questions*. https://adata.org/top-ada-frequently-asked-questions

American Psychological Association. (2020). *Publication manual of the American Psychological Association 2020: The official guide to APA style* (7th ed.).

Berne, P. (2015). *Disability justice – a working draft.* Sins Invalid. https://www.sinsinvalid.org/blog/disability-justice-a-working-draft-by-patty-berne

Brown, S. E. (2015). Disability culture and the ADA. *Disability Studies Quarterly*, *35*(3). https://doi.org/10.18061/dsq.v35i3.4936

CAST. (2018). *Universal design for learning guidelines*. https://udlguidelines.cast.org

Centers for Disease Control and Prevention. (2023). *Disability impacts all of us.* https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html

Collier, R. (2012). Person-first language: Noble intent but to what effect? *Canadian Medical Association Journal*, *184*(18), 1977–1978. https://doi.org/10.1503/cmaj.109-4319

Cone, K. (n.d.). *Short history of the 504 sit in*. Disability Rights Education and Defense Fund. https://dredf.org/504-sit-in-20th-anniversary/short-history-of-the-504-sit-in/

Dolmage, J. T. (2017). *Academic ableism*. University of Michigan Press.

Elmore, K., Saia, T., & Thomson, E. A. (2018). *Special feature: An introduction to disability cultural centers in U.S. higher education, part I.* Association on Higher Education and Disability. https://www.ahead.org/professional-resources/publications/hub/hub-nov-2018/hub-nov-2018-special-feature-disability-cultural-centers

Feather, K. A., & Carlson, R. G. (2019). An initial investigation of individual instructors' self-perceived competence and incorporation of disability content into CACREP-accredited programs: Rethinking training in counselor education. *Journal of Multicultural Counseling and Development*, *47*(1), 19–36. http://doi.org/10.1002/jmcd.12118

Grigely, J. (2017). The neglected demographic: Faculty members with disabilities. *The Chronicle of Higher Education.* https://www.chronicle.com/article/The-Neglected-Demographic-/240439

Hale, J., & LeBrecht, N. (Directors). (2020). *Crip camp* [Film]. Higher Ground Productions.

Hayman, B. (2019). *Independent living history.* Access Living. https://www.accessliving.org/newsroom/blog/independent-living-history/

Heumann, J. (2020). *Being Heumann: An unrepentant memoir of a disability rights activist*. Beacon Press.

Heumann, J., Salinas, K., & Hess, M. (2019). *Road map for inclusion: Changing the face of disability in media*. Ford Foundation. https://www.fordfoundation.org/wp-content/uploads/2019/02/judyheumann_report_2019_final.pdf

Leduc, A. (2020). *Disfigured: On fairy tales, disability, and making space*. Coach House Books.

Lewis, T. A. (2022, January 1). *Working definition of ableism: January 2022 update.* https://www.talilalewis.com/blog/working-definition-of-ableism-january-2022-update

Mairs, N. (1986). *On being a cripple*. https://faculty.uml.edu/bmarshall/mairsonbeingacripple.pdf

Miserandino, C. (2003). *The spoon theory*. But You Don't Look Sick. https://butyoudontlooksick.com/articles/written-by-christine/the-spoon-theory/

National Center for Education Statistics. (2018). Table 311.10. Number and percentage distribution of students enrolled in postsecondary institutions, by level, disability status, and selected student characteristics: 2015–16. *Digest of Education Statistics*. https://nces.ed.gov/programs/digest/d20/tables/dt20_311.10.asp

RespectAbility. (2021). *A brief history of the disability rights movement.* https://www.respectability.org/people-with-disabilities-at-work/history/

Rutherford, A. (2022). *Control: The dark history and troubling present of eugenics.* Abrams Press.

Schweik, S. M. (2011). Kicked to the curb: Ugly law then and now. *Harvard Civil Rights-Civil Liberties Law Review Amicus*, *46*, 1–16. https://journals.law.harvard.edu/crcl/wp-content/uploads/sites/80/2013/01/Schweik_Vol46_Amicus.pdf

Sins Invalid. (2015, September 17). *10 principles of disability justice*. https://www.sinsinvalid.org/blog/10-principles-of-disability-justice

Smith, S. L., Choueiti, M., Pieper, K., Case, A., Yao, K., & Choi, A. (2017). *Inequality in 900 popular films: Examining portrayals of gender, race/ethnicity, LGBT, and disability from 2007-2016*. Annenberg Foundation. https://annenberg.usc.edu/sites/default/files/Dr_Stacy_L_Smith-Inequality_in_900_Popular_Films.pdf

U.S. Department of Education. (2013). *South Carolina technical college system OCR compliance review no. 11-11-6002*. https://www2.ed.gov/about/offices/list/ocr/docs/investigations/11116002-b.html

Wilson-Beattie, R. (2018, September 18). *…And the disability revolution will be tweeted*. Open Transcripts. http://opentranscripts.org/transcript/disability-revolution-will-be-tweeted/

Wood, C. (2014). *Criptiques*. May Day Publishing.

Woodburn, D., & Kopić, K. (2016, July). *The Ruderman white paper on employment of actors with disabilities in television*. Ruderman Family Foundation. https://rudermanfoundation.org/wp-content/uploads/2016/07/TV-White-Paper_7-1-003.pdf

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