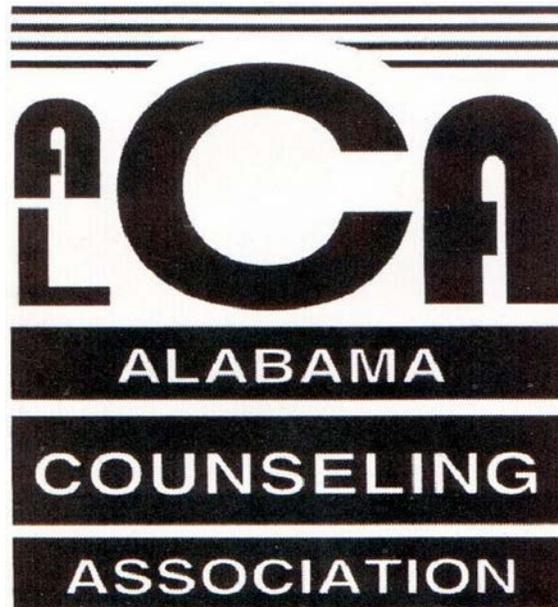


The Alabama Counseling Association Journal



- Enhancing human development through the lifespan
- Promoting public confidence and trust in the counseling profession
- Caring for self and others
- Acquiring and using knowledge
- Respecting diversity
- Empowering leadership
- Encouraging positive change

Letter from the Editor

Welcome to the Fall 2016 edition of The Alabama Counseling Association Journal. This has been an exciting and challenging year. There are so many current issues impacting the counseling profession; including, legislation and laws relative LGBT, the general fund budget, and changes to counselor supervision for licensure. CACREP and CORE are about to merge which will have a significant impact on counselor education programs.

Professional or specialized accreditation is the process whereby a college or university professional program (e.g. counseling) voluntarily undergoes review by an accrediting body such as the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) or its corporate affiliate, the Council on Rehabilitation Education (CORE). CACREP, along with CORE, evaluate graduate education programs in professional counseling against the preparation standards developed and endorsed by the counseling profession. The purpose of establishing standards for graduate education in counseling is to promote excellence in each program's curricular offerings and to prepare competent counseling practitioners. CACREP and CORE are recognized by the Council for Higher Education Accreditation (CHEA) which oversees the practice and procedures of over 60 academic accreditation bodies.

Government sanctioned credentialing is usually called licensure and is based on the legal concept of the regulatory power of the state. This power holds that the state has the right and obligation to pass laws and take other such actions as it may deem necessary to protect the health, safety and welfare of its citizens. Passage of a state licensure or credentialing law for a given profession restricts or prohibits the practice of that profession by individuals not meeting state-determined qualification standards, and violators may be subject to legal sanctions such as fines, loss of license to practice, or imprisonment.

Separate from state laws and regulations, voluntary certification from independent professional certification organizations for counseling and a host of specializations within the counseling profession have been created to establish recognition of those practitioners as having met the minimum standards of education and supervised clinical experience as set by the profession. Certification is not required; rather it is strictly voluntary. This certification attests to the fact that the holder of this certification has met the standards of the credentialing organization and is therefore entitled to make the public aware of this as further documentation of his or her professional competence. In and of itself, however, this certification is not a practice credential but rather a professional credential in that it does not give the holder permission to practice. That permission is given only by the governmentally sanctioned entity. The two leading certification organizations for the counseling profession are the National Board for Certified Counselors (NBCC) and the Commission on Rehabilitation Counselor Certification (CRCC).

We as a profession need to stand strong together to bring about ways to better serve our clients and the community. This is also an election year that hopefully will bring about new changes rather than more setbacks. Please don't forget to VOTE.

Dr. Eddie Clark

Editor



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Proposal for Crisis Management Training in Counselor Education Programs

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Abstract

In this paper, the authors explore leading early interventions for crisis management in Disaster Mental Health (DMH). Specifically, the practices of Critical Incident Stress Debriefing (CISD), Psychological First Aid (PFA), and additional trainings outside of the academic setting such as HOPE Animal-Assisted Crisis Response (HOPE AACR) are investigated through the examination of several resources. There is a growing expectation for the counseling profession to be more involved with providing services to individuals effected by disasters. Thus, an exploration of the Council for Accreditation of Counseling & Related Education Programs (CACREP) 2016 standards regarding crisis and disaster training in counselor education programs is conducted. The authors propose an exploratory content analysis to determine what is currently being taught in CACREP accredited southeastern counselor education programs and if it aligns with current DMH research.

Keywords: disaster mental health, counselor education, crisis, critical incident stress debriefing, psychological first aid, training

Proposal for Crisis Management Training in Counselor Education Programs

The beginnings of disaster mental health (DMH) started in the 1980s as a way to study large amounts of people in the aftermath of a disaster, so mental health practitioners could have a better understanding of personal crises (Halpern & Tramontin, 2007). Disaster is defined as a traumatic event on a large scale that affects a wider area and population of people, often leaving a permanent mark on the environment or community (Myers & Wee, 2005). According to Eranen & Liebkind (1993) and Green (1991), disasters typically result in a social disruption in which the social structure and the function of the local community are threatened, resulting in an increase of community needs. Individual crisis management has been around since the 1970s (Pope & Marsh, 2012). However, crisis counseling has been around since World War II due to the need for psychologists and psychiatrists to treat soldiers with post-traumatic stress disorder (PTSD). This allowed for soldiers to return to duty quicker than without any treatment (Pope & Marsh, 2012). It was not until 1989 that crisis interventions were formally recognized by the American Psychiatric Association, 2013 (Hillman, 2002). DMH has changed significantly from its beginnings during World War II to present day and will continue to transform, as there is no academic specialty, only certifications and additional training for this line of work.

DMH professionals and services are needed more than ever due to advances in technology, the development of highly populated cities in the past, and the increase of disaster events (Pope & Marsh, 2012). These technological and industrial growths allow for acts of terrorism, human-caused disasters, and natural disasters that can affect enormous amounts of people. The Oklahoma City, Boston Marathon Bombings, 9/11, Hurricane Katrina, and the Virginia Tech Shootings all had an instrumental impact on mental health providers requiring training on preparing and responding to violence, trauma, and tragedies. The American

Counseling Association (ACA) created a Crisis Response Planning Task Force to address these challenges. This task force focused on preparing counselors to implement DMH services in response to natural disasters, terrorist acts, and incidents of group violence; however, while the need for this training has been established there are still questions about the content and nature of this. Thus, it is important that the methods and training that have been recommended be considered related to research, application, and training. The purpose of this manuscript is to review the current literature on DMH interventions and discuss how they apply to the CACREP standards and counselor preparation in counselor education programs.

Critical Incident Stress Debriefing

An area that has been integrated into crisis management training is debriefing. This is one intervention that has been used with disaster survivors and is defined as “a structured group process that responds to the cognitive, emotional, physical, and social reactions resulting from disasters and other traumatic events” (Miller, 2003, p. 7). One method of debriefing that has been empirically supported is Critical Incident Stress Debriefing (CISD) which was originally identified as a treatment for trauma by Mitchell in his seminal 1983 article, *When disaster strikes ... The critical incident stress debriefing process*. Since that time, there has been research both encouraging its use and claiming that it is harmful.

CISD is a small group intervention for homogenous groups consisting of members who have experienced a critical incident. It was originally designed for use with first responders such as military personnel (Mitchell, 1983). The group is typically based on seven phases with the goal of making it possible for the group members to return to duty. The seven phases utilized are the introduction phase, fact phase, thought phase, reaction phase, symptom phase, teaching phase, and re-entry phase (Mitchell, 1983). During the introduction phase, team members are

introduced and the process/guidelines are discussed. In the facts phase, participants are asked to provide a brief overview of the event, however providing too much detail is discouraged. This is also used as an opportunity to get each member to share. In the thought phase, participants are asked to describe their initial thoughts and again, each group member is asked one by one to contribute. The reaction phase is the main focus of CISD as it highlights the impact on the participants. It is common for anger, sadness, loss, and other charged emotions to be manifested; as participants are asked questions to help illicit these emotions. In moving to the symptoms phase, participants are asked what physical, emotional, behavioral, and cognitive symptoms they have been experiencing. This information is then utilized to inform the focus of the next phase, teaching. During the teaching phase, symptoms are discussed and normalized. It is also common for specific information and education to be provided specifically related to the type of incident that occurred. Finally, during the re-entry phase, participants are encouraged to ask any other questions or to state any final statements regarding their experience regarding the incident or CISD process. The facilitator also summarizes what has been discussed and final guidance or directives are given to the participants (Mitchell, 1983; Everly, Flannery, & Mitchell, 2000).

These phases illicit the group members to discuss the incident itself, such as what stood out to them most, as well as the symptoms they are currently experiencing or will experience. The idea being that by completing the phases this will help the group members make sense of the situation and process their reactions. Finally, the CISD facilitators provide stress reduction information and potential referrals if necessary. The main goal of CISD being to decrease the psychological stress associated with critical incidents that impair functioning (Everly, Flannery, & Mitchell, 2000).

Since the development of CISD, there has been some confusion when discussing CISD due to CISD being a part of a larger intervention model called Crisis Incident Stress Management (CISM) (Everly & Mitchell, 1997). According to Talbott (2009), CISD is a component of CISM that relies on survivor “reconstruction/recall of images and emotions, ventilation and normalization of reactions to traumatic experiences.” Thus indicating that CISD should not be examined as a standalone mechanism for helping those in crisis, but rather as a main component of CISM. CISM is characterized by a multi component approach, including CISD, but also individual support, family support, general education and consultation with those organizations that are involved (Robinson, 2004). This is important to note as it is one of the rebuttals made against current research that speaks critically of CISD.

CISD has inspired a large body of outcome research (Wei, Szumilas, & Kutcher, 2010; Paterson, Whittle, & Kemp, 2014; Mitchell, 2004; Richards, 2001), though most current research seems to be highly critical, especially looking at CISD as a standalone intervention (Richards, 2001). Wei, Szumilas, and Kutcher (2010) found in their meta-analysis of research data that CISD was not an effective intervention, and in some instances appeared to cause harm. Specifically, they found that CISD was ineffective at lessening poor psychological responses to trauma. Similar findings were indicated in a more recent study by Paterson, Whittle, & Kemp (2014). This study applied CISD techniques on undergraduates exposed to a stressful video and found that CISD did not prevent intrusive thoughts about the images they viewed. The research of Paterson, Whittle, & Kemp (2014) also indicated that the groups in which CISD had been used showed inaccuracies when describing their experience after the techniques had been administered.

Conversely, other researchers have found support for utilizing CISD as part of a CISM protocol instead of a standalone intervention (Mitchell, 2004; Richards, 2001). Mitchell (2004) specified that much of the research seemed to use a single session of CISD, which is not the recommended use. Research that is supportive of CISD also shows that it is more effective when utilized as part of CISM and other multifaceted approaches (Richards, 2001). Richards (2001) indicated that these include pre and post incident interventions as well as referrals to further counseling when appropriate. Leeman-Conley (1990) found that when comparing bank employees who experienced a trauma event, those who were a part of CISM seemed to have fared better than those who did not as evidenced by reduced use of sick leave. In a more recent study, Boscarino, Adams and Figley (2005) looked at people working in New York City at the time of the World Trade Center attacks who were offered crisis intervention services compared to other workers who were not provided any type of services. They found lower rates of issues such as depression and anxiety among those individuals that had been a part of CISM.

While there may be controversy currently surrounding the effectiveness of CISD on its own, it is still widely used and researched. Thus, there is a need for continued discussion of the topic as it relates to the field of counselor education. If this intervention is going to be integrated into the curriculum of counseling students as part of crisis intervention classes, then there is a need to take the critical research into account, as well as the original designed purpose of the intervention as laid out by Mitchell (1983).

Psychological First Aid

Psychological First Aid (PFA) is another intervention method that was developed for disaster survivors through the National Child Traumatic Stress Network (NCTSN) and the National Center for PTSD by a team of researchers and consultants based on previous research

with post-disaster interventions (Hobfoll et al., 2007). PFA is a systemic approach designed to provide support and care for people after a crisis event with a focus on natural disasters (Ruzek et al., 2007).

PFA “focuses on immediate practical support and assistance to protect the victims from further trauma, normalizing the victims reactions, and connecting the victim to family and other support systems” (Talbot, 2009). The goal of PFA is to mitigate the initial distress related to the traumatic event and to improve short and long term functioning. In order to do this, practitioners of PFA implement the following eight specific actions: contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social supports, information on coping support, and linkage with collaborative services (Ruzek et al., 2007). Unlike other methodology for helping people after a traumatic event, PFA focuses on offering practical interventions and services in order to ensure the safety and immediate needs of those who have experienced the traumatic event. PFA is also unique in that it incorporates a variety of interventions via these eight actions, instead of only a single, specific counseling intervention. Due to this, PFA is utilized as part of an overall disaster intervention plan that is implemented by multiple organizations such as the American Red Cross.

There is not a great deal of evaluation-based research on the effectiveness of PFA (Ruzek et al., 2007). This lack of outcome-based research is also noted after the implementation of PFA in an attempt to measure its effectiveness as a crisis intervention strategy in response to the 9/11 attacks (Pandya, 2013). While the lack of outcome studies are apparent and further research is encouraged, there is reasoning as to why research is difficult to obtain due to the nature of PFA. Since it is a multifaceted systems approach that emphasizes plugging the individual into multiple resources and other services, it is difficult to measure which elements are producing positive

outcomes. According to Fox et al. (2007), proving PFA's effectiveness could affect the implementation process and therefore impact the effectiveness itself. The wide use of PFA, current limited evidence, and a positive view by field experts has provided PFA's viability and that is why it is utilized without supportive research (Fox et al., 2007). Another obvious benefit of using PFA is its adaptability to a variety of mass crisis incidents due to its systems-based approach.

For counselor educators, there is a need for further outcome-based research for PFA to help solidify it as an intervention that should be taught as part of a crisis course. In spite of this, counselors do need to understand PFA-based programs because of their widespread use by multiple national organizations. This includes understanding that applying a PFA systems approach means being a part of a larger team, instead of applying a single intervention.

Trending Intervention

A current early intervention for disaster relief is HOPE Animal-Assisted Crisis Response. Research has demonstrated the effectiveness of Animal-Assisted therapy due to the human-animal bond associated with this intervention. In 2004, a professor and licensed psychologist at California State Polytechnic University piloted a study to see how patients felt about having animals as a part of the therapeutic setting (Fine, 2004). Patients reported feeling more relaxed, comfortable, and open when the animals were present, according to Fine (2004). As a result of this research and similar studies, HOPE AACR was established in 2001 to provide therapeutic services to victims of crises and disasters (HOPE, n.d.).

Since its establishment in 2001, HOPE AACR has comforted victims and witnesses of individual and large-scale emergencies such as school shootings, fires, hurricanes, transportation accidents, and others. Specifically, HOPE AACR teams have provided services to victims and

survivors of Hurricane Katrina in 2005, the Virginia Tech shootings in 2007, super storm Sandy in 2012, and many more (HOPE AACR, n.d.). HOPE AACR teams have worked with a wide range of local agencies, which include schools, fire departments, and law enforcement (HOPE, n.d.). They have also paired up with national response agencies such as the Federal Emergency Management Agency, National Organization for Victim Assistance, American Red Cross, Salvation Army, and National Voluntary Organizations Active in Disaster (HOPE, n.d.).

HOPE AACR is a non-profit 501(c)(3) national organization that utilizes volunteers to respond to crises and disasters. HOPE AACR teams include a handler and dog that are both taught how to respond in stressful and emotional environments; the handler is also trained in first aid/CPR, Incident Command System, and other techniques for emotional first aid (HOPE, n.d.). Besides aiding individuals directly affected by the disaster or event, HOPE AACR also provides support to the first responders (HOPE, n.d.). HOPE teams are able to travel via several modes of transportation to guarantee availability on short notice (HOPE, n.d.). To become a HOPE AACR volunteer team, the human and dog must have experience working in Animal-Assisted Activity or Animal-Assisted Therapy; however, team leaders who work without a dog are able to apply instantly (HOPE, n.d.). All applicants go through a screening to ensure they are suitable for crisis response work (HOPE, n.d.). In some cases, the team is a therapist and dog. In those teams, the therapist uses the theoretical orientation in which they are trained. When the team consists of a handler and dog, they must join with a therapist for the treatment process. In those instances, the therapist takes the lead role and the handler only participates when directing or handling the dog.

With the recent success of HOPE AACR and animal-assisted therapy, it is easy to see why more organizations are utilizing animals as a therapeutic intervention in treatment. Whether this involves individual therapy, group therapy, or crisis response, adding animals to the process

may very well aid the healing process. There are multiple examples of the benefits of animals in most settings, but the literature is scarce when discussing disaster relief. Therefore, further research is necessary.

Because HOPE AACR does not utilize a specific intervention, it is important to recognize the possible increase of effectiveness when implementing animals into the aforementioned interventions, CISD and PFA. As counselor educators, knowing when to include animals and when to avoid the trend is imperative. Further research regarding this intervention is essential to guarantee that the victims of these disasters are receiving the best care possible.

Additional Training

Some counselors may seek out training specific to disaster mental health that goes beyond the skills they acquired in their graduate programs. In those cases, there are several options. According to Shallcross (2012), Dr. Michael Dubi, the president of the International Association of Trauma Professionals (IATP), states that his association offers multiple certifications. These certifications include Certified Clinical Trauma Professional, Certified Expert Trauma Professional, and Certified Master Trauma Professional. The certifications offered by IATP typically involve workshops, online training, and exams (International Association of Trauma Professionals, 2014).

The American Counseling Association (ACA), in partnership with the American Red Cross, also emerged with a new specialty area in DMH. Through the ACA, a counselor can become a Red Cross DMH Volunteer (Disaster Mental Health, 2016). In order to meet the minimum requirements to receive such training, the counselor must be a member of ACA and have a valid practicing counseling license. This can be a hindrance for some counselors, as many do not pursue their license but are willing to provide counseling services to such a population.

Seminars and continuing education credits are also obtainable through PESI Healthcare and Cross Country Education (Shallcross, 2012). Counselors that want to work with children and adolescents have the option of receiving training from the National Child Traumatic Stress Network (Shallcross, 2012). These trainings come in several forms such as online, in-person, at conferences, or by purchasing training products.

It is likely that a disaster may exacerbate symptoms of individuals with pre-existing disorders, which further demonstrates the importance of having DMH and/or PFA training integrated into the counseling curriculum (Graham, 2010). Regardless of the specialty a counselor may want to focus on, training is copious. Counselor educators need to be aware of what they can offer students in their counseling program and what areas may require the student to seek further training or education.

Graduate Program Standards

As indicated earlier, there is an increasing amount of human-generated and natural disasters. It is also likely and expected, that people will respond with short-term stress and anxiety when dealing with these disasters (Graham, 2010). Some individuals will move on with no mental health issues beyond the event, while some will require additional mental health services. With those facts in mind, there is a growing expectation for the counseling profession to be more involved with servicing individuals dealing with disasters. “Howard Smith (2005) ...was one of the early counselors to caution, ‘Providing mental health services in a disaster environment requires an additional set of skills that are noticeably lacking in counselor education programs,’ (Webber & Mascari, 2009, p. 126). Integration of disaster training throughout various courses in the counseling curriculum and a development of a skills training model specific for

disasters should be incorporated in a counseling program in order for future counselors to be successfully prepared in a disaster environment (Webber & Mascari, 2009).

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) is assiduous in maintaining standards that meet the ever-changing needs of our society (D'Andrea & Liu, 2009). CACREP (2016) implemented standards that apply to all entry-level and doctoral-level programs which require disaster and crisis training throughout the counseling curriculum, specifically in the Human Growth and Development area, as well as in the Counseling and Helping Relationship area. For all CACREP accredited programs, the following must be covered and documented within the curriculum: “effects of crisis, disasters, and trauma on diverse individuals across the lifespan” (CACREP, 2016 Section II, Standard F, 3.g); and crisis intervention, trauma-informed, and community-based strategies, such as Psychological First Aid” (CACREP, 2016, Section II, Standard F, 5.m). Most specialty areas of the CACREP (2016) standards include: counselors’ roles and responsibilities as members of an interdisciplinary emergency management response team during a local, regional, or national crisis, disaster or other trauma-causing event; effects of crises, disasters, and other trauma-causing events on persons of all ages; crisis intervention and suicide prevention models, including the use of psychological first aid strategies; differentiates between diagnosis and developmentally appropriate reactions during crises, disasters, and other trauma-causing events; and understands the operation of the school emergency management plan and the roles and responsibilities of the school counselor during crises, disasters, and other trauma-causing events. CACREP has also identified specific disaster training standards for the core areas in counseling and it is incumbent of the institution of learning to equip counselors in training with the adequate skills to serve in disaster or trauma environments. Institutions should be obligated to incorporate

disaster standards into course assignments, have counselors-in-training become familiar with these standards and expectations of the profession, as well as requiring students to demonstrate competence (D'Andrea & Liu, 2009).

According to Minton (2010), many counselors view crisis as a primary concern and feel as if they are not prepared to adequately handle clients in crisis or disaster situations. The literature regarding preparation for crises, particularly disasters, is minimal when looking at counselor education; however, there is a great deal of literature regarding disaster/crisis intervention for paraprofessionals (Minton, 2010). As a counselor, one is ethically bound to operate within his or her scope of expertise. If counselors feel inadequately trained for disaster situations, they cannot ethically practice or be of assistance to that particular population. With the 2016 CACREP standards including terms such as: emergency, trauma, disaster, and psychological first aid, it is expected that counselors-in-training should feel knowledgeable and equipped to serve their population of focus - whether it be community, clinical, school, higher education, etc. (Minton, 2010). However, it is not evident that this practice is being followed.

Implications for Future Research

Due to the paucity of research on disaster counseling education for counselor educators and the implementation of such training, understanding what is currently being taught and how training is being implemented is imperative. Future research is recommended to focus on several components in order to address these concerns. The first being what content is being taught to counselors in both education programs and independent trainings. This would include examining how PFA and CISD are presented, as well as if alternative methods such as HOPE are introduced. As indicated by the literature, these treatment modalities may not be explained correctly or at all. It would also be beneficial to address the learning outcomes of those that

participate in such trainings, as there does not appear to be clear evidence in the literature to support a particular training modality.

The recommendation is to conduct an exploratory content analysis of crisis courses and curriculum from universities in the United States that currently hold CACREP accredited counseling programs at the masters level. It is recommended that the primary focus of the content analysis be to examine whether or not programs require a crisis course, if there is comprehensive content on disaster, and what methods are being taught regarding disaster. The focus of the content analysis is recommended to be derived from keywords and terms found in the review of literature and standards, including terms such as: crisis, emergency, trauma, disaster, disaster mental health, critical incident stress debriefing, psychological first aid, and crisis training. This would provide a better overall understanding of the type of content and how it is being presented by counselor educators.

Conclusion

It is well established through historical events that DMH is an essential part of our society's survival; therefore, inclusion of disaster training is vital for counselor education programs. Current research leaves much to be desired about the effectiveness of leading interventions (CISD, PFA, & HOPE-AACR) and there is an obvious need for continued research to determine the best evidence based practices that should be utilized. In spite of the uncertainty of the effectiveness of these interventions, it is still necessary for counselors-in-training to receive education on the current intervention protocols that are used in a disaster to be prepared for such an event. In fact, CACREP requires that training on this content be provided in their accredited masters level counseling programs. However, it is still unclear what is actually being

taught in the classroom and if what is being taught adequately prepares counselors to feel competent in providing DMH intervention services.

All in all, to remedy the issue of the unknown DMH academic training occurring in programs, the authors propose a research study to conduct an exploratory content analysis of crisis courses and curriculums from regionally accredited universities in the southeastern United States that currently hold CACREP accreditation at the masters level. The main focus is to determine what is being taught, if that matches the current CACREP requirements and current research in DMH, and if that leads to counselors feeling competent to provide such interventions during a disaster event. There continues to be a growing concern regarding the level of preparedness of future counselors' ability to help society survive when disaster strikes.

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Building Resiliency in Counselors in Training for Counselors Educators

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Abstract

Professional counselors are encountering clients who are experiencing severe and pervasive crisis and trauma. Occupational hazards such as compassion fatigue, burnout, and vicarious trauma are common to the counseling profession. Those entering the profession, counselors-in-training, require resilience to protect their well-being, aid wellness and ensure professional fitness. The purpose of this article is to provide techniques for building resilience in counselors-in-training for counselor educators.

Keywords: resilience, problematic behavior, compassion fatigue, burnout, vicarious trauma

Building Resiliency in Counselors in Training for Counselors Educators

Counselors are at risk of burnout throughout their career. Counselors are at an increased risk of burnout if they treat clients experiencing crisis, trauma or trauma exposure (Dupre, Echterling, Meixner, Anderson & Kielty, 2014; Ling, Hunter & Maple, 2014). Counselors are working with clients who are experiencing more severe and pervasive crisis than in years past (Eiser, 2011). Current news stories of school shootings, natural disasters, bombings, police brutality, police shootings, angry drivers, enraged and politically charged communities are an indication of the critical events experienced by potential clients (Datz, 2015; Murphy, 2015; Plumer, 2013). These experiences also have a bearing on counselors. Treatment of clients in crisis has had an impact on the professional and personal lives of counselors (Lambert & Lawson, 2013).

Crisis, as defined by the American Psychological Association (APA; 2016), is a client's inability to face or cope with specific changes (i.e., developmental, situational and existential) and experiences that exceed the individual's problem-solving skills or resources. This definition centers on the client's response to an experience. McAdams and Keener (2008) referred to the escalation of crisis treatment by counselors in the field as an occupational hazard. Given the potential for occupational hazard, it is evident that counselor education programs should promote the need for *resiliency* as a part of self-care and wellness.

Resiliency has been defined as the ability to cope in the face of adversity (Lambert & Lawson, 2013). The American Psychological Association (2016) defined resiliency as “the process of adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress — such as family and relationship problems, serious health problems, or workplace and financial stressors” (para 1). APA suggested resiliency is “bouncing back from

difficult experiences” (para 1). Resiliency as a protective factor may help insulate students and practitioners against burnout (Grant & Kinman, 2012). Resiliency also serves to help protect well-being, aid in wellness (Lambert & Lawson, 2012), and may help ensure professional fitness that contributes to the ability to provide quality care.

Resiliency can be learned and developed (Meyer, Licklider, & Wiersema, 2008). Meyer, Licklider, and Wiersema (2008) found in their study of resiliency in first-semester freshman the potential to develop resiliency through resiliency development education. While resiliency is an important personal attribute (Taplin, 2011), little emphasis exists on developing and promoting this attribute as a component of counselor preparation programs and within the field, in general. This article will explore the need for resiliency training in counselor education programs, review American Counseling Association (ACA) ethical codes and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards that address counselor wellness. Further, this article will identify techniques for building resilience in counselors-in-training (CITs) for counselor educators.

The Need for Resiliency Training

Resilience is an essential skill set for CITs (Thompson, Frick, & Trice-Black, 2011), social work practitioners (Grant & Kinman, 2012), psychologists (Newman, 2003), and psychiatrists (Greenhill, Fielke, Richards, Walker, & Walters, 2015). Specifically, counselors providing crisis response and having prolonged exposure to secondary trauma are “doubly taxed emotionally and physically” (Lambert & Lawson, 2013, p. 261). The impact of this secondary trauma can result in burnout and compassion fatigue (Figley, 1995) or vicarious traumatization (McCann & Pearlman, 1990). The risks increase for counselors who work with large caseloads

and who serve clients with chronic histories of trauma. Therefore, those working towards these professions, such as CITs should be made aware of, educated on, and supported in the development of resilience.

Counselors overtaken by the impact of frequent and pervasive client crisis can experience a variety of maladaptive behaviors themselves such as compassion fatigue. Figley (1995) referred to compassion fatigue as emotional and physical exhaustion resulting from prolonged empathic exposure to the pain of others. Other terms such as vicarious trauma and secondary traumatic stress have been used to describe symptoms similar to those of compassion fatigue. The American Counseling Association (2011) provided this definition of vicarious trauma: “the emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured”(p. 1). Secondary traumatic stress is often used interchangeably with vicarious trauma to demonstrate the impact of exposure counselors have to trauma experiences.

Compassion fatigue, secondary traumatic stress, and vicarious traumatization are all forms of indirect trauma that can be caused by hearing or recalling a client's traumatic experience. Counselors may also experience burnout, which entails the emotional, physical and psychological exhaustion that leaves them unable to provide ethical and competent services (Lambert & Lawson, 2013). A counselor addressing a client in crisis is required to ensure the safety of everyone involved. Meeting this challenge could include the ethical management and assessment of the situation, the client, and themselves simultaneously. Counselors serving clients in crisis may also experience various emotions themselves, including anger, shock, confusion, demoralization, and traumatic reactions (Dupre, et al., 2014). These emotions may have an impact on the counselor’s judgment of best response to the needs of the client (Pearlman

& Saakvitne, 1995; Saakvitne & Pearlamn, 1996). Thus, it is important that counselor education training supports CITs in exploration and education on adaptive behaviors in addressing client crisis so that the best and most ethical care is delivered.

While compassion fatigue, secondary traumatic stress, vicarious trauma, and burnout all have the potential to negatively impact the therapeutic process and its outcomes, alternative adaptive responses to these maladaptive behaviors exist. Focusing solely on the negative responses of counselors working with clients in crisis provides an unbalanced and flawed perspective of how counselors can emotionally address these concerns. Counselors can engage in a spectrum of feelings and emotions to include positive personal and professional outcomes (Ling, Hunter & Maple, 2014).

Lambert and Lawson (2013) suggested that both adaptive and maladaptive responses can coexist. An example of an adaptive response is compassion satisfaction, the perceived efficacy of counselors from their work (Lambert & Lawson, 2013). A second consideration of an adaptive response is the existence of post-traumatic growth, which is defined “significant positive psychological change” that occurs as an outcome of an individual experiencing trauma (Cohen & Collens, 2013, p. 571). Adaptive responses highlight the counselor’s skills, strengths, and abilities to positively address crisis and adversity in a way that fosters transformational development to promote fulfillment, well-being, and thriving. This shift in thinking, at times referred to as positive psychology, detracts from a singular view of the worst to attending to the positive that can occur from the situation.

Ethical and Accreditation Standards

The American Counseling Association (ACA) Code of Ethics does not directly reference the concept of resilience. However, a counselor's professional responsibilities include self-care. More specifically, the code requires counselors to "engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (ACA, 2014, p. 8). Adherence to this mandate helps to ensure fitness and contributes to alleviating the potential for impairment.

CACREP accreditation standards reference resilience specific to curriculum instruction (CACREP, 2016). Wellness is evident in the counseling curriculum for the human growth and development course as well as a component of specialty areas for addiction counseling and marriage, couple, and family. Further, CACREP accreditation standards note the importance of including self-care specific to the counselor role in the professional counseling orientation and ethical practice curriculum requirement (CACREP, 2016). Professional fitness deals with self-awareness and emotional stability (CACREP, 2016) and often correlates with student retention considerations and policies that address appropriateness for the profession.

Professional Dispositions and Problematic Behaviors

The ACA Code of Ethics (2014) defines impairment as "a significantly diminished capacity to perform professional functions" (p. 20). Many terms are used to describe impairment, namely, problematic behavior. Wilkerson (2006) defined problematic behavior as "those behaviors, attitudes, or characteristics that need to be the focus of attention and change but are not considered excessive or inappropriate" (p. 211). These behaviors may, in fact, be important components of the learning experience (Wilkerson, 2006). Problematic behaviors may

manifest as a result of limited or weakened resilience and lend themselves to professional disposition concerns. Professional dispositions are an integral part of matriculation within counseling programs. CACREP standards require identification and assessment of these dispositions throughout program enrollment (CACREP, 2016). This assessment of problematic behaviors could result in the identification of a CITs inability to perform professional functions as delineated by the ACA Code of Ethics.

Need for Awareness

Counselors-in-training, as new helping professionals, often fail to consider the importance of taking care of themselves particularly in situations that lead to professional disposition concerns. Self-care, an imperative that could be taught as an intentional and continuous practice of the profession as suggested in the ACA standards. The therapeutic relationship is foundational to the therapeutic process. The therapeutic process can only be as healthy as the facilitator, making it important for CITs to gain competence in this area. Venar, Voss, and Pitcher-Heft (2007) contended that the counselor's behaviors in therapy have just as much impact on the development and maintenance of the therapeutic relationship as the use of words. Counselors who encourage, model well-being, and demonstrate a wellness balance to clients can have an enhanced therapeutic relationship that can lead to enhanced outcomes.

Counselor education programs additionally challenge students to explore values and personal and professional identities Counselors-in-training are often enrolled in courses, working a full-time job, and managing families simultaneous to learning life impacting skills and theory (Shallcross, 2009). Juggling multiple responsibilities while meeting the demands of curriculum

that requires one to be introspective can be stressful, promote distress, and burnout prior to the end of the program increasing the likelihood of problematic behavior and dropout.

Building Resiliency

Given that CACREP standards and ACA ethical standards address the importance of counselor self-care, it is evident that counselor resilience should be addressed with CITs. The impact of limited resilience on the therapeutic relationship indicates that program matriculation, disposition, and professional fitness hinges on developing resiliency and adaptive coping skills. Intentional building of these coping skills and fostering resilience is necessary to insulate CITs against the risks of working with clients in crisis. Many techniques support the development of resilience and can serve as a protective factor for the occupational hazards that come with the profession.

Assessment

One of the many techniques that support the development of resilience is placing an emphasis on its importance at the onset of application and admissions processes for counselor education programs (Grant & Kinman, 2012). As identification of resilience is consistent with CACREP requirements regarding professional dispositions, assessment at program entry would aid gatekeeping and help with identification of students with resilience which might minimize issues of student concern, development, and impairment early on. The Connor-Davidson Resilience Scale (Connor & Davidson, 2003) and the Scale of Protective Factors (Ponce-Garcia, Madewell & Kennison, 2015) can be used at program entry to assess for resilience. Students can engage in ongoing assessment throughout their training program. For example, during courses that deal specifically with crisis and trauma, students can complete self-assessments, such as TSI

Life Event Scale (Pearlman, 1996) to identify sources of their trauma that can be activated when being exposed to other's trauma. During field experience, students can complete self-assessments, such as the Compassion Fatigue Self-Test (Figley, 1996) to determine if their work with clients is having a negative impact.

Education

Resilience has been identified as an internal factor that contributes to educational success (Clark, Brooks, Lee, Daley, Crawford & Maxis, 2006). While the CACREP standards include resilience as a content area within the human growth and development course the opportunity to educate on the topic is not reserved to this one course. Educating CITs on the reality of the client issues they will address in clinical practice and the magnitude these issues can have should better prepare them for how to address the resulting concerns (Merriman, 2015).

Education on the experiences encountered in clinical practice involves intentional discussions that can occur throughout the program yet are most critical in the clinical courses such as techniques/facilitation skills and group, as well as during practicum and internship. Discussions around self-care and the quality of self-care are important as they act as a protective factor that can enhance resilience (Merriman, 2015). Trippany, Kress, and Wilcoxon (2004) discussed the benefits of education and training in the reduction of vicarious traumatization of counselors who work with traumatized clients. Incorporating such information in the counselor education curriculum through discussions, assignments, and experiential opportunities that require CITs to identify areas requiring self-care can result in the development of a personal self-care plan. Moreover, these discussions, assignments, and activities would satisfy ethical responsibilities that require one to “engage in self-care activities” (ACA, 2014, p. 8).

Consequently, this could enhance capacity and reduce the potential for burnout, compassion fatigue, and impairment which help “to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities” (ACA, 2014, p. 8).

Ongoing Self-Assessment

Reflection and self-assessment are critical to the counseling profession. Further, to develop and increase resilience, CITs and counselors need to ensure they self-assess and self-examine) for the needs regarding and presence of resilience (Lambert & Lawson, 2013. Counselors that are self-aware are at reduced risk for compassion fatigue (Merriman, 2015).

To increase self-awareness, one must monitor self and be a reflective practitioner. Young (2013) wrote “being a reflective practitioner means that you make a commitment to personal awareness” (p.3). Incorporating this assessment process into training and educational platforms is necessary. A number of helpful tools are available for CITs to use to assess wellness and/or personal risk. These tools include the Professional Quality of Life Scale (ProQOL) (Stamm, 2009) and the Self-Care Assessment Worksheet (Saakvitne & Pearlman, 1996). Use of Socratic questioning, journaling, and participation in groups can help foster reflection and also lend themselves to identifying resilience. Such opportunities allow emphasis to be on “processing rather than dealing with content” (Shallcross, 2010, “Finding the time,” para 1) which is essential to foundational counseling skills that CITs will employ with their clients.

Wellbeing Days

Grant and Kinman (2012) discussed the use of *Wellbeing Days* to enhance resilience. These Wellbeing Days include subject specific workshops which focus on resilience, self-care,

well-being, performance, and implementing techniques that develop resilience. The authors suggested topics such as “mindfulness, thinking skills (Cognitive Behavioral Techniques), utilizing supervision for reflective practitioner, peer coaching to enhance social support and promote wellbeing, and self-awareness and action planning” (Grant & Kinman, 2012, p. 612).

Support Services

Self-assessment, self-examination, and formal identification of problematic behaviors may help institutions and programs more effectively configure support services and programs to foster and promote resilience. Support programs intended to maximize resiliency and the social and developmental aspects of students may need to be employed. For example, promotion of the university counseling center and its programs and services provide opportunity to address concerns that may impact resilience and allow for identification of protective factors to insulate concerns. For universities or programs that do not have a counseling center, formal agreements with a provider(s) that can offer student assistance to address behavioral health and work-life balance concerns allow for the ability to manage challenges better and provide support. Equally, faculty and staff can provide a positive influence on students creating a sense of community that encourages resilience and impacts counselor identity, wellness, and self-care. Utilization data on students who access such services and programs coupled with evaluation can be used to demonstrate the effectiveness of reducing stress, compassion fatigue, problematic behavior, burnout, and retention.

Supervision

Counselor educators have a unique opportunity through supervision to educate, coach, and model resiliency factors to CITs. A study conducted by Thompson, et al., (2011) reported

that a lack of training and instruction occurs during the practicum and internship experience for CITs with regard to personal wellness and prevention practices that may prevent burnout and support resilience. Practicum and internship students are at a higher risk for burnout and need for protective factors as their newness to the field of practice and eager disposition can make them susceptible to taking on unrealistic challenges and roles that accompany clients. Further, CITs can be unaware of cues that signal the onset of maladaptive behaviors. The emotional demands of clients coupled with the CITs simultaneous personal development in the profession can be taxing. These combined factors make supervision ideal for the implementation of skills that support resilient behaviors (Thompson, Frick & Trice-Black, 2011).

The inexperience of CITs can limit the ability to identify and balance personal needs. The supervision process provides a protective learning environment that can allow for honesty, reflection, and feedback that can be limited in the classroom setting (Thompson, Frick & Trice-Black, 2011). The supervisory process allows counselor educators to engage in a true gatekeeping process by providing unique skill sets to students, such as teaching them to say no to demands that exceed their skill and readiness and by modeling hardiness behaviors that promote wellness and lead to resiliency. Supervisors can also help students examine and explore unrealistic self-worth perspectives tied to the work of helping clients and develop realistic measures of success. Counselor educators have the opportunity to make an impression on CITs in the area of promoting wellness that can sustain throughout their career.

Silent Sitting

Silent sitting is a strategy used in the Sathya Sai Education in Human Values (SSEHV) model. Silent sitting is considered a relaxation exercise that aims to quiet the mind and reduce

stress. The SSEHV model focuses on education with specific goals that tap into resilience by addressing the conscious (i.e., mind), subconscious (i.e., body), and the superconscious (i.e., spirit; Taplin, 2011). Taplin (2011) encouraged multiple ways silent sitting be infused into the classroom. For example, through “concentration exercises, listening to silence, listening to breathing, listening to suitable music, listening to a visualization” (Taplin, 2011, p. 80). Use of these techniques can be included at any point within a class, during stressful times, and as a means for reflection. CITs can model these techniques in mock counseling sessions and utilize them during practicum and internship as appropriate to the clinical situation that might require a focus on well-being and cultivate resilience.

Implications for future research

To ensure professional fitness and wellness, CITs and counselors should practice intentionality with regard to self-care. Self-care is particularly critical in light of exposure to vicarious trauma (Lambert & Lawson, 2013). Greater emphasis on self-care and wellness during the academic preparation of CITs and to those within the profession to enhance resilience is warranted. Professional organizations can use this information to encourage or require a designated number of continuing education hours. Continuing education could contribute to protecting clients from harm and ensure services align with ethical requirements. Additional research around the efficacy for silent sitting in higher education programs specific to counselors and those in helping professions could be of benefit.

An additional consideration for counselor educators and CITs is related to the impact of resilience factors on retention in counselor education programs. While studies have been conducted in the area of retention and higher education (Tinto & Pusser, 2006), limited research

has been completed specifically in the area of resilience. Prior studies in the area of retention and higher education have focused on factors related to program expectations, feedback and perceived support of students by the school. The noted factors focus on things external to the student. However, an opportunity exists to evaluate deeper the explanation indicating what motivates students to stay engaged and enrolled under stressful circumstances. These efforts would help in ensuring CITs are prepared to be ethical in their responsibilities, effective in their work with clients, and could reduce potential for impairment, burnout and compassion fatigue.

Conclusion

With an influx of clients presenting with severe and pervasive crisis, resilience is a critical skill set for counselors to navigate these career challenges with success. The potential for burnout, compassion fatigue, and vicarious traumatization are occupational risks associated with counselors. Therefore, CITs must intentionally commit to attending to their self-care and wellness. The techniques presented in this article offer opportunities to build upon existing platforms within counselor education programs that address adaptive strengths and coping. Consistent with a counseling approach, a strengths-based approach allows CITs to strengthen their resilience while learning valuable techniques they can utilize in practicum, internship, and in their career. Intention to establishing, insulating, and fostering resilience can reduce the potential for problematic behavior and minimize the risk of ethical concern.

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Nontraditional Students in Counselor Education: Informing Recruitment and Retention

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Abstract

As the population in the United States becomes increasingly diverse, the demographics of mental health counselors will need to reflect their clients' diversity. It is important that counselor educators understand how to attract, and retain, minority and nontraditional students. Although minority and nontraditional students' experiences have been investigated in a range of disciplines and academic levels, counselor education research has only focused on the experiences of specific demographics within this population. To increase counselor knowledge, this review of the research investigates the experiences and studies of nontraditional undergraduate and graduate college students. Recommendations are presented for recruitment and retention of diverse counselor education students. Pedagogical changes are discussed. Implications for further research are provided.

Keywords: nontraditional students, counselor education, mental health counseling, diversity

Nontraditional Students in Counselor Education: Informing Recruitment and Retention

As the United States population becomes more diverse and the need for multicultural mental health counselors increases, the recruitment and retention of nontraditional students is essential to create a counseling profession that reflects clients' diversity. Currently, of the 802,000 counselors identified in the 2015 Labor Force Statistics (U.S. Department of Labor, 2015), 71.4% are women, 18.4% are Black or African-American, 2.5% are Asian, and 9.5% are Hispanic or Latino. To improve recruitment and retention of nontraditional students, counselor educators must understand this student population and the factors that influence their interest in entering the counseling profession and successfully completing counselor education programs.

Definition of Traditional Versus Non-traditional Students

The definition of traditional students varies across researchers, with Brock (2010, p. 113) identifying undergraduate traditional students as “the high school graduate who enrolls full-time immediately after finishing high school, relies on parents for financial support, and either does not work during the school year or works only part-time.” While the Department of Education defined highly nontraditional students as 20 years old or older, working, or raising children, researchers consider nontraditional students to be those who are older than 24, with dependents, financially independent, attending college part time, the first in the family to attend college, students of color, students with disabilities, and from a disadvantaged socioeconomic status (Bundy & Smith, 2004).

Current Trends in Nontraditional Student Higher Education Achievement

Substantial gaps in educational progress still exist between the groups that make up the nontraditional student population and traditional students. Although higher numbers of ethnic minorities enroll in college, their graduation rates are lower (Kena et al., 2015). “Access to

higher education has increased substantially, although some racial and ethnic groups remain underrepresented. But success in college—as measured by persistence and degree attainment—has not improved at all” (Brock, 2010, p.110). The population of students graduating in higher education is still not reflective of the US population (Kena et al., 2015). In 2013, 25-29 year old graduates of bachelor’s or higher degree programs were mostly women, 37% versus 30% for men. This was true for women among Whites (44% to 37%), Blacks (19% to 17%), Hispanics (19% to 13%), Asians (64% to 55%), American Indian/Alaskan Native (16% to less than 1%), and those of two or more races (30% to 29%). The highest number of graduates were Asian women and men. Whites continue to maintain the next highest rates, although Blacks and Hispanics have also increased graduation. Still the gaps between Whites and both Blacks and Hispanics attaining degrees has widened (Kena et al., 2015).

For students who attended high school in 2002, those with high socioeconomic levels had graduated with a bachelor’s or higher degree by 2012 at a rate of 60%, while middle socioeconomic levels and lower socioeconomic levels were 29% and 14% respectively. Closing these gaps increases the number of diverse student in higher education who successfully graduate, and the availability of a more diverse counselor education student population. As the nontraditional student population in counseling programs increases, these students will experience the social belonging and autonomy that are “a crucial factor in student success” (Clark, Mercer, Zeigler-Hill, & Dufrene, 2012, p.178).

Educators believe the history of discriminatory laws and attitudes toward racial and ethnic minorities and women’s limited access to and hopes for higher education also affect the numbers of nontraditional students considering higher education (Brock, 2010). Lack of financial

aid prior to 1965, and the benefit of the federal G.I. Bill for primarily white men also skewed higher education toward higher socioeconomic level students and white men.

Recruitment and Retention

Researchers have attempted to understand persistence and completion rate differences in college students, focusing on race, ethnicity, gender (Brock, 2010), socioeconomic status, age, parent education, having children, age of children, hours worked, sex (Ballantyne, Madden, & Todd, 2009) and first generation college students (Giancola, Munz, & Trares, 2008; Unverferth, Talbert-Johnson, & Bogard, 2012). Traditional undergraduate students are predicted to have high persistence and completion rates while nontraditional student characteristics are negatively correlated with persistence (Brock, 2010; Unverferth et al., 2012). “All of the characteristics used to define nontraditional status—delayed entry into college from high school, working full-time, single parenthood, and so on—are considered ‘risk factors’ because they are negatively correlated with persistence” (Brock, 2010, p. 115). Since “higher education is a vehicle for both economic advancement and social justice” (Bowl, 2005, p. 122), counselor educators have a responsibility beyond ensuring the diversity of counselors in the field (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2009), this supports a need for counselor education curriculum to address recruitment and retention of nontraditional students, especially for counseling students training to work in kindergarten through high school and at higher education settings.

Understanding the demographics that contribute to persistence and completion is not enough to increase the successful recruitment, retention, and successful completion of nontraditional students (Brock, 2010). Researchers have identified the need to understand students’ skills and abilities, personal motivation and objectives, and external commitments.

Also, researchers questioned whether student integration into the classroom and informal student meeting places; the quality and frequency of interactions with students, faculty, and staff; cultural norms; and school organizational structure and process affect persistence or completion. Or what combination of student factors and program factors affect student outcomes?

While there has been some research on recruitment and retention of students based on socioeconomic status (SES), age, gender and ethnicity, there has been less focus on the impact of the curriculum, pedagogy, and classroom interactions on the learning of non-traditional students (Bowl, 2005). Since the correlation of demographics with recruitment and retention is not enough to engage nontraditional students, counselor educators need to pay attention to the specific needs of nontraditional students and effective institutional characteristics that support their wellbeing (Bowman & Small, 2012; Myers & Mobley, 2004). Bowman and Small (2012) define student wellbeing as satisfaction and a sense of purpose and state these are important in student retention. The campus racial climate also affects minority students', as well as majority students', adjustment and sense of belonging.

Research of nontraditional students perceptions have attempted to inform recruitment and retention. An Australian study investigated nontraditional student perceptions of their first year experiences, the influence of their background, and their attitudes toward learning. The students reported a high value in studying personally interesting subjects, developing skills important to their chosen field of study, and improving job prospects (Ballantyne et al., 2009). Although socioeconomic status (SES) only moderately affected perceptions, the majority of medium and high SES students believed academic staff were approachable, while more than 20% of the lower SES students were not confident in their ability to engage academic staff. Ballantyne et al. (2009) found age had a significant impact on student perceptions regardless of differences in

SES. Students over 25 years old had stronger sense of purpose, higher learning, and high motivation, enjoyed being at the university and intellectual challenges, were less influenced by family, were more confident in math skills and less in computer skills. Age did not impact accessing online systems.

Findings for parents in higher education are varied. In undergraduates, Quimby and O'Brian (2006) found both psychological distress and benefits for women balancing academic and family responsibilities. The researchers found secure attachment, parent and student self efficacy, and social support (Syed, Azmitia, & Cooper, 2011) contributed to prediction of psychological distress (Quimby & O'Brian, 2006). While in first year nontraditional Australian college students, the researchers (Ballantyne et al., 2009) found significantly more parents enjoyed their courses. Parents were confident in their occupation choice, had higher class attendance, and used support services regularly. Still, the authors noted that family commitments may affect coursework and require flexibility.

While there is a dearth of research on recruitment and retention of students from sexual minorities in counselor education, educators have expressed concerns that faculty trained prior to 1986, when homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM), may not understand current research on sexual minorities, including critical thinking about heterosexist views in psychological theories (Bennett, 2002). Further, "discussions about sexual orientation may be profoundly uncomfortable for the sexual minority student or the student with unexamined or unresolved views about sexuality" (Bennett, 2002, p. 137). For both students with negative personal or religious views toward sexual minorities and sexual minorities, discussions of legal, ethical, and professional standards prohibiting discrimination of sexual minorities may result in hostility, defensiveness, and strong emotional

responses. While Bennett (2002) suggests responding to students' sharing with mutual curiosity and empathy to increase understanding, the effects on sexual minorities is not understood. Furthermore, there is no research addressing the current effects of states legalizing discrimination.

Hayes, Chun-Kennedy, Edens, & Locke (2011) questioned whether sexual minority students who were also ethnic minorities had increased psychological distress due to being double minorities. While sexual minority students experienced more psychological distress than heterosexual and majority culture students, those students who were also ethnic minorities experienced no additional distress. The researchers suggested this may be due to intersectional invisibility, having multiple marginalized identities within a group of a single marginalized identity rendering the individual invisible (e.g. an African American and lesbian student within LGBT group) and less likely to experience additional discrimination. Sexual minority students who were also ethnic minorities did experience more psychological distress than ethnic minority students. This may be due to the prevalence of heterosexism in ethnic minority cultures (Hayes et al., 2011)

Another population of nontraditional students that has been under examined is religious minorities (Bowman & Small, 2012). While there is a positive correlation between religiosity and mental health, including lower depression and anxiety, life satisfaction, hope and optimism, happiness, and purpose and meaning, the research on college students and religion has mixed results and methodological flaws (Bowman & Small, 2012). "Religious minority students may be acutely aware of their marginalized status on campus and American society, which may lead to diminished well-being" (Bowman & Small 2012, p. 493). Bowman and Small (2012) proposed that the "privileging of Christian Beliefs and norms at most institutions, along with potential

prejudice and discrimination faced by non-Christian groups”(p. 494) contribute to students’ negative emotions and dissatisfaction with life. The effects on students’ positive relationships and sense of competence and purpose were less clear, often depending on the specific minority group considered. Two important findings across students were that religious engagement and an ecumenical worldview, understanding and accepting all spiritual and religious beliefs, were positively related to well-being. Bowman and Small (2012) recommend that since successful coping had a positive effect on wellbeing, schools should focus on building those skills in students and supporting religious and spiritual groups that provide them.

Since first generation students are often minorities, women, immigrants, parents, and older than 24, as well as having low SES, they share some of the same challenges (Giancola et al., 2008; Unverferth et al., 2012). They see their abilities and potential as inferior, overestimate tuition, do not connect career goals to education requirements, have poor retention, have lower degree goals, and attend school part time. If they are also low SES and minority, first generation students likely lack knowledge of financial aid and how to complete college admissions. And due to financial stresses, first generation students may have to work harder, take fewer hours, and forgo participation in extracurricular activities. They may also have to work harder on their coursework, since they often have lower math, reading, and critical thinking skills. Other research shows they report low satisfaction with, but high importance of, admissions and financial aid services, effective instruction, academic advising, effective registration, campus climate, safety and security, and academic services, (Giancola et al., 2008).

Minority and Nontraditional Student Culture and Counselor Education

Culture Challenges for Students

Ethnic minority graduate experience significant challenges, including reporting discrimination, prejudice, stereotyping and emotional distress (Clark et al., 2012; Cole, 2010). A study of African-American college students found they often experienced negative racial-based interpersonal exchanges with friends and in intimate situations, resulting in significant emotional impacts, mostly anger (Swim, Hyers, Cohen, Fitzgerald, & Bylsma, 2003). Students that experience this emotional distress reported lower levels of belonging, which correlated with lower academic engagement (Clark et al., 2012). Lack of belonging and negative beliefs about competence may result in impostor feelings, which can lead to unrealistically high standards, depression, anxiety, and low self-esteem (Cokley, McClain, Enciso, & Martinez, 2013). Imposter feelings are the internal sense of intellectual phoniness and fear of exposure. Those experiencing imposter feelings do not believe their success is due to their own skill or intelligence, instead crediting hard work, luck, or a mistake. Cokley et al. (2013) found Asian Americans were especially prone to imposter feelings, showing that even positive stereotypes can affect student mental health.

Minority students also respond differently to faculty and peer interactions within the classroom. African American students showed significant effects on grade point averages (GPA) in response to peer and faculty interactions (Cole, 2010). While course-related faculty contact was positively related to GPA, advice and criticism from faculty negatively affected African-American students more than other ethnic minorities. Course-related faculty contact was on course and program issues. Advice and criticism from faculty included corrective feedback on skill development, and the adequacy or quality of assignments or papers.

Faculty must understand minority student culture to address these disproportionate effects on student learning experiences. Students that are from collectivist cultures require social relationship variables, especially social connectedness, for mental health (Yoon, Jung, Lee, & Felix-Mora, 2012). Social connectedness is defined as the interpersonal closeness in the social world. Students who have immigrated from collectivistic cultures often lose previous social connections when entering the highly individualistic mainstream culture of the United States (US), with its historic marginalization of ethnic minorities. Yoon et al. (2012) further identify that ethnic minorities live in distinct contexts – mainstream society and the ethnic community – and may have a different sense of connectedness depending on psychological factors like acculturation and enculturation; and national and ethnic identity. Contextual factors such as ethnic density; and social acceptance and rejection, also contribute to the sense of connectedness.

Minority students who are unable to negotiate the majority culture, as well as their own, experience higher levels of perceived minority stress (Cokley et al., 2013; Wei et al., 2010). Minority stress occurs as the result of discrimination and prejudice or experiencing differences from the majority culture, including interethnic difficulties, within-group conflicts, and achievement stress. Minority students who have perceived minority stress and do not have the ability to negotiate the majority culture, called bicultural competence, are more likely to experience depressive symptoms, low self-esteem, and low retention rates (Wei et al., 2010).

When entering a campus where nontraditional students view themselves as the minority and a perceived threat, these students may identify more with groups that represent their minority status, according to social identity theory (Syed et al., 2011). Although the theory proposes students do this to increase self-worth and maximize social support, they may experience the opposite due to awareness of negative stereotypes for the group. Syed et al. (2011) note that

negative stereotypes of the groups' achievement potential may lead to the students' doubts about their ability and disengaging from school.

Cultural values of respect for authority may be reflected in nontraditional students' class participation levels and help seeking behavior (Alvarez, Cervantes, Blume, & Thomas (2009). These students may view critical discourse as rude or disrespectful. Majority culture faculty may view this lack of active participation as disinterest, not understanding materials, and poor assertiveness skills.

Alvarez et al. (2009) identified other cultural challenges. Students who are not proficient in writing or speaking English face challenges with understanding lectures, readings and research papers, as well as expressing and responding to emotional material in a second language. Also, students who have a different view of the flow of time may be challenged by time management, priority setting, and the academic calendar.

For students who have families, there may be differences in family values about the prescribed roles and responsibilities within families and these may conflict with academic responsibilities (Alvarez et al., 2009). The additional responsibility of financial support for the family may create financial barriers. "This tension will likely impact how students are perceived and evaluated, decisions for retention, the volume of research that is generated, and students' professional involvement." (Alvarez et al., 2009, p. 183).

Discrimination

Many nontraditional students' experience discrimination and prejudice. Minority students often have a distrust of educational institutions due to these experiences and historic institutional discrimination (Alvarez et al., 2009). Stereotype threat has also affected minority students, with African-American students experiencing the greatest effects (Cokley et al., 2013). Stereotype

threat is a higher awareness of the negative stereotypes associated with a group. Discrimination has been associated with higher levels of low self-esteem, psychological distress (Wei et al., 2010), social isolation, substance use, depression, anxiety (Alvarez et al., 2009), and academic engagement (Clark et al., 2012). Academic engagement includes participation/ interaction, skill engagement, emotional engagement, and performance. Along with the presence of microaggressions, and prejudice or discriminatory interactions causing stress to minority students, faculty and curriculum with a Eurocentric focus that do not connect to the student's culture may cause alienation (Alvarez et al., 2009). Faculty with negative or positive stereotypes of minority students will have distorted perceptions and evaluations. Minority students may internalize these stereotypes, causing increased stress for performance.

Also, faculty's prejudices, isms, and stereotypes may be reflected in what they choose to teach, ignore, attend to, and interpret in student contributions (Bennett, 2002). Whether the instructors demonstrate strong negative reactions to student views, or lack the skill or intention to manage conflicting views, their response may inhibit students' understanding of alternative points of view. Further, students who experience negative cues in the classroom may develop perceptions of faculty that affect their willingness to initiate interactions with faculty outside the classroom (Cole, 2010). These accessibility cues, positive or negative, affect frequency of interaction with faculty outside the classroom and influence academic achievement.

Implications for Counselor Education

Recruitment and Retention

Effective nontraditional student recruitment and retention requires counselor education programs to identify a specific plan that addresses the needs of the students (Robinson, Lewis, Henderson, & Flowers, 2009); an institutional commitment to diversity of students, faculty, and

staff; creating partnerships for recruitment, training, and retention; using a comprehensive review process for admissions; student support services for academic, administrative and personal needs from academic through graduation processes; opportunities for networking and connection to counselor education leaders (Kreuter et al., 2011). Robinson et al. (2009) recommend recruitment and retention plans have a mission statement of the intention to increase nontraditional student success in the program, specific recruitment assignments for faculty and staff, adequate funding, and a mentoring process for faculty and students.

For recruitment of nontraditional students, counseling programs should provide financial assistance, financial aid information, and mentoring for completing the application process, meeting social needs (Unverferth et al., 2012), developing a realistic timeline to deal with students' moving, family responsibilities, and work concerns (Robinson et al., 2009). Faculty mentors would begin communication with students before and during the admissions process. And universities would address the issues of cost, time, and scholarly productivity for faculty mentors (Kreuter et al., 2011). Recruitment would access diverse media and other social outlets, for example faculty engaging with social service organizations serving minority communities.

Counseling program efforts to retain nontraditional students should include faculty and students genuinely welcoming nontraditional students, a commitment to a safe and relevant learning environment, and clear guidelines for addressing discrimination (Robinson et al., 2009). Unverferth et al. (2012) added the need for positive small group peer and faculty interactions, promoting a sense of belonging, activism and risk taking, inspirational teaching and a clear academic plan.

Program characteristics, such as recruitment, curriculum, and pedagogy, are also important in attracting and retaining nontraditional students (Bennett, 2002; Bidell, Turner, &

Casas, 2006). Attracting nontraditional students to mental health counseling programs has not been investigated, but research into psychology program recruitment provides findings that may be generalized. Bidell, Turner, and Casas (2006) found that psychology programs that included salient information for racial and sexual minority students had significantly higher multicultural student populations. The major themes that were important to minority students included: financial aid for minorities, program requirements, course descriptions, student body demographics, and the clarity and quality of the materials. The minor themes that were important were the faculty research interests, admissions procedures, community information, and personal letters and contacts. Other information considered were inquiries of the applicant's prior experiences with diverse populations, antidiscrimination policy, statements on commitment to diversity training and recruitment of a diverse student body, information on a diversity minor, and faculty research interests in multicultural issues. The researchers note that one way to increase a diverse student body, as required by ethics and accreditation standards, is to improve the recruitment materials to reflect the programs' multicultural competence and diversity commitment (Bidell, Turner, & Casas, 2006).

Since minority students' ability to negotiate the majority group and their own without losing their sense of cultural identity, bicultural competence, moderates negative emotional symptoms of minority stress (Wei et al., 2010), minority students would benefit from learning the coping resources that make up the competence. Two components of bicultural competence that showed the most buffering were social groundedness and cultural knowledge (Wei et al., 2010). Personal factors like internalized heterosexism and the stage of racial identity development affect minority students' appraisal of stressors. The bicultural competence that helps minority students maintain positive mental health and to remain in school despite minority

stress, includes knowing cultural beliefs and values, positive beliefs about majority and minority groups, belief that a person can engage in two cultures without compromising the person's cultural identity, ability to communicate effectively, have appropriate behaviors for both cultures, and have social networks in both cultural groups (Wei et al., 2010).

Research on campus climate effect on LGBT academic and career development and retention (Tetreault, Fette, Meidlinger & Hope, 2013) could be applied to counselor education programs. Tetreault et al. (2013) identified the need for campuses to institute policies, procedures and facilities to be more inclusive, so students have the ability to be open about sexual orientation and gender identity, and experience social support after disclosure. Faculty, staff, and students that are welcoming and inclusive, including providing student programs and services that involve LGBT and other minority students on campus, encourage the sense of belonging researchers have identified as necessary for minority students. As minority student populations increase on campuses, all students increase their understanding of multiple perspectives and think about problems in more complex ways.

Curriculum and Pedagogy

While curriculum in a CACREP accredited program follows the standards, pedagogy is not addressed. Bennett (2002) recommends pedagogy based on intersubjective theory, which requires faculty to think critically about multicultural implications of curriculum and invite student questions and challenges. Although there is no current research, current events that reflect discrimination based on a minority status may be important additions to the curriculum for discussion. The theory instructs faculty to be self-aware of their experience of the teaching process and the meaning to enhance learning. Faculty are not only facilitators for learning, but they affirm the students' knowledge and experience, attend to nonverbal cues, and address group

dynamics (Bennett, 2002). According to the theory, when the instructor encourages curiosity about the cultural meaning of the curriculum, lectures, and what is not shared, students increase their critical thinking. When considering the needs of female parents, counselor education faculty need to recognize women who “perceived safe and supportive relationships as well as relationships in which their skills and competence were recognized demonstrated low levels of distress” (Quimby & O’Brian, 2006, p. 456). Brock (2010, p. 119) adds the importance of “pedagogical practices that emphasize “high structure” and “high challenge” – for example, giving students step-by-step guidelines for undertaking complicated academic tasks, while also engaging them in authentic debate and intellectual exchange.”

Research into student and faculty interactions with ethnic minorities should also inform faculty interactions with students in the classroom, in evaluation, and mentoring. While ethnic minority students benefit from contact with faculty to discuss course related issues, faculty need to consider the negative effects of faculty advice and criticism on ethnic GPA (Cole, 2010). Cole (2010) recommends that faculty identify student academic and skill development as incremental, not entity – a fixed ability. Faculty would give feedback to ethnic minority students focused on knowledge and skill development instead of ability. Also, students would receive information on learning styles and strategies to increase learning and skill development. This would include learning how to ask questions about critical thinking, as well as the resulting answers.

Counselor education programs need to understand the differences between students’ cultures and the culture of academia, which is often Eurocentric (Alvarez et al., 2009). Since gender, socioeconomic status, age, sexual orientation, acculturation, ethnic identity affect students’ experiences of discrimination, race, ethnicity, and culture, faculty “need to proactively engage students in discourse, be aware and respectful of diverse cultural behaviors, and be aware

of the potential history and consequences of discrimination and internalized oppression” (Alvarez et al., 2009, p. 183). Alvarez et al. (2009) also believe faculty must be aware of their personal history, assess their own racial and ethnic identity, and understand the professional impact of their own cultural identity. The implications for counselor education programs are the importance of considering environmental factors like the number of similar ethnic minority students (Clark et al., 2012) and faculty (Alvarez et al., 2009), acceptance of the ethnic minorities’ culture, understanding of individual acculturation or enculturation, and the practice of addressing discrimination and microaggressions in the classroom (Clark et al., 2012; Yoon et al., 2012). For students that are enculturated, inclusion of cultural behavior, food, language, music, emotions, identity, beliefs, knowledge, and values, in the counseling program would encourage social connectedness. Faculty who model values of inclusion and respect for differences help minority students identify their own values (Alvarez et al., 2009). This means encouraging discussion of cultural similarities and differences between faculty and students, and understanding influence of culture on faculty and student relationships. Also, students and faculty with the same worldviews and beliefs affiliate with each other, often based on ethnic identification, skin color, facial features, and shared languages (Alvarez et al., 2009). This may require a balance between providing support and maintaining professional boundaries.

Alvarez et al. (2009) believe ethnic identity theories help provide the conceptual framework for faculty members to address their psychological identification with culture and their resulting behavior. Faculty that understand (Helm, 1995), emphasize and value culture will model this for students (Alvarez et al., 2009), as well as facilitate increased awareness for those with lower cultural identity (Helm, 1995). Conversely, when students have greater racial identity development than faculty, there is a greater likelihood of challenge and conflict (Helm, 1995).

For example, faculty ethnic identity often is reflected in research interests, policy advocacy, and professional association membership. For faculty, this means not only understanding themselves culturally, but relating that to their assumptions about students' communities; their understanding of oppression, power, and privilege, and their ability to openly address and include culture in their relationships with students.

Faculty working with student advisees should address culture by supporting the student navigating two cultures, focus on career development, fostering a close, personal relationship, recognize the stressors of financial responsibilities, maintain awareness and discuss differences in cultural behaviors, and identify students' values to support a balance of academic and family or cultural responsibilities. This may mean discussing with students how to develop relationships with faculty; awareness of cultural rules about power and authority; how to understand cultural norms and expectations of academia; cultural values, practices and worldview integration into professional identity; and management of discrimination, stereotypes, and prejudice. Further, faculty advisors may identify students' awareness and thoughts about race (Clark et al., 2012), ethnicity, and culture, to increase their awareness of advisees' culture and racial identity

Faculty working with first generation college and older students need to be aware of pedagogy that is more relevant to this population (Giancola et al., 2008). These students have rich personal and work experiences that develop into values and identities that impact their college perceptions. This includes the need to connect what they are learning in the classroom to their life experiences and career goals.

Conclusion

The field of counselor education would benefit from more research exploring the experiences of nontraditional students to help inform pedagogy and practices. When viewing

nontraditional students across subgroups, what becomes clear in the research is there are negative correlations between beliefs about these students' preparation for college success, programs do not demonstrate a welcoming and inclusive campus, there are experiences of discrimination and prejudice, and the curriculum and pedagogy is not multicultural. As advocates, counselor educators need to identify primary, secondary, and postsecondary institutions that do not have the resources or willingness to provide quality educations and advising to nontraditional students and advocate for reform, rather than only holding nontraditional students accountable for lack of preparation. Further, counselor educators need to review their institutions recruitment policies and procedures to ensure they are designed to meet the identified needs of nontraditional students. In counselor education programs, faculty, staff, and students can implement policies and procedures that create the welcoming and inclusive structure that addresses all of the subgroups that make up nontraditional students. And counseling faculty can apply the curriculum and pedagogy practices that support nontraditional student retention.

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Improving Minority Student Mental Health: Implications and Strategies for Campus
Mental Health Providers

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Abstract

Enrollment at colleges and universities has increased tremendously over the last few decades. Similarly, college enrollment has increased for racial and ethnic minority (REM) students. With this increase diversification, college counselors have to consider the type of student that would be utilizing services and make changes that would be conducive to culturally sensitive and competent care. This study explores factors such as mental health stigma, discrimination, and socioeconomic class as a potential barrier for REM students considering seeking mental health treatment. Implications and considerations for counselors working with student populations, including outreach programming and specialized interventions are discussed.

Improving Minority Student Mental Health: Implications and Strategies for Campus Mental Health Providers

Discrimination, lack of access to quality mental health services, cultural and historical mistrust of health care providers, and stigmatization of mental health issues and treatments are barriers that hinder racial/ethnic minorities from seeking professional mental health services. These same barriers appear to discourage racial/ethnic minority students from utilizing services at college campus counseling centers. The following will address these barriers and offer suggestions for campus mental health providers to assist in increasing the utilization of services by racial/ethnic minority students. In this document, the term racial/ethnic minorities will be utilized as the terminology is congruent with the language of the professional literature.

Discrimination

Racial and ethnic discrimination has been a prominent factor for members of racial/ethnic minority groups, historically and even in today's culture. Cheng, Kwan, & Sevig (2013) discussed that anticipation of discrimination was a predictor for underutilization of mental health services even after considering factors such as "access to health care, mental health, and physical status" (p.100). Research suggests a correlation between perceived discrimination by members of racial/ethnic minority groups and concerns about being stigmatized for obtaining mental health services by others (Cheng, Kwan, & Sevig, 2013).

"Institutional and societal racism of REM [racial and ethnic minorities] have been historically stigmatized as deficient, weak, problematic, or dangerous" (Cheng, Kwan, & Sevig, 2013, p. 100). Discrimination and racism have been identified as factors that influence the development of stigma related to mental illness and seeking mental health services (Davidson, Yakushka, & Sanford-Martens, 2004 ; Cheng, Kwan, & Sevig, 2013). Brinson & Kottler (1995)

discussed that minority's perspectives are often associated with past and current encounters with racism in modern culture.

Historically racial/ethnic minorities have had a tumultuous relationship with the health care system in the United States. According to Boulware et al. (2003), "African Americans have been shown to have greater awareness of documented history of racial discrimination in the health care system than white Americans" (p.363). Significant historical incidences such as the Tuskegee Syphilis Study, which lasted 40 years (1932-1972) took place during the lifetime of adults that are ages 42 and older. These incidents could potentially be seen as the most prominent factor related to generational distrust of the health care system by the African American community, especially health care institutions that are research and clinically based care (Boulware et al., 2003; Gamble, 1997).

Previous to the Tuskegee Syphilis study, there were concerns about the unfair medical treatment and experiments that were completed on ethnic/racial minorities by white doctors (Boulware et al., 2003; Gamble, 1997). In the early 20th century, black-run and operated hospitals were established across the country (Gamble, 1997). "The founders of Black hospitals claimed that only Black physicians possessed the skills required to treat Black patients optimally and that Black hospitals provided these patients with the best possible care" (Gamble, 1997, p. 1775). Brinson & Kottler (1995) discussed the ways in which the historical contexts of distrust could potentially lead individuals of the racial/ethnic minority groups to be suspicious of the practitioner's motives to help them especially if the practitioner is a member of the dominant culture.

According to Masuda, Anderson, & Edmonds (2012), "psychosocial factors, such as poverty, lack of access to services or transportation, racial-ethnic mismatch, and mistrust of

provider, have been shown to relate to service underuse and preference among African Americans” (p. 774). The history of the relationships between Caucasians and specific racial/ethnic minority groups (i.e. African American, Mexican Americans and American Indians) could be a barrier to overcome in order to ensure an effective relationship such as a counselor/client relationship (Brinson & Kottler, 1995). Ford (2013) suggested factors such as “geographic or financial inaccessibility and lack of clinician diversity” (p. 4) could be potential barriers preventing successful utilization of mental health services among racial/ethnic minority groups.

Socio-Economic Class

Another factor that should be considered is socioeconomic status and its association with utilization of mental health services. According to Cook et al. (2014), “greater socioeconomic status was generally positively associated with greater utilization and expenditures, whereas lack of insurance and being fully employed were negative predictors of utilization and expenditures” (p. 219). Ford (2013) found that racial/ethnic minorities with lower income and less education were more likely to not utilize mental health services, but as the income level and education attainment increased within the racial/ethnic minority population, mental health service utilization increased. It should be noted that although the utilization increased among the racial/ethnic population, research suggests that the members of the racial/ethnic minority group were more likely to prematurely terminate services in comparison to their white counterparts (Ford, 2013).

Roy-Byrne, Joesch, Wang, & Kessler (2009) discussed the idea that socioeconomic status is related to the quality of treatment, such as the type of mental health treatment setting, the availability of medication, and the quality of the therapeutic services. Settings such as

community mental health centers are often limited in the services they can provide to the community due to “provider shortages and funding cuts to community health centers, Medicaid, and state mental health agencies” (Shin, Sharac, & Mauery, 2013, p. 495). Community Mental Health Centers were initially established to be comprehensive in treating a wide variety of mental health concerns, but are now focused on treating more debilitating mental health issues. It leaves the conversation open for a discussion of what services are available to individuals from low socio-economic backgrounds whose mental health concerns are not debilitating but are causing some conflict within the individual’s daily functioning. This could potentially contribute to the assumption that mental health services are for the severely mentally ill and/or the rich.

Mental Health Stigma

Mental health stigma is an additional factor to take into consideration because of its impact on racial/ethnic minority group underutilization of mental health services. According to Barksdale & Molock (2009):

Stigma associated with mental illness has been identified as a primary obstacle to the progress made in mental health prevention, treatment, and research. African Americans have been found to hold more stigmatizing beliefs about individuals with mental illness and voice more concern about stigma related to mental health treatment compared to Caucasians. Research suggests that African Americans consider stigma a salient barrier to seeking professional treatment for mental illness. (p. 288)

Mental health stigma is an issue that can be seen in differing racial/ethnic groups, including the majority culture. Davidson, Yakushka, & Sanford-Martens (2004) discussed that among the African American population mental health stigma has been a predictor of mental health service utilization. Caesar-Richardson (2012) discussed the idea that “the existence of

drug addiction becomes more normal than the existence of mental health concerns and ultimately stigmatizes mental illness in the Black community” (p. 103). Mental health stigma, even if the stigma is perceived, often deters individuals from seeking psychological treatment and interferes with returning to care, if the individual has started receiving services (Cheng, Kwan, & Sevig, 2013).

Cheng, Kwan, & Sevig (2013) discussed mental health stigma in two categories, *public stigma* and *self-stigma*. Public stigma is defined as “the belief that a person who seeks mental health service is perceived by the general public as flawed and socially undesirable, whereas self-stigma refers to an individual’s negative perceptions about herself or himself for seeking psychological help” (Cheng, Kwan, & Sevig, 2013, p. 99). Barksdale & Molock (2009) found similar concepts related to the African American community and social norms. In their research it was suggested that:

African Americans believe that seeking professional help for mental illnesses was not acceptable to family and friends. In tight-knit family networks, when mental health help-seeking norms are not congruent with formal service use, the individual in need of help is often discouraged from seeking formal help. Indeed, the cultural teachings among African-American families, such as the high value of privacy (e.g., “keep family business within the family”), may deviate from the basic principles of formal treatment (e.g., disclosure) and may inevitably translate into underutilization of professional mental health services. (p.288)

Improving Minority Student Mental Health

Improving minority student mental health is not an exact science. According to Locke, Bieschke, Castonguay, & Hayes (2012), “services seem to positively influence outcome; and that

the ability of therapists to create effective alliances with clients facilitates positive outcomes” (p.237). Research suggests that racial/ethnic minority college students, especially African Americans, are found to be less likely to seek out campus mental health services (Masuda, Anderson, & Edmonds, 2013; Barksdale & Molock, 2009; Caesar-Richardson, 2012). If professional mental health services improves mental health outcomes and racial/ethnic minorities are underutilizing mental health services, it is conceivable that the first steps to improve outcomes for minority students mental health concerns would be to learn to how improve service utilization of the population. The following will address research suggestions to improve utilization among racial/ethnic minority groups, with specific implications for improving African American student’s utilization.

Counseling Center Staff

Hayes et al. (2011) found that a higher number of minority students sought counseling services when there were therapists of the same or similar ethnic/racial background. Similarly, Brinson & Kottler (1995) suggests that a reason racial/ethnic minority students do not utilize campus counseling services is due to “the lack of ethnically similar counselors, the lack of culturally sensitive treatment approaches, the focus on individual rather than on environmental forces, and the staff’s lack of familiarity with cultural differences” (p. 373). Such research suggests that, not only does the campus counseling center have to have racial & ethnically diverse staff members to assist with increasing minority student utilization, but that the staff in its entirety have to be familiar with treatment modalities that are conducive to providing culturally appropriate care for the target population. Davidson, Yakushka, & Sanford-Martens (2004) added:

Counselors should be encouraged to have an open discussion with all of their clients, especially their racial and ethnic minority clients, about the process of psychotherapy. Such a discussion may reduce the occurrence of racial and ethnic minority clients not returning to counseling after a single session. Additionally, counseling centers may want to consider evaluation of current services to determine whether interventions are culturally appropriate. (p.268)

Counseling Center Programming

One method that some campus counseling centers use to gain more visibility on campus and to foster relationships with students and faculty/staff is outreach programs. These programs are often held in locations away from the counseling center as a way to reach students as well as faculty and staff in a neutral and less formal setting. Suggestions have been made that outreach programming could be used to assist in increasing minority student's utilization of counseling center services. Brinson & Kottler (1995) discussed the campus counseling center staff should consider:

presenting workshops on subjects of special interest to minority students (racial identity, racism, interracial marriages, and so on), consulting with minority student organizations on campus, showing greater visibility of counseling staff in settings where minority students spend their time (e.g., residence halls, sporting events, libraries), and making presentations to classes that cover the services provided (especially those that might be attractive to minority populations). (p. 377)

Further research suggests that in addition to providing special interest programs to minority groups, counseling center staff should also consider programs that are more traditional in nature. This could help normalize some concerns the students may be experiencing such as

stress, relationships, sleep concerns, anxiety, adjustment, and academic issues as well as information about the services offered at the campus counseling center (Masuda, Anderson, & Edmonds, 2012; Davidson, Yakushka, & Sanford-Martens, 2004). Davidson, Yakushka, & Sanford-Martens (2004) discussed that “students who attended programming that was culture specific were much more likely to feel motivated to hear the message, and find it personally relevant to them, than were their counterparts who heard a more standard colorblind message” (p. 268). Additionally, it is recommended that outreach programs during campus-wide events, especially those attended by parents of racial/ethnic minority students, provide information about campus counseling center services as well as information to assist in reducing mental health stigma (Cheng, Kwan & Sevig, 2013).

Beyond outreach programs, some research recommended counseling center staff consider creating therapy groups specifically for clients of color; these groups should be held in locations outside of the campus counseling center preferably in a location where minority students would deem as familiar and comfortable (Davidson, Yakushka, & Sanford-Martens, 2004). These psychotherapy groups could be fashioned to appear less formal but still productive in the manner that it allows the group member to become more familiar with the therapeutic process. The groups could be symptom specific (e.g., stress management, time management, study skills) or the group could potentially be a process group where a variety of concerns are discussed; regardless of the group type, the group should still be culturally specific.

Campus/Community Collaboration

Minority student support groups and mentor programs could be an intervention utilized to familiarize students with the benefits of counseling, providing social support and a sense of accountability. Brinson & Kottler (1995) suggests pairing minority students with faculty

members who provide support which includes academic assistance as well as helps “students to become aware of resources that are available on campus: financial assistance, social opportunities, academic tutoring, and counseling services” (p.377). Through this form of outreach, the counseling center staff will educate the faculty members on how to identify at-risk students and how to refer students to the counseling center (Brinson & Kottler, 1995). Beyond educating the faculty mentors, the counseling center staff should also consider educating their allies. Allies are often faculty/staff and community members who are not directly involved with the counseling center, but could be referral sources. Masuda, Anderson, & Edmonds (2012) discussed African American students often seek out “non-psychological professionals such as familial members, close friends, and community members for emotional and psychological assistance” (p. 781). In this regard, it is imperative that the counseling center staff include community members who are connected to the target population in an effort to educate them on the services offered, how to identify distressed students, and how to refer. These community members could be an advisor of a minority interest group, campus/local spiritual group leaders, doctors, or minority faculty/staff members.

Conclusion

Although some misconceptions and barriers may be extensions of familial beliefs, racial/ethnic minority college students also appear to be discouraged from utilizing campus counseling services. Implications such as ensuring racial/ethnic diversity of counseling staff, and implementing multicultural strategies into services and interventions are research-supported recommendations for college counseling centers and their staff. Specialized outreach programs, psychotherapy groups, and community collaboration are suggested to assist in improving

minority student utilization of services, dismantling myths regarding mental health concerns/treatment, and ultimately improving minority student mental health.

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The CACREP/CORE Merger: Implications for the Rehabilitation Counseling Identity

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Abstract

The recent merger agreement between the Council on Rehabilitation Education (CORE) and the Council for Accreditation of Counseling and Related Education Programs (CACREP) has reintroduced long-term concerns about the future of the rehabilitation counseling profession, and in particular, the preservation of the rehabilitation counseling identity. This article reviews the evolution of the rehabilitation profession, the scope of professional practice and the rehabilitation counseling identity, licensure and certification issues, and counseling accreditation of education programs. Finally, an update on the current state of the merger of CORE and CACREP is given with some predictions about the potential shortcomings and benefits to the fields of clinical mental health and rehabilitation counseling.

Evolution of the Rehabilitation Counseling Profession

Counseling (including rehabilitation counseling) is a relatively new profession (Hagedorn, Culbreth, & Cashwell, 2012). Vocational rehabilitation is distinguished from other counseling specialties in that it was mandated through federal legislation, the Smith-Fess Act of 1920 (Barros-Bailey, 2015). Many historians, not only credit the passage of the Smith-Fess (Vocational Rehabilitation) Act with the establishment of the public rehabilitation program (Wright, 1980; Leahy & Szymanski, 1995), but also acknowledge that it was the “Act” that facilitated rehabilitation counseling’s emergence as a full time occupation.

When rehabilitation legislation was included in the 1935 Social Security Act the occupation began to be seen as a more permanent service and line of work; however, it was not until the 1954 Vocational Rehabilitation Act Amendments were enacted that the field of rehabilitation counseling was well established as a profession. Prior to 1954, rehabilitation counselors held various college degrees because formal training in rehabilitation counseling was not available. A major focus of the Amendments was that it established funding for the creation of the first rehabilitation counseling graduate education programs. During this time, scholarships were also provided to recruit students for careers in the field by offering financial incentives for earning the newly developed rehabilitation counseling degrees. This scholarship program laid the groundwork over sixty years ago for the long-term training grants that are awarded universities by the Rehabilitation Services Administration (RSA) today.

Although rehabilitation counseling training programs were becoming available throughout the United States, many individuals working as rehabilitation counselors had undergraduate degrees or graduate degrees in majors other than counseling. The need for highly qualified rehabilitation counselors was identified in the Comprehensive System of Personnel

Development provisions of the 1992 and 1998 Amendments to the Rehabilitation Act of 1973 (Chapin, 2004); however, specific suggestions for increasing the quality of rehabilitation counselors were not provided. The term, *highly qualified personnel* was generally interpreted by the State Vocational Rehabilitation Agencies to mean that rehabilitation counselors should have a Master's Degree in Rehabilitation Counseling (or a closely related field) and/or be certified in the field. Agencies had until 2009 to show substantial compliance with the standards for qualified personnel; and, as of 2015, nearly 100% of rehabilitation counselors held graduate degrees in the field.

Scope of Professional Practice and Rehabilitation Counseling Identity

Professional identity is defined by knowledge, skills, and attitudes identified by and congruent with the development of ethical standards (Saunders, Barros-Bailey, Ridman, & Dew, 2007). Although it is one of the other counseling professions, the rehabilitation counseling identity is unique in that it is based on service to people with disabilities, knowledge about legislation, and a focus on careers and employment. Extensive research has been, and continues to be, conducted on the roles, job functions, and competencies that are needed for performing effectively as a rehabilitation counselor (Jacques, 1959; Leahy, Shapson, & Wright, 1987; Leahy, Szymanski, & Linkowski, 1993; Muthard & Salamone, 1969; Rubin et al., 1984; Wright & Fraser, 1975). Rehabilitation counselors have sometimes been considered to be more similar to caseworkers, social workers, or other human services personnel than counselors because so much of their work involves case management, needs assessment, goal-setting, vocational-specific counseling, and referrals for services outside their expertise (Jenkins, Patterson, & Szymanski, 1992). However, the practice of counseling is evident in the delivery of professional rehabilitation counseling services. In fact, a thorough knowledge of counseling theories and

techniques is necessary for carrying out the many activities involved in assisting people with disabilities in their personal and employment lives.

The rehabilitation counseling profession is continually changing because of internal forces such as the results of research and because of external forces such as rehabilitation legislation, managed care, third-party reimbursement systems, counselor licensure legislation, private practice, and technology (Chapin & Goodwin, 2006). Accreditation, certification, and licensure issues have extensive influence on the evolution of the rehabilitation counseling profession.

Licensure and Certification Issues

The National Board for Certified Counselors (NBCC) was established in 1981 (Adams, 2005); however, the certification procedures for rehabilitation counselors were developed prior to any other credentialing process for counselors (Hedgeman, 1985; Leahy & Holt, 1993). Interest in a professional credential for rehabilitation counselors had been building for some time. The National Rehabilitation Counseling Association (NRCA) and the American Rehabilitation Counseling Association (ARCA) joined together and formed the Commission on Rehabilitation Counselor Certification (CRCC) in 1973 (Leahy & Holt, 1993). Membership on the CRCC was diverse and included representation from the Council on Rehabilitation Education (CORE), the Council of State Administrators of Vocational Rehabilitation (CSAVR), the National Association of Rehabilitation Facilities (NARF), the National Association of Non-White Rehabilitation Workers (NANWRW), as well as employers and disability consumer groups. (Hedgeman, 1985; Saunders, et al., 2007). As a result of the work of the CRCC, the first Certified Rehabilitation Counselor (CRC) examination was given in 1976 (Leahy & Holt, 1993).

Of course, change within a profession often causes a degree of friction, and the CRC credential was met with concerns. The initial certificants were not very reliable subjects for research because as volunteers, they were assumed to be highly interested and motivated to become the first credentialed counselors in their field. In order to keep the CRC examination relevant, the CRCC researched the rehabilitation counselor position in the mid 1980's and made a commitment to replicating the research every few years. In 1990, CRCC and CORE began "joint validation content research" (Leahy & Holt, 1993, p. 48) to analyze the relevance of the CRC examination and the CORE accreditation standards (Leahy & Holt, 1993), and to determine if rehabilitation graduate education was producing competent practitioners (Gill, 2005). Today, there are over CRCs in the United States and Canada. The CRC is the preferred credential of employers; however, the Licensed Professional Counseling (LPC) credential is also important for rehabilitation counselors who are employed in a mental health setting. (Chapin & Goodwin, 2006).

Accreditation

A group of rehabilitation professionals and various association members met in 1969 to discuss the need for accreditation of rehabilitation counselor education (RCE) programs. As a result, the Council on Rehabilitation Education (CORE) was incorporated in 1972 (Szymanski & Linkowski, 1993). Five professional rehabilitation organizations were represented on the CORE Board: the American Rehabilitation Association (ARA), formerly the International Association of Rehabilitation Facilities; the American Rehabilitation Counseling Association (ARCA); the Council of State Administrators of Vocational Rehabilitation (CSAVR); the National Council on Rehabilitation Education (NCRE), formerly the Council of Rehabilitation Counselor Educators; and the National Rehabilitation Counseling Association (NRCA) (CORE, 2016).

The Association for Counselors Education and Supervision (ACES) developed standards for voluntary accreditation of counseling programs in the late 1960's and the 1970's. ACES, in collaboration with the American Personnel and Guidance Association (APGA), the precursor to the American Counseling Association (ACA) began cooperative accreditation efforts that led to the establishment of the Council for Accreditation of Counseling and Related Education Programs (CACREP) in 1981. (Diambra et al., 2014; Steihauser & Bradley, 1983).

Accreditation bodies such as CORE and CACREP seek to promote a comprehensive and diverse curriculum taught by qualified counselor educators. It should be noted, however, that while accreditation offers many benefits, there are concerns about the effect on counseling programs, as well. For example, some opponents of accreditation worry that some unintended consequences of requiring universities to conform to uniform standards are that it discourages innovation, encourages complacency, and interferes with the academic freedom of faculty (Myers, et al., 2002). Cost of accreditation is also an issue. With lean budgets, universities may have to curtail program expansions and development activities in order to pay accreditation fees. Ongoing research is needed to affirm the benefits of counseling accreditation for students, graduates, and most importantly, for the clients who seek counseling from graduates of accredited programs.

The CORE and CACREP Merger

Joint counseling accreditation has been considered for many decades. In fact, at an annual meeting of CORE in 1989, the possibility of a CORE and CACREP merger was introduced, but was met with disfavor by rehabilitation counselors who were concerned about losing the professional status that separated their work from that of other counselors (Linkowski & Szymanski, 1993). After many years of proposals and review, an affiliate agreement between

CACREP and CORE for “clinical rehabilitation counseling” was signed in 2013 (Barros-Bailey, 2015; CORE 2015). The agreement allowed university rehabilitation counseling programs that were currently offering a 60 semester hours curriculum with a focus on mental health to apply for joint accreditation. In other words, rehabilitation counseling programs meeting the newly established clinical rehabilitation counseling criteria could be accredited by both CORE and CACREP. The affiliate agreement was seen as a compromise between separate accreditation and a complete merger. Two years later, after many discussions between the two accreditation boards, a full merger was announced:

On July 20, 2015, the counseling profession’s two major accrediting organizations – the Council on Rehabilitation Education (CORE) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP)– signed a Plan of Merger Agreement. The Plan, approved by both the CORE Board and CACREP Board at their respective summer meetings, represents several years of discussions on strengthening the counseling profession through the establishment of a single unified accreditation process for counselor preparation programs... (CORE Press Release, July 20, 2015).

Beginning July 1, 2017, CORE will no longer be active and CACREP will carry out the mission of both organizations. Rehabilitation counselor education programs that are accredited by CORE and are considered to be in good standing as of July 1, 2017 will automatically become accredited by CACREP for the remainder of the time they would have been if CORE had continued as an accreditation body. When their accreditation period expires, the rehabilitation

counseling education programs will be required to apply under the *CACREP Standards for Rehabilitation Counselor Education Programs* that are currently under development.

At an April, 2016 symposium for CORE/CACREP peer site reviewers at the annual meeting of the National Council on Rehabilitation Education in Newport Beach, California, both beneficial and problematic issues concerning the merger were introduced. Some of the issues discussed are described below (CORE/CACREP, 2016).

Potential Problems Associated with the CACREP/CORE Merger:

- Although current rehabilitation counselor educators will be “grandfathered” as CACREP approved faculty, doctoral educators in rehabilitation counseling may need to make significant changes in the curriculum provided future educators.
- Disability studies as part of rehabilitation counseling education may be diluted in order to allow more courses in mental health to be added to the rehabilitation counseling curriculum.
- Rehabilitation counseling may be conceptualized as a specialty area of counseling practice rather than as an independent profession.
- CACREP only accredits graduate programs; therefore, undergraduate rehabilitation services programs that are currently accredited by CORE will no longer be accredited. (Undergraduate programs will need to seek accreditation from another field such as Human Studies or be satisfied to be on a registry with CACREP.)

Likely Benefits of the CACREP/CORE Merger:

- One accreditation review process for university programs that currently have both CORE and CACREP programs will be more time and cost efficient.

- The unification of the counseling profession may have more influence on legislation affecting counselors and their clients.
- An increased number of rehabilitation counselors may be eligible for the Licensed Professional Counselor (LPC) credential in states that do not accept rehabilitation counseling education as a requisite counseling degree. (Currently, graduates of 48 semester hour rehabilitation counseling programs accredited by CORE are eligible for licensure in both Alabama and Georgia; however, Florida requires graduates to hold a 60 semester hour clinical mental health degree. Licensure requirements vary across the nation with the CACREP degree often being required.)
- Clinical mental health students may learn about disabilities from their rehabilitation counterparts, and as a result become interested in taking the additional courses and internships needed for eligibility as a Certified Rehabilitation Counselor (CRC).

Summary

The rich history of the rehabilitation counseling profession in the United States includes nearly a century of continuous growth; therefore, it is reasonable to expect that the new challenges posed by the CACREP/CORE merger will be met with positive change. In many respects, rehabilitation counseling will be recognized as a true partner by the larger counseling community as unification efforts take place (Estrada-Hernández, 2016). Most importantly, rehabilitation counseling's focus on advocacy for people with disabilities will begin to be immersed throughout the other counseling professions, and rehabilitation counseling students and educators alike will gain valuable insight from their association with their counseling colleagues.

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The Alabama Counseling Association Journal

An official publication of the Alabama Counseling Association, The Alabama Counseling Association Journal is an electronic journal published twice a year. A primary purpose is to communicate ideas and information which can help counselors in a variety of work settings implement their roles and develop the profession of counseling. The Journal may include thought-provoking articles, theoretical summaries, reports of research, and discussions of professional issues, summaries of presentations, reader reactions, and reviews of books or media. The ALCA Journal is located on the ALCA website (www.alabamacounseling.org).

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