Journal of Counseling in Illinois

Volume 6: Number 1

Summer 2020

CO-EDITORS

Katherine Helm
Professor
Graduate Program Director of Counseling
Lewis University

Email: helmka@lewisu.edu

Ken Oliver
Professor
Education Division Chair
Counseling Program Director
Quincy University

Email: oliveke@quincy.edu

The Illinois Counseling Association is a partnership of associations representing professional counselors who enhance human development.

EDITORIAL BOARD

ICA Publications Committee

ICA OFFICERS

ICA WEBSITE

www.ilcounseling.org

ICA CONTACT INFORMATION

P. O. Box 367
DeKalb, IL 60115
(877) 284-1521

Information on making submissions to the Journal of Counseling in Illinois can be found on the ICA website under Publications. Manuscripts should be sent to the editors electronically.

Brief Welcome

Welcome to Volume 6:1 of the Journal of Counseling in Illinois! Journal Co-Editors, Dr. Ken Oliver and Dr. Katherine M. Helm, are thrilled to share the summer 2020 edition with ICA readership. This edition is being released amid the global COVID-19 pandemic and ongoing struggles for racial and social justice. It is our collective hope that you and your families remain safe and that this edition can provide some sense of normalcy during this challenging time.

Co-Editor Bios

Ken Oliver, PhD., LPC has served as a clinical mental health counselor in mental health, residential, and educational settings for more than 20 years. A St. Louis native, Dr. Oliver currently serves as Professor, Division Chair for the School of Education, and Program Director in the Graduate Counseling Program at Quincy University in Illinois and is a Licensed Professional Counselor in Missouri. He has served on several ACA-division journal editorial boards and previously served on the Board of Directors for the Schultz Foundation. He is married and the father of one boy and two girls.

Katherine M. Helm, PhD is a Professor of Psychology and Director of Graduate Programs in Counseling at Lewis University where she teaches a wide range of graduate counseling courses in the clinical mental health counseling. Dr. Helm is a licensed psychologist and regularly sees individual and couples clients. Dr. Helm supervises masters and doctoral practicum and internship students. Her scholarly contributions are in the areas of individual and couples counseling, sexuality issues and education, counselor training and supervision, multicultural issues in counseling, the treatment of trauma for sexual abuse, pedagogy of multicultural courses, and cultural competency training. Dr. Helm has counseling and consultative experiences in psychiatric hospitals, community mental health, college counseling centers, and other agency settings.

CO-EDITORS NOTES: THE JOURNAL OF COUNSELING IN ILLINOIS

In the latest edition of the Journal of Counseling in Illinois, we are pleased to present five diverse articles counseling-related topics. The first article Heidi Larson and Nick Caldwell explores teacher perceptions of mental health systems within their schools. Additionally, teachers were asked to characterize their own roles within the system and concluded that they were critical to a healthy, functioning mental health network within schools. The authors offer several critical recommendations outlining the need for counselors to assist, train, and support teachers in their efforts to promote a healthy mental health system within the school.

The second article by Alyssa Swan investigates the impact of Child-Parent Relationship Therapy (CPRT) on perceived parent-child relationships. A research study was conducted to assess changes in adoptive parent self-reported ratings related to relationship quality throughout treatment. This article adds to the ever-expansive body of literature touting CPRT's effectiveness.

The third article by Sandra Gavin highlights the utilization of the Discrimination Model of counseling supervision as a basis for developing LGBTGEQIAP+ competence and self-efficacy. The author proposes a well-conceived conceptual linkage between these complex, often

obtuse constructs. Additionally, a case illustration along with corresponding action steps are provided.

The forth article by James Morris III explores various aspects related to undergraduate male college success. Participants were assessed on their perceptions of social support and how these perceptions relate to academic self-concept. Results indicate a strong case for the promotion of self-concept and social support as a correlate with undergraduate college success.

The fifth article by Mike Caverly explores the utility of Acceptance and Commitment Therapy (ACT) as an effective treatment for dealing with clients' traumatic experiences. Mechanisms of ACT and the connection to traumatic experience is described in detail. A case illustration is presented with an ACT treatment focus to illustrate applicability.

This diverse collection of articles serves as further evidence of JCI's vast scope. As typical, we believe that the articles in this edition of the journal have significant potential to inform our work with clients and students as well as provide readers with promising opportunities to delve into areas which broaden their own professional knowledge base. Thank you for your interest in the latest edition!

KEN OLIVER
CO-EDITOR
oliveke@quincy.edu

KATHERINE HELM
CO-EDITOR
HelmKa@lewis.edu

Journal of Counseling in Illinois (JCI) Sections and Guidelines for Authors

The Journal of Counseling in Illinois is dedicated to increasing the quality and quantity of professional dialog among Illinois counselors by publishing articles concerned with contemporary issues for mental health professionals.

Sections:

Research: These manuscripts focus on qualitative and quantitative research studies that are useful to counseling practice. Studies may be small in nature and can include preliminary findings that will lead to larger research projects. These manuscripts may include program evaluation studies. However, all studies must adhere to rigorous data analysis standards. In these manuscripts, the review of the literature provides the context and need for the study, logically leading to the purpose and research questions. The methodology includes a full description of the participants, variables and instruments used to measure them, data analyses, and results. Authors are expected to discuss the clinical significance of the results.

Practice: These manuscripts focus on innovative approaches and techniques, counseling programs, ethical issues, and training and supervision practices. They are grounded in counseling or educational theory and empirical knowledge. Some evidence of effectiveness in practice is provided. The goal of this section is to offer ideas and techniques for immediate application to practice.

Professional Exchange: These manuscripts are designed to provide readers with information about significant current issues and/or trends in the counseling field. These manuscripts may be reviews of the literature and/or position papers. Relevant areas include diversity, accreditation, licensure, certification, counselor function, needs of special client populations, supervision issues, issues effecting Illinois counselors, issues effecting divisions, regions, or chapters, and other timely topics.

Professional Dialogue: These manuscripts are written to stimulate dialogue, discussion, and debate related to critical issues of interest to the JCI readership. Initial submissions will include a well-reasoned, thought-provoking manuscript on a topic of interest and the names of two potential contributors who will respond/react to the concepts in the original manuscript.

Media Reviews: These manuscripts are written to review current media relevant to mental health professionals. Each review must include information about how the reader may excess the media and background of author relevant to materials being reviewed. Authors may submit reviews on media they have written or developed themselves.

Reviews must be informational and scholarly in nature and cannot be advertisements for the media.

Manuscript Preparation: All manuscripts should be prepared according to the Publication Manual of the American Psychological Association (6th ed.). Authors should consult the APA Publication Manual for guidelines regarding the format of the manuscript, abstract, citations and references, tables and figures, and other matters of editorial style. Tables and figures should be used only when essential. No more than three tables and two figures with each manuscript will be accepted. Figures (graphs, illustrations, line drawings) must be supplied as camera-ready art (glossies prepared by commercial artists) whenever possible. If electronic artwork is supplied, it must be a minimum resolution of 600 dots per inch (dpi) up to 1,200 dpi. Halftone line screens should be a minimum of 300 dpi. JPEG or PDF files are preferred. (See APA Publication Manual, pp. 150–167 for further details on figure preparation.) Figure captions are to be on an attached page, as required by APA style. JCI does not publish footnotes. Instead, incorporate any footnotes into the text or include an endnote.

Authors must also carefully follow APA Publication Manual guidelines for nondiscriminatory language regarding gender, sexual orientation, racial and ethnic identity, disabilities, and age. Lengthy quotations (generally 500 cumulative words or more from one source) require written permission from the copyright holder for reproduction, as do reproductions or adaptations of tables and figures. It is the author's responsibility to secure such permission, and a copy of the publisher's written permission must be provided to the Editor immediately upon acceptance for publication.

Manuscript Length Limitations: Each manuscript submission is limited to no more than three tables and two figures. In total, manuscripts submitted to the Research section must not exceed 20 pages, including references. Manuscripts submitted to the Practice, Professional Exchange and Professional Dialogue are not to exceed 15 pages. Media review manuscripts are not to exceed 10 pages.

Manuscript titles are limited to 80 characters. Abstracts are limited to 75 words. Any submissions that do not adhere to length limitations may be returned without review.

JCI Editorial Review: Manuscripts are reviewed by at least two editorial board members. Manuscripts typically undergo revision before final acceptance. The Editors make final decisions regarding publication.

JCI has a completely electronic manuscript submission and review process. Electronically submit as attachments one copy of the manuscript with authors' names and affiliations on the cover sheet, along with a letter briefly describing the topic of the manuscript and identifying the appropriate JCI section to oliveke@quincy.edu and/or helmka@lewis.edu. The subject line of the e-mail message must state "JCI: manuscript submission."

JCI expects authors to follow the ACA Code of Ethics (ACA, 2014) regarding publication, including authorship, concurrent submission to only one publication, and informed consent for

research participants, and piecemeal publication of research data. In a cover letter, authors should include statements indicating that they have complied with specified ACA ethical standards relevant to their manuscript.

TABLE OF CONTENTS

Volume 6 Number 1 Summer, 2020

Teachers' Perception of Mental Health in the School System

Heidi Larson
Eastern Illinois University

Nick Caldwell
Shelbyville High School

Abstract

This study examined teachers' perceptions of their school's mental health system. The study was guided by three research questions: How do teachers perceive their role in identifying mental health problems within the school system? How do teachers perceive the effectiveness of the identification and treatment of mental health problems? What improvements do teachers have to address mental health problems? Six teachers from a rural high school participated in a single interview for discussion. Results indicated that teachers generally believed they were the first identifiers of mental health problems, felt somewhat prepared, and wanted more effective training in mental health.

Adolescent Mental Health

Adolescents experience many stressors in their lives. Their social relationships, home lives, and school have expectations and responsibilities for them, such as expectations for their behavior, chores, and assignment deadlines. Adolescents experience peer-to-peer bullying; peer pressure; academic difficulties; problems with teachers; parental expectations; conflicts with peers, parents, or siblings; and social difficulties related to the emergence and/or development of self-identities (e.g., sexual orientation, religious identity; Steinberg & Morris, 2001). Adolescents may use/misuse illicit substances to cope with these stressors (Steinberg & Morris, 2001). Clinically significant mental health problems affect up to half of adolescents across their lifetimes with most of these adolescents failing to receive treatment (Merikangas et al., 2011). Early and accurate identification of mental health problems are crucial for healthy adolescent development (Lane & Menzie, 2003).

Mental Health in the School System

Students are often identified and treated for mental health problems within the school because they frequently impair a student's ability to function within the school system (Mychailyszyn et al., 2011). Within the school setting, school counselors along with other mental health professionals (i.e., social workers and school psychologists) are co-responsible for the treatment of mental health problems (Foster et al., 2005). However, mental health professionals rarely are the first to identify a mental health problem. They lack the time to observe and develop high-quality relationships with all students whereas teachers regularly spend more time with students (Erford, 2014).

Teachers. Teachers are in a unique position to identify mental health problems because maladaptive behaviors are easier to identify in a classroom setting (Johnson et al., 2011; Mychailyszyn et al., 2011). Teachers can use their experience and time spent with groups of adolescents to observe their behaviors and identify deviant behaviors (Headley & Campbell, 2011). Many adolescents develop strong and positive relationships with teachers they trust (Fredriksen & Rhodes, 2004). Furthermore, students often look at teachers as role models and sources of knowledge and advice (Fredriksen & Rhodes, 2004). Because of this relationship, students often confide in teachers for personal help and may develop strong relationships with them if teachers are supportive. Adolescents who are referred for mental health services within the school are often referred by teachers because of the significant amount of time spent with them in the classroom (Mychailyszyn et al., 2011). For these reasons, teachers are a necessary link for adolescents to receive timely mental health services in the school setting.

RtI. Research has suggested the use of Response-to-Intervention (RtI), which is a multi-tiered system that integrates the academic, social, emotional, and behavioral needs of students and may benefit all students if well-implemented (Stephan, et al., 2015). RtI is composed of three tiers and is implemented to provide a continuum of support for students based on their identifiable social, emotional, and behavioral needs. RtI is designed for school-based mental health professionals to collaboratively work with teachers to provide student-based services in an efficient way (Stephan et al., 2015). The first tier within the RtI model addresses the academic, social, emotional, and behavioral needs of all students within the school. Students in Tier II often receive services in small group settings. Tier III interventions often are individualized, and progress is frequently monitored to help reduce problematic behaviors and significantly increase social, emotional, behavioral, and academic functioning. Teachers, who are the most important component of the model since initial student progress occurs under their supervision, seldom have their input formally recognized within the literature. It is important for teachers to recognize their role in identifying adolescents with mental health problems (Johnson et al., 2011), and receiving their input will be important for successful implementation of the RtI model.

School counselors have well-integrated roles within the RtI system (Erford, 2015). In the first tier, counselors use standards- and competency-based curriculum presented schoolwide to students (Hatch, 2014). In the second tier, they implement preplanned and research-based interventions to address selected group members' academic, behavioral, or social-emotional functioning. In the third tier, counselors provide intensive services to individuals. If teachers cannot effectively identify and refer students, school counselors may need to revise their roles. For example, school counselors may need to more frequently conduct functional behavioral assessments to better understand individual students and their needs in the classroom environment (Scott et al., 2004).

Previous Teacher Input

Teachers' perceived role. Some preliminary research has been conducted on examining teachers' perceptions of their role within the school-based mental health system. Most teachers generally recognize they have a role in the identification process (Andrews, McCabe, & Wideman-Johnson, 2014), though they may struggle to clearly define their role (Alisic, 2012).

Andrews et al. (2014) conducted an online survey to examine teachers' knowledge regarding mental health issues and their perceived roles. Most participants (62.7%) agreed or strongly agreed that it is their "responsibility to support, address, and make any necessary referrals" for students with mental health problems (Andrews et al., 2014, p. 267). However, teachers may struggle to identify how to respond to students. Alisic (2012) conducted a study which utilized semi-structured interviews with 21 elementary school teachers. The author investigated teachers' perspectives on how to interact with children after a traumatic event, such as a loss of a parent or serious accident. Alisic (2012) found that teachers struggled spending time balancing the needs of the student as opposed to the needs of the class. Teachers struggled with whether to focus on a student's trauma or focus on other aspects of the student's life, such as their strengths. Teachers also struggled to create a safe space for students to discuss their emotions and what to talk about during times of crisis.

Teacher concern. One problem associated with identifying students with mental problem problems is teachers' views toward mental health. Although most teachers believe they will encounter students with mental health problems (Moon, Williford, & Mendenhall, 2017), many teachers do not believe all students can learn and achieve at high levels (Erford, 2015). Teachers are more concerned about children with externalizing mental health problems (i.e., emotional and behavioral problems which affect others), because these students disrupt regular classroom activities, disobey classroom rules, and distract other students (Loades & Mastroyannopoulou, 2010). Because certain mental health problems are inwardly focused and rarely disrupt the regular flow of class, some teachers do not view the identification and support of these students as their responsibility (Roeser & Midgley, 1997).

Teacher training. Teachers are not formally trained in mental health services. A lack of training led some teachers to believe they would not be able to accurately identify students with mental health problems (Papandrea & Winefield, 2011). Teachers also lack confidence interacting with these students (Andrews et al., 2014), especially for inexperienced teachers (Alisic, 2012). Per Andrews et al. (2014), 93.3% of teachers disagreed or strongly disagreed with the statement, "I felt prepared upon graduating from my Bachelor of Education with regards to mental health issues in my students" (p. 268). Experienced teachers reported that learning through experience was not the best way to interact with students with mental health problems (Alisic, 2012). Knowing how teachers view the mental health system will inform professionals on how to approach consultation services and may help adjust roles if necessary.

Purpose

The purpose of this study was to inform various school-related personnel how teachers view the mental health system in the school. CACREP-accredited programs require counseling programs to teach professional consultation (CACREP, 2015). Three research questions are posed and are the following:

1. How do teachers perceive their role in identifying mental health problems within the school system?
2. How do teachers perceive the effectiveness of the identification and treatment of mental health problems within their school?

3. What improvements do teachers have to address mental health problems within the school?

Methodology

A non-experimental, exploratory qualitative research design was conducted to gain information regarding teachers' perceptions of their role in the mental health system within their school. This design was utilized to examine the acquired information within the study without any manipulation of the data (Johnson & Christensen, 2006). Qualitative exploratory analysis was utilized to obtain detailed information about teachers' beliefs, experiences, and behaviors and to evaluate the collected data (Guest, Namey, & Mitchell, 2013).

Participants

One high school was selected for participation. The selected high school was in rural, southeastern Illinois and enrolled approximately 1,000 students and 75 teachers (Illinois State Board of Education, 2018). The student body was 88% White, 4% Hispanic, 4% Black, and 4% another race/ethnicity (ISBE, 2018). Teachers within the district were 97% White, 2% Black, and 1% Asian (ISBE, 2018). Slightly less than half of students are low-income (47.4%), which is lower than the state average (48.8%), and about one-sixth of the students have at least one disability (15%), which is above the state average (13%; ISBE, 2018).

The criteria for participation were high school teachers who regularly had contact with students (>20 hours per typical week) within a classroom setting. Six participants volunteered to participate. Participants represented every grade level and had teaching experience ranging from one year to 30 years of teaching experience. Per the request of participants, several adjustments were made to maintain confidentiality. Instead of providing a specific number of years of teaching experience, participants are grouped into three categories of experience. The categories are the following: low experience (e.g., 0-5 years), moderate experience (e.g., 6-14 years), and high experience (e.g., 15+ years). Four participants identified as female, but gender-neutral pseudonyms were used to allow the reader follow ideas of individuals. Subject taught is also removed.

- Alex had a high amount of teaching experience, had a Bachelor of Arts, and taught grades 10 through 12. Alex served in at least one role with students outside of teaching (e.g., coaching, mentorship).
- Blaine had a low amount of teaching experiences, had a master's degree, and taught all grades in high school. Blaine served in at least one role with students outside of teaching and previously worked in different teaching positions at a different school.
- Casey had a high amount of teaching experience, had a Bachelor of Arts, and taught all grades in high school. Casey previously worked in different teaching positions at different schools.
- Drew had a moderate amount of teaching experience, had a master's degree, and taught grades 11 and 12. Drew served in at least one role with students outside of teaching and previously worked in different teaching position at different schools.
- Emerson had a low amount of teaching experience, had a Bachelor of Arts, and taught grade 9. Emerson served in at least one role with students outside of teaching and previously worked in different teaching positions at a different school.

- Francis has a low amount of teaching experience, has a Bachelor of Arts, and taught grades 9 through 11. Francis served in at least one role with students outside of teaching and previously worked in a different teaching position at a different school.

Procedures and Data Collection

Data collection occurred through an in-person, semi-structured interview after participants consented to interview. The interviews and study were approved by an institutional review board. Interviews were between 30 and 60 minutes and was recorded and transcribed directly after each interview's completion. Recording and transcribing assisted researchers in identify thematic responses across participants. Participants' demographic information was collected including their primary teaching grade, primary teaching subject, previous teaching experience, additional school-based roles, educational credentials, race/ethnicity, and gender.

Data Analysis

Qualitative analysis was used to help understand teachers' perceptions of their school's mental health system and may help professionals gain information about the mental health system within the school. Thematic analysis (Braun & Clarke, 2006) helped identify and analyze patterns in teachers' responses and provided flexibility and versatility in analyzing answers to a variety of questions. Braun & Clarke (2006) provided a step-by-step approach to effectively utilizing thematic analysis including becoming familiarized with the data (e.g., transcribing, reading and re-reading the data), generating initial codes (e.g., coding interesting features of the data), searching for themes (e.g., collating codes into themes, collecting all relevant data to each theme), reviewing themes (e.g., checking the relationship of the theme to coded extracts and the entire data set), defining and naming themes (e.g., refine specifics of the theme, generate clear definitions and names of each theme), and producing the report (e.g., final analysis).

Results

This study attempted to provide teachers with the opportunity to discuss their perspectives on the mental health system at their school. Several themes emerged based on teachers' perceptions of their role in the mental health identification process, the effectiveness of their school's mental health system, and improvements to the system.

Teachers' Role in Identification

First line of defense. Three participants identified themselves as the first to identify students with mental health issue. Alex and Francis stated teachers are the "first line of defense." Alex stated teachers "know if a student changes how they behave [and] how they're reacting" in the classroom. Casey, who has a high amount of teaching experience, and Francis look for irregular behavior. Casey would figuratively, "take the temperature of each student every day" based on their behavior.

Eliciting a response. When observing a student with a mental health problem, Alex and Francis would pull the student out to the hallway and discuss what they observed. Blaine, who

has a low amount of teaching experience, will look for a student who is "a little more quiet… or [makes] less eye contact." Blaine naturally engages the student. For example, Blaine approaches a student reading a book and ask what he or she is reading. Blaine shared that he rarely makes referrals.

Consultation. Three participants found it important to have a team with whom to consult. Alex stated that teachers are not "equipped to deal with every situation" and will refer them when necessary. Blaine and Emerson consult with team members who have the same student to compare the student's behavior between classes. Not every participant perceived that he or she could refer a student. Emerson, who has a low amount of teaching experience, stated, "I don't feel like I have enough training or enough knowledge on the topic of mental health in order to properly be able to refer a student." Alex, Blaine, Casey, Drew, and Francis stated they would send the student to the school counselor or another mental health professional within the school (e.g., social worker, school psychologist). Emerson will try interventions including moving students' seating chart or redirecting students before referring students. Three participants consult outside the school. Casey and Francis communicate with parents. Drew stated teachers should "know what resources are available in my school community" and "know about my community at large too."

Post-referral relationship. Every participant indicated the continuation of the relationship after the referral. Alex and Emerson stated that some students will demonstrate gratitude from the teacher making the referral. Alex, Emerson, and Francis each have experienced student backlash. Emerson described the post-referral relationship as awkward. Casey emphasized to "continue communicating with the student." Blaine and Drew would "follow up with [his or her] teachers and [the] counselor." Blaine included parent contact because "the parent relationship can be incredibly important. They're part of the team even the difficult parents." Francis would tell the student, "I care about you and that's why I [referred you]." Drew would "make sure that student knows that there's help available and that we're here for them" by showing them that "there's always someone here unconditionally that listens to them and not judge them." Casey would continue to monitor the student to "see if they're showing any signs that they could be suicidal."

Preparation and training. Although two teachers felt very prepared, four teachers felt moderately prepared for interacting with students with mental health problems but could use more preparation. Drew explained teachers' preparedness: "I would say on a scale of one to ten, I'm probably about a seven" and "I think I'm prepared as I can be at this point with the resources that we have available." Blaine stated, "I'm comfortable with it. I don't know how well prepared I am necessarily." Emerson stated, "I think I could be more prepared." Francis was prepared "if it's something minor… I could talk through those things," but then added "if it's something like severe depression, I definitely need to call somebody else."

Mental Health System Effectiveness

Improvements needed. Two participants had a positive outlook but stated that improvements could be made. Drew stated, "I think there's more professional development needed." Drew also expressed a positive outlook about the teachers' efforts in the process,

"[teachers'] hearts are in the right place." Casey explained, "we're getting better, but I think we need more." Casey also stated that the severity of the mental health problems influences the school's effectiveness: "when they're not as serious, I think we're excellent. When they reach that point of say homebound, we're somehow not reaching those kids."

Weaknesses. Three participants, who all had a low amount of teaching experience, discussed weaknesses of the system. Emerson stated, "I think that the school system is overwhelmed with mental health problems." Emerson continued, "I already think that we're dealing with a lot more anxiety than schools have dealt with in the past," which includes, "cyberbullying or all the uses of social media." Francis stated, "I would say there's half the people that are very, very good at what they do, and I feel like half the people are not in it for the right reasons." Francis said, "There are people who don't truly care about the well-being of students, or maybe they do, and they just don't know how to show it." Blaine acknowledged several limitations within the mental health system. These limitations included "legal and… regulatory structures [that] create constraints." Schools may be legally required to act "in defiance of what parents want." The distribution of resources was also concerning. Blaine explained, "I think there is a tendency to focus on the discreet minority on the very small subset of students and we begin shifting a ton of resources in that direction often at the detriment of the broader population." Furthermore, "if you have a classroom of 20 kids, we don't ignore that problem and yet we can't ignore 19 for one either."

Mental Health System Improvements

More training. Blaine, Drew, and Emerson each mentioned more training was necessary. Blaine mentioned a potential change to the structure of student-based meetings: "the team [could] met for 15 or 30 minutes before the parent and/or student was sitting there" as a "strategy huddle." Blaine acknowledged that it was "hard to find time and get the team together" for additional discussion of students.

Philosophical changes. Two participants discussed the nature of interacting with students. Alex and Francis, who both had low amounts of teaching experience, discussed the need for some students to experience "tough love." Francis explained, "Talking about their feelings… is great" but "if they're being a little soft… we're going to have to find a way through it." Francis continued, "That is very, very true about the real world, not so much in the school." Teachers should be more "proactive" in helping students overcome obstacles and continued, "It's okay to be upset, but we have got to find a way to get over it." Drew contrasted this view, "the old school kind of mind set of just kind of carry on and deal with it" may be a barrier if teachers "don't believe that mental health issues should be handled."

Lack of resources. Alex, Casey, and Emerson each discussed a lack of at least one of the following resources: funding, time, and/or training. Emerson stated, "training is out there," but teachers first need to acquire access to it. Blaine mentioned that teachers' experience in interacting with students with mental health problems was a barrier to accurately identifying those problems.

Teacher interactions. Teachers discussed three types of teacher interactions. First, Casey stated that teachers often do not want students pulled out of their class for counseling-related services. "All of us feel like our class is the most important… Sometimes we have to get over those kind of barriers." Drew also talked about the stigma associated with mental health problems and shared, "Mental health issues are not necessarily a negative" and are "not supposed to be a crutch to stop you from succeeding or pushing yourself." Second, Blaine identified how "cultural barriers" exist to address certain types of mental health problems. Third, Alex discussed how involved teachers should be in a student's life, "We can't ask kids, or we can't address [mental health] with kids because there's an unspoken wall between how far do you go, how far do you push, how far do you get involved."

Improvements in communication. Three participants wanted improved communication regarding specific health information of students. Blaine would like counselors to, "communicate to us the individual circumstances or diagnoses." Blaine continued by wanting to know "the array of treatments and responses specific to the classroom." Drew wanted to be informed of students' mental health problems "through a database or through a paper copy." Francis also wanted a "chart" and counselors to inform the teachers by saying, "You might want to be on the watch out for this."

Mental health workshops. Several participants discussed their views on the effectiveness of mental health workshops. Alex, who has a high amount of teaching experience, stated one workshop was "life changing," and that this workshop "dealt with suicide, it dealt with bullying, it dealt with self-harm, it dealt with family issues, it dealt with self-perception." Alex described mental health workshops" as "really, really… beneficial." These workshops can help you "[realize] what you can deal with and what you can't deal with." Alex stated that workshops are important because teachers sometimes "[do] not feel equipped to dive into that issue." Blaine, who has a low amount of teaching experience, had attended an "amazingly well-done" workshop which "talked specifically about suicide." Blaine stated that mental health workshops can teach you "proper interventions and services" and how "to do [them] effectively." Casey, who has a high amount of teaching experience, attended a mental health workshop which was "enlightening" about "those students who you might miss." Casey believed workshops are "extremely important." "It's got to be in your toolbelt that you can identify those kids," and it would be "very beneficial if we would expand [the toolbelt]." thought mental health workshops are "amazing," but the workshop "has to be effective." Drew attended a workshop that was "really great" where "law enforcement officials… come in and give some of the background on some of the cases they see and a lot of it is about this person had this happen to them in childhood, and it created this mental health issue." However, mental health workshops can become repetitious: "I'm just hearing the same thing that I've already been told."

Francis and Emerson, who both had a moderate amount of teaching experience, had less favorable experiences with mental health workshops. Francis, who has a low amount of teaching experience, stated, "I've never really been to a workshop that I feel was productive." Francis explained, "You have a kid. You try, try, try. It doesn't work. You go on to the next kid." Per Francis, workshops may need to be effectively marketed to teachers: "I think if you could get all the teachers to buy in, it'd be great." Emerson stated, "I think the only professional development or workshop that I've ever been to… [was] where we watched [a] movie." Emerson continued, "The movie itself was incredible. The application not so much." Emerson stated, "I think if

implemented correctly, that [mental health workshops] would be very effective." Emerson finished, "Sometimes I feel we go to professional developments that are kind of just thrown together last minute."

Discussion

This study examined teachers' perceptions of their role in the identification of mental health problems in students, how effective their school's system is at addressing mental health problems, and their suggestions for improvement. The researchers sought to acquire in-depth data on teachers' perceptions and beliefs. Teachers are often the first to identify adolescents with mental health problems because of their unique position in a classroom (Johnson et al., 2011), so their input into the process of mental health treatment is valuable and may inform other teachers, school administrators, student service staff, and researchers.

The first research question asked how teachers perceive their role in the identification of students' mental health problems. Participants frequently stated that they were often the first identifiers of mental health problems in students. Because of their position to view student behavior on a relatively normative scale (Headley & Campbell, 2011) and frequency of students trusting in and confiding in them (Fredriksen & Rhodes, 2004), teachers are in an ideal position to identify mental health problems. In this study, every participant discussed referring students to other professionals. However, participants with a low amount of experience discussed addressing the issues within their classrooms before making a referral. Several participants discussed the importance of building relationships with parents.

When a teacher observes a student with a mental health problem, the role of consultation is important in successfully addressing the mental health problem (Dowdy et al., 2015). Several participants described consulting with teachers on their team or counselors about the behavioral concerns of students within their class. Three participants disclosed receiving backlash from the students they referred because of the referral. It will be important for the teacher to build up the trust of the student again and develop a strong relationship with him or her to maintain desirable outcomes such as academic achievement (O'Connor & McCartney, 2007).

Participants reported being moderately prepared for dealing with students with mental health problems. Previous research found that teachers lacked confidence in dealing with mental health problems (Andrew et al., 2014). Two participants described how their preparatory programs did not adequately support training in mental health. Participants with higher levels of experience stated that teaching experience helped prepare them.

The second research question regarded the effectiveness of the mental health system. Most participants positively responded to their school's mental health system; however, participants who were less experienced tended to believe their school's mental health system was not sufficiently effective. There were no clear agreements among participants as to how to improve the mental health system, and no participants provided detail on improvements they would like to see happen. Teachers with more experience had the benefit of seeing changes to the system over time and how those changes affect students' mental health. Several participants discussed limitations to the mental health system. Blaine stated that a lot of resources are now devoted to a small number of students. Blaine considered it problematic if resources should be available for all students, yet not all students receive services.

The third research question focused on improvements to the mental health system. Participants stated they believe more training and resources would benefit the mental health

system in their school. Stigmas, time, and resources were barriers frequently discussed. Improvements teachers can make include removing social stigmas which create barriers for receiving services, holding students to high yet attainable standards, and taking mental health problems seriously. One participant stated that some teachers either do not care or do not know how to demonstrate care for students.

Teachers were asked about their experiences with mental health workshops. Their responses were mixed with several participants responding favorably and others unfavorably toward workshops. Alex described workshops where information related to bullying, suicide, self-harm, family issues, and self-perception was presented, and those workshops were helpful. Drew described a workshop where a law enforcement official described the childhood background on some cases involving adults having mental health problems. Several participants responded by saying mental health workshops were not productive or did not provide specific information on how to improve their interactions with students with mental health problems. These same participants remained somewhat optimistic by saying that they would attend workshops if they were effective and well-marketed to teachers. Several participants stated their time was valuable, so they would not attend a workshop unless it was worth their time. Nearly every participant stated that mental health workshops should be effective at helping them identify or refer students with mental health problems.

Recommendations

The information obtained in this study will help administrators, teachers, counselors, and other support staff, parents, and researchers understand general recommendations regarding schools' mental health systems. Teacher relationships with students are important, as students often look to teachers as role models (Fredriksen & Rhodes, 2004). Teachers should develop trust and demonstrate support for students who have mental health problems (Fredriksen & Rhodes, 2004). When teachers experience resistance because of a referral, teachers should be encouraged to continue to provide support to the student. High quality teacher-student relationships are associated with desirable outcomes (O'Connor & McCartney, 2007), so it will be important for teachers to regain the student's trust.

Three participants mentioned wanting a database or a chart for information on students' situations. However, sharing specific information in a counseling session may be considered an ethical and/or legal violation, and counselors can only disclose certain types of information in specific instances (ASCA, 2016). Counselors should provide ongoing consultation with teachers regarding referred students and provide teachers with appropriate classroom-based interventions if necessary. Counselors and other support staff should also communicate what they can and cannot share with teachers to manage teacher frustration.

Participants favorably described mental health workshops which included information about bullying, suicide, self-harm, family issues, and self-perception. The use of law enforcement also was effective at helping teachers understand how mental health problems affect individuals across their lifespan. Additionally, some participants frequently consulted with other teachers and support staff who provide additional perspectives on how to interact with a specific student. If teachers have difficulty finding time for individual students with mental health problems, it is recommended that teachers refer the student out.

Finally, counselors and other support staff may use the information obtained in this study to act as an agent of change. It is recommended to utilize best practices within the field of

counseling including family involvement and having a strong relationship with the student (Karver, Handelsman, Fields, & Bickman, 2005). Participants in this study wanted concise workshops that provide applicable information on what they should do. Participants were generally willing to attend workshops, and several participants mentioned willingness to attend workshops during the summer, weekends, or weeknights. However, not every participant stated willingness to attend workshops during these times, so workshops should be held with their potential participants in mind. Participants stated willingness to attend workshops for incentives including professional development credits, lunch, and pay.

Limitations

There are several limitations of this study. First, the study was limited to one geographical location with participants who volunteered without incentive. Participants who voluntarily participated in a study about mental health may have attracted teachers who already have certain views of the mental health system within their school and may not represent all perspectives within the school. Second, follow-up questions to participants' responses were not utilized and may have been beneficial to allow participants to fully elaborate on their perspectives. Third, the presence or lack of certain questions may have affected the results of the study.

Future Directions

There are several directions for researchers to acquire new and valuable information regarding topics discussed within this study. The same study could be conducted with more participants who work in different settings and with different populations. Acquiring more and varied perspectives on the mental health system within schools may provide more insight on how to successfully operate and improve the system.

No known study has identified effective mental health workshops for teachers. It is currently unknown which workshops, if any, have improved teachers' identification rate. The contents and applicability of such an efficacious workshop are presently unknown. To improve the mental health system, researchers will need to analyze the outcome effects of attending mental health workshops and determine which workshops are the most helpful.

References

Alisic, E. (2012). Teachers' perspectives on providing support to children after trauma. A qualitative study. *School Psychology Quarterly*, *27*(1), 51-59. doi:10.1037/a0028590

American School Counselor Association (ASCA). (2016). *ASCA ethical standards for school counselors*. Alexandria, VA: Author

Andrews, A., McCabe, M., & Wideman-Johnson, T. (2014). Mental health issues in the schools: Are educators prepared? *The Journal of Mental Health Training, 9*(4), 261-272. doi:10.1108/JMHTEP-11-2013-0034

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Council for Accreditation of Counseling and Related Educational Programs (CACREP). (2015). *2016 CACREP standards*. Alexandria, VA: CACREP.

Dowdy, E., Furlong, M., Raines, T. C., Bovery, B., Kauffman, B., Kamphaus, R. W., & Murdock, J. (2015). Enhancing school-based mental health services with a preventive and promotive approach to universal screening for complete mental health. *Journal of Educational and Psychological Consultation, 25*(2-3), 178-197. doi:10.1080/10474412.2014.929951

Erford, B. T. (2015). *Transforming the school counseling profession* (4th ed.). Upper Saddle River, NJ: Pearson Education, Inc.

Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., & Teich, J. (2005). *School mental health services in the United States, 2002-2003*. DHHS Publication Number (SMA) 05-4068. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Retrieved March 17, 2018, from https://eric.ed.gov/?id=ED499056

Fredriksen, K., & Rhodes, J. (2004). The role of teacher relationships in the lives of students. *New Directions for Youth Development, 103*, 45-54. doi:10.1002/yd.90

Guest, G., Namey, E. E., & Mitchell, M. L. (2013). *Collecting qualitative data: A field manual for applied research*. Thousand Oaks, CA: Sage Publications.

Hatch, T. (2014). *Hatching results: The use of data in school counseling*. Thousand Oaks, CA: Corwin.

Headley, C. J., & Campbell, M. A. (2011). Teachers' recognition and referral of anxiety disorders in primary school children. *Australian Journal of Educational and Developmental Psychology, 11*, 78-90.

Illinois State Board of Education (ISBE). (2018). *Illinois Interactive Report Card*. Retrieved March 22, 2019, from https://www.illinoisreportcard.com/

Johnson, B., & Christensen, L. (2006). *Educational research: Quantitative, qualitative, and mixed approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Johnson, C., Eva, A. L., Johnson, L., & Walker, B. (2011). Don't turn away: Empowering teachers to support students' mental health. *Clearing House: A Journal of Educational Strategies, Issues and Ideas, 84*(1), 9-14. doi:10.1080/00098655.2010.484441

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2005). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different

relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review, 26*(1), 50-65. doi:10.1016/j.cpr.2005.09.001

Lane, K. L., & Menzies, H. M. (2003). A school-wide intervention with primary and secondary levels of support for elementary students: Outcomes and considerations. *Education and Treatment of Children, 26*(4), 431-451.

Loades, M. E., & Mastroyannopoulou, K. (2010). Teachers' recognition of children's mental health problems. *Child & Adolescent Mental Health, 15*(3), 150-156. doi:10.1111/j.1475-3588.2009.00551.x

Merikangas, K. R., He, J., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., … & Olfson, M. (2011). Service utilization for lifetime mental disorders in U. S. Adolescents: Results of the National Comorbidity Survey–Adolescent Supplement (NCS-A). *Child & Adolescent Psychiatry, 50*(1), 32-45. doi:10.1016/j.jaac.2010.10.006

Moon, J., Williford, A., & Mendenhall, A. (2017). Educators' perceptions of youth mental health: Implications for training and the promotion of mental health services in schools. *Children and Youth Services Review, 73,* 384-391. doi:10.1016/j.childyouth.2017.01.006

Mychailyszyn, M. P., Beidas, R. S., Benjamin, C. L., Edmunds, J. M., Podell, J. L., Cohen, J. S., & Kendall, P. C. (2011). Assessing and treating child anxiety in schools. *Psychology in the Schools, 48*(3), 223-232. doi:10.1002/pits.20548

O'Connor, E., & McCartney, K. (2007). Examining teacher-child relationships and achievement as part of an ecological model of development. *American Education Research Journal, 44*(2), 340-369. doi:10.3102/0002831207302172

Papandrea, K., & Winefield, H. (2011). It's not just the squeaky wheels that need the oil: Examining teachers' views on the disparity between referral rates for students with internalizing versus externalizing problems. *School Mental Health, 3*(4), 222-235. doi:10.1007/s12310-011-9063-8

Roeser, R. W., & Midgley, C. (1997). Teachers' views of issues involving students' mental health. *Elementary School Journal, 98*(2), 115-133. doi:10.1086/461887

Scott, T. M., Bucalos, A., Liaupsin, C., Nelson, C. M., Jolivette, K., & DeShea, L. (2004). Using functional behavior assessment in general education settings: Making a case for effectiveness and efficiency. *Behavioral Disorders, 29*(2), 189-201. doi:10.1177/019874290402900207

Steinberg, L, & Morris, A. S. (2001). Adolescent development. *Journal of Cognitive Education and Psychology, 2*(1), 55-87. doi:10.1891/194589501787383444

Stephan, S. H., Sugai, G., Lever, N., & Connors, E. (2015). Strategies for integrating mental health into schools via a multitiered system of support. *Child and Adolescent Psychiatric Clinics of North American, 24*(2), 211-231. doi:10.1016/j.chc.2014.12.002

Authors' Notes: Dr. Heidi Larson is a professor in the Department of Counseling and Higher Education at Eastern Illinois University in Charleston, Illinois. Correspondence concerning this article should be addressed to her at halarson@eiu.edu. Nicholas Caldwell works as a guidance counselor at Shelbyville High School in Shelbyville, Illinois.

Adoptive Parents' Self-Ratings of Relational Experiences with Preadolescent Children in CPRT

Alyssa M. Swan
Counseling and Play Therapy Services

Abstract

The goal of this small descriptive investigation was to demonstrate the changes in adoptive parents' ratings of their self-identified goals, specific to their parent-child relationship, throughout participation in Child-Parent Relationship Therapy (CPRT). Eleven parents completed 10-week CPRT intervention and weekly ratings of self-identified goals. All parents reported improvement in self-ratings of relationship with their preadolescent children throughout CPRT. Results support previous CPRT literature that participation in CPRT enhances adoptive parents' experiences of their preadolescent-parent relationships.

Keywords: child-parent relationship therapy, attachment, self-identified goals, parenting

With over 40 outcome studies on its effectiveness, Child-Parent Relationship Therapy (CPRT; Landreth & Bratton, 2006, 2020) is an evidence-based mental health intervention (Ray & McCullough, 2015) for improving child behavior, parent-child relationship stress, and parental empathy. CPRT is a filial therapy model, based on the pioneering work of Bernard and Louis Guerney who developed filial therapy (Guerney, 1964) as a means of supporting parents to learn child-centered play therapy skills and to conduct play sessions with their children (Guerney & Guerney, 1989). In an effort to increase treatment adherence and research fidelity, Landreth & Bratton (2006) manualized filial therapy into a 10-week group format, known as child-parent relationship therapy (CPRT). The CPRT textbook and manual were revised and updated in 2020; the new editions include modified treatment protocols for adoptive families, toddlers, teachers/mentors, and preadolescents (Landreth & Bratton). A CPRT certification program was launched by University of North Texas Center for Play Therapy in 2017 to increase quality training opportunities in the CPRT filial therapy model as well as support its designation as an evidence-based intervention (Center for Play Therapy, 2020).

Based on attachment theory and play therapy intervention, CPRT focused on strengthening the child-parent relationship for parents to learn how to respond to their child's inner experiences and emotions in a new way. In CPRT, parents learn child-centered play therapy attitudes and skills, including relational responding, therapeutic limit setting, and choice giving, during 2-hour weekly parenting group sessions. Parents practice child-centered play therapy (CCPT; Landreth, 2012) skills during at-home video-recorded one-on-one times with their children. Select toys and creative materials are utilized during one-on-one times to allow children to express themselves to their parents through play. Parents share their video-recorded sessions during weekly CPRT groups and receive supervision, engage in peer discussion, and make personal observations of their relationship dynamics with their child (Landreth & Bratton, 2020). CPRT contains three main components: 1) CPRT therapists teach parents CCPT attitudes

and skills using the 10-session treatment protocol, 2) parents attend weekly CPRT group with other parents to engage in group process and discussion of relational dynamics with their children each week, and 3) parents facilitate at-home one-on-one times with their children (Landreth & Bratton, 2020; Center for Play Therapy, 2020), designated as special play times for young children and "me and you" time or "one-on-one" time with older children and preadolescents (Ceballos et al., 2020). The ultimate goal of CPRT is to strengthen the child-parent relationship, although CPRT researchers have demonstrated additional positive effects on child behavior, parental empathy, and child-parent relationship stress.

Attuning to parents' experiences within their child-parent relationships can be therapeutically beneficial (Doyle Buckwalter et al., 2018) in supporting parents to self-reflect and understand their personal experiences that impact their relational experiences. Leathers et al. (2019) demonstrated factors associated with difficult parenting experiences reported by foster parents, including behavior problems, low parenting support, and stress. These factors align with a CPRT qualitative exploration of adoptive parents' reasons for self-referring for CPRT services (Swan et al., in-review). Carnes-Holt & Bratton (2014) conducted a large randomized trial investigating the effects of CPRT with adoptive parents of young children. They reported large treatment effects and improvement in parental empathy, parenting stress, and child behavior, in favor of CPRT over a waitlist control group. Opiola & Bratton (2018) conducted a replication study, adding an active control group, and found similar results with large treatment effects in favor of CPRT as an effective intervention for adoptive parents of young children. Based on findings from these two studies, Ni Chobhthaigh and Duffy (2018) credited CPRT research as demonstrating positive outcomes and protections against threat of research bias due to randomization and treatment adherence measures. CPRT is an established intervention to improve overall functioning of children and strengthen child-parent relationships (Lin & Bratton, 2015).

Equipping adoptive parents with a support group, tools to respond to children's behavior, and opportunities to strengthen their child-parent relationship is an important avenue to increase placement permanency among these families. CPRT is a well-researched supportive post-adoption service option for these families. White (2016) cited placement stability as impacted by presenting concerns (i.e., child behavior, parenting issues), continued family support services post-adoption, and parent support groups post-adoption. Rolock and White (2016) reported results of a large-scale, long-term study of child welfare records in the State of Illinois, in which they examined the permanency rates of adoption placements among youth adopted out of foster care. They concluded that efforts to promote placement permanency should be targeted toward families of adopted adolescents due to increased risk of placement disruption for older children and for children who experienced a higher number of years in foster care. Parolini et al. (2018) reported a similar trend related to age that transitioning to adolescence was related to increased risk of placement disruption, specifically youth ages 13-17 years old compared to children under the age of six.

Swan, Bratton, Ceballos, & Laird (2019) conducted a small repeated measures pilot study to investigate effects of preadolescent-adapted CPRT, increasing the target age of children of focus and piloting the use of the preadolescent-adapted CPRT protocol (Ceballos et al., 2020). Like previous CPRT researchers (Carnes-Holt & Bratton, 2014; Opiola & Bratton, 2018), Swan et al. (2019) reported the use of standardized instruments to measure change in preadolescent behavior (Child-Behavior Checklist; Achenbach & Rescorla, 2001), parental empathy (Measurement of Empathy in Adult-Child Interactions; Stover et al., 1971), and child-parent

relationship stress (Parenting Stress Index; Abidin, 2012) over time. The current study will describe the use of weekly rating forms, an unstandardized data collection method, to investigate change over time for adoptive parents of preadolescents who participated in CPRT intervention. Only one other published CPRT study (Cornett & Bratton, 2014) utilized self-identified goals ratings to analyze change over time. Motivated by the goal of capturing unique family changes rather than measuring collective behavioral change across an aggregate group of parents, Cornett & Bratton (2014) conducted a well-designed study to investigate the therapeutic impact of CPRT using self-identified family goals to measure change. Experience in the family unit impacts youth's ability to regulate emotions and cope with stressors. For example, Shirtcliff et al. (2017) reported the predictive relationship between youth-perceived positive parenting during adolescence and their body's response system (i.e., cortisol functioning) six years later during young adulthood.

The goal of the current descriptive study was to investigate the changes in adoptive parents' ratings of their self-identified goals, specific to their parent-child relationship, throughout participation in Child-Parent Relationship Therapy (CPRT; Landreth & Bratton, 2006, 2020). The guiding research question for this study was: Do the eleven adoptive parents who participated in the study, report improved relational experiences with their preadolescent children throughout CPRT, as measured by weekly rating forms of individual self-identified goals?

Methods

Participants

Eleven parents participated in this study. Parents (45% female) ranged in ages from 25 to 64. All parents identified as adoptive parents of at least one preadolescent child, and all were married. All parents attended CPRT with their spouse/partner, with the exception of one parent whose partner was unable to attend. In regard to race and ethnicity, participants identified as European American (n = 6), Asian American (n = 2), Black American (n = 1), Latino American (n = 1), and Biracial (n = 1). At the time of study, four parents had one child, one parent had three children, two parents had four children, two parents had six children, and two parents had nine children total.

For the clinical purpose of CPRT, parents identified a preadolescent child of focus for intervention and weekly ratings. Pseudonyms are used throughout manuscript to maintain participant confidentiality and allow for description of individual parents' experiences. See Table 1 for matched demographics of parent participants and their preadolescent children of focus.

Table 1. *Demographic Information*

Family	**Parents**			**Preadolescent Children of Focus**			
	Pseudonym	**Age**	**Gender**	**Pseudonym**	**Age**	**Gender**	**Age at Adoption**
1	Karen	53	Female	Anthony	12	Male	11
	Jacob	52	Male	Gabby	8	Female	7
2	Craig	55	Male	Alex	9	Male	1
	Henry	48	Male	Rachel	9	Female	2

3	Pamela	66	Female	Thomas	12	Male	1.5
4	Joyce	56	Female	Luke	9	Male	8
	William	60	Male	Katie	12	Female	9
5	Lena	29	Female	Jared	14	Male	11
	Aaron	29	Male				
6	Christine	59	Female	Elena	8	Female	2
	Ronald	60	Male	Anthony	12	Male	11

Procedure

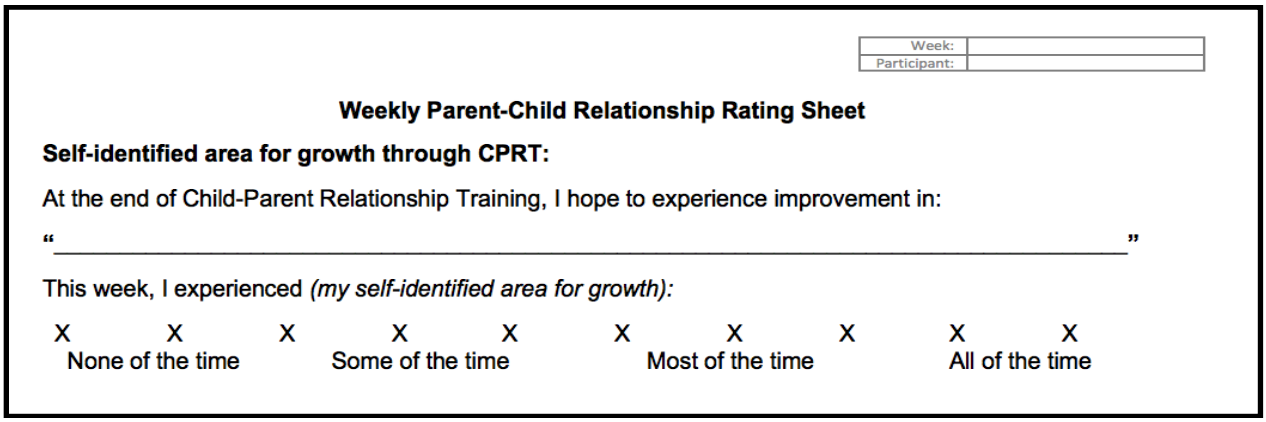
Upon approval from the Institutional Review Board, flyers were distributed to advertise Child-Parent Relationship Therapy (CPRT) groups for adoptive parents of preadolescents aged 8 to 14 years old. Flyers were distributed at local counseling clinics/providers, adoption support groups, and churches to recruit participants for CPRT groups. Eighteen parents were recruited and consented to participate in this study. Seven parents were excluded from data analysis due to withdrawal from CPRT intervention or incomplete data. Eleven parents included in data analysis received CPRT intervention. CPRT groups were facilitated by two doctoral level counselors, both who received advanced training and instruction in play therapy and filial therapy/CPRT and supervision from an expert in Child-Parent Relationship Therapy.

CPRT intervention included parents attending 10 two-hour weekly group sessions (combined components of weekly group sessions: group counseling, learning play therapy attitudes and skills, and live-supervision) and 7 thirty-minute at-home one-on-one times with their preadolescent child using a special activity kit of materials and toys. Activity kits and childcare during CPRT groups were provided. CPRT groups were free of cost. Inclusion criteria for study were: parents were 18+ years of age; parents identified as an adoptive or foster-to-adopt parent of a preadolescent child between the ages of 8 to 14 years old; parents consented to participate in study; parents received and completed CPRT intervention; and parents completed a minimum of 7 weekly rating forms throughout CPRT intervention. Parents received 10 week CPRT intervention (Landreth & Bratton, 2006), including participation in ten 2-hour weekly parent group sessions and conducting 7 at-home one-on-one special times with their preadolescent children. CPRT sessions were conducted using the preadolescent CPRT protocol (Landreth & Bratton, 2006, 2020; Ceballos et al., 2020).

Data Collection and Analysis

Eleven parents completed individualized weekly rating forms (see Figure 1), beginning at intake and after selection of a *self-identified goal:* an area of focus which parents wish to improve in relationship with their child during CPRT intervention. Prior to each weekly CPRT group session, parents rated observation of their self-identified goals on a 10-point Likert scale ranging from "none of the time" to "all of the time." The weekly rating forms were not standardized and were used primarily as a clinical tool to track individual parent goals throughout CPRT intervention. Rating forms helped to quantify individual parents' goals and observations in relationship with their children during CPRT. Rating forms were collected by group leaders and entered into a research database on a weekly basis. During the last session of CPRT, parents discussed how their self-identified goal ratings changed throughout CPRT

intervention. Due to the nature of self-identified goals being unique to each parent-child dyad and the lack of standardization of the weekly rating forms in this study, parents' scores were compared within-subject using descriptive data only; no between subjects' differences were calculated. Individual score changes in self-identified goal ratings are reported and described below for each parent-child dyad.



Week:
Participant:

Weekly Parent-Child Relationship Rating Sheet

Self-identified area for growth through CPRT:

At the end of Child-Parent Relationship Training, I hope to experience improvement in:

"_____"

This week, I experienced *(my self-identified area for growth):*

X X X X X X X X X X

None of the time | Some of the time | Most of the time | All of the time

Figure 1. *Example of an initial weekly rating form*

Results

All parents reported improvements in self-identified relational goals following Child-Parent Relationship Therapy (CPRT) intervention, indicating perceived enhancement in relationship with their preadolescent child-of-focus. Karen's self-identified goal was "to experience a more positive relationship" with her son, Anthony. Karen completed a total of ten weekly ratings with a rating of 4 at pretest and 7 at posttest. In the last four weeks of CPRT, Karen rated a consistent 7 for her weekly self-identified goal, indicating stability in her experiencing a more positive relationship with Anthony "most of the time" by the end of CPRT. Jacob's self-identified goal was "to increase communication and honesty" in relating with his daughter, Gabby. Jacob completed a total of ten weekly ratings with a rating of 4 at pretest and 7 at posttest and a mode rating of 6 throughout CPRT.

Craig's self-identified goal was "to understand what motivates Alex." Craig completed a total of eleven weekly ratings with a rating of 3 at pretest and 9 at posttest. In the last five weeks of CPRT, Craig rated a consistent 9 for his weekly self-identified goal, indicating stability of his self-reported improvement in understanding what motivates his son's behaviors by the end of CPRT. Henry's self-identified goal was "to get along better and have more positive interactions" with his daughter, Rachel. Henry completed a total of eleven weekly ratings with a rating of 3 at pretest and 6 at posttest and a mode rating of 6 throughout CPRT.

Pamela created two separate self-identified goals to rate each week: 1) "to have more positive communication with Thomas" and 2) "more hugs" between herself and Thomas. Pamela completed a total of seven weekly ratings for each goal throughout CPRT. Pamela rated her first goal with a 4 at pretest and 9 at posttest. Pamela rated her second goal with a 4 at pretest and 10 at posttest ("all the time"). Pamela's ratings from pretest to posttest indicate Pamela's perception of experiencing more positive communication and increased physical affection in the parent-child relationship by the end of CPRT. During the last CPRT session, Pamela offered a

subjective verbal self-report related to her surprise of her preadolescent son's increased desire to seek her out for hugs and emotional affection.

Joyce's self-identified goal was "to feel more securely attached" to her son, Luke. Joyce completed a total of ten weekly ratings with a rating of 3 at pretest and 7 at posttest, indicating Joyce's perception of feeling securely attached to Luke "most of the time" by the end of CPRT. William's self-identified goal was "to have more meaningful conversations" with his daughter, Katie. William completed a total of eight weekly ratings with a rating of 2 at pretest to 6 at posttest.

Lena's self-identified goal was "to experience Jared feeling safer and more secure in the family." Lena completed a total of ten weekly ratings with a rating of 3 at pretest and 6 at posttest and modes of 5 and 7 comprising six of the ten ratings. Aaron's self-identified goal was "to perceive Jared as a good steward." Aaron completed a total of nine weekly ratings with a rating of 2 at pretest and 7 at posttest, indicating a self-reported change in Aaron perceiving his son as a good steward "most of the time" by the end of CPRT.

Christine's self-identified goal was "to increase her ability to communicate and be in relationship" with her daughter, Elena. Christine completed a total of nine weekly ratings with a rating of 3 at pretest and 7 at posttest. By week 3 of CPRT, Christine consistently rated her goal at a 7, "most of the time," for her remaining six ratings until the end of CPRT. Ronald's self-identified goal was "to experience improvement in handling Elena's behaviors." Ronald completed a total of nine weekly ratings with a rating of 4 at pretest and 7 at posttest and a mode rating of 7 throughout CPRT.

Discussion

Consistent with child-centered play therapy principles taught to parents in Child-Parent Relationship Therapy (CPRT; Landreth & Bratton, 2006), parents created individual goals in relationship with their preadolescent children. CPRT is a humanistic counseling approach to working with parents and children. This individualized approach to goal-setting allowed parents to attune and respond to their children's unique relational and emotional needs. Each parent-child dyad, although a homogenous group of adoptive parents with similar presenting concerns, presented with a range of different adoption experiences and pre-adoptive relational and trauma histories.

Prior to each of the ten weekly 2-hour CPRT group sessions, each parent completed a weekly rating form tailored to assess their unique self-identified goals. Parents' self-identified goals in relationship with their children focused on improvement in the following areas: parent-child communication (n = 4), relational security/attachment (n = 4), parent perception of child (n = 2), empathic response to child behaviors (n =1), healthy parent-child physical affection (n =1). One parent created 2 goals and rated both on a weekly basis. All parents reported improvement in pretest to posttest ratings of their self-identified relational goals, indicating that the 11 adoptive parents in this study indicated improvement in relationship with their preadolescent children during CPRT intervention.

Weekly rating forms (basic example presented in Figure 1), can be utilized as a clinical tool for counselors to acknowledge and encourage parent's awareness of relational moments in their child-parent relationship. In this study, weekly rating forms provided an opportunity for parents to attune to their preadolescents' experience at least once a week to complete their assessment. Parents in this study appeared to utilize weekly ratings as an opportunity to engage

in discussion with other parents to process new awareness and observations of their preadolescent children. Self-identified goals and rating forms served as quick, weekly "check-in" to encourage intentional reflection, focusing on just one component of the parent-child relationship rather than desiring to change all parts of the relationship at once.

For example, after completing her weekly rating form one week, Pamela, whose weekly relational goal was to increase "hugs" with her preadolescent son, tearfully and honestly described her 12-year desire to feel attached to her son, since his adoption. When she initially set her weekly goal, she described that it was her son who did not desire to hug her. Through weekly reflection and group process, Pamela became aware of her own hesitancy and fear in emotionally attaching to her son related to past placement disruptions. Through processing her emotions in group after completing her rating form each week, her new awareness freed Pamela to view her son in a new way and assume a greater sense of agency in initiating physical affection with her son. As reflected in her self-identified scores, by the end of CPRT, Pamela rated physical affection with her son as happening "all the time." Pamela did not just gain physical affection with her son; Pamela gained acceptance of her son and awareness of the role she played in the emotional distance once experienced in their relationship.

With a firm foundation of clinical practice and research investigations demonstrating its effectiveness (Bratton et al., 2015), CPRT is established as an evidence-based and attachment-focused humanistic counseling approach for parents and children. CPRT has been successfully adapted for parents of preadolescents. The University of North Texas Center for Play Therapy offers a new Child-Parent Relationship Therapy certification program, during which clinicians are trained and supervised in CPRT protocol and application (Center for Play Therapy, 2020).

Limitations and Future Research

To increase rigor in this study, more frequent ratings of self-identified goals (e.g., daily or multiple times per day) can improve the reliability of these results and allow for quantitative statistical analysis rather than reliance on descriptive data. For example, Cornett & Bratton (2014) conducted an outcome study utilizing self-report data to investigate effects of CPRT on family functioning. Future researchers can conduct follow-up interviews post-intervention to provide qualitative validation of weekly ratings results. Additional studies (e.g., Carnes, Holt & Bratton, 2014; Opiola & Bratton, 2018) utilized standardized instruments to investigate the effects of CPRT intervention on relational healing among adoptive families. However, the goal of this study was not to determine the effect of CPRT, rather to demonstrate the influence of CPRT on individual parents' relational goals, specifically targeting awareness of changes in their parent-child relationships. Small sample size and one geographic location of study threaten generalizability of results. For this research with a small sample size and unstandardized instrumentation, we presented data as reported by parents in written form and numeric ratings, using descriptive statistics of individual score changes within subjects to avoid exaggerating findings.

Conclusion

Findings from this small descriptive study indicate improvement in individual self-identified goals of parents of preadolescents who participated in CPRT intervention. This investigation contributes to CPRT literature by illustrating descriptive accounts of parents' goals

and experiences in CPRT through the creation of and weekly ratings of self-identified goals as a therapeutic tool in CPRT intervention. According to self-identified goal weekly ratings, all parents in this study reported improvement in relationship with their preadolescent children throughout CPRT. This descriptive study attempts to honor the individuality of parents' relational goals in CPRT as well as promote CPRT as a viable and recommended treatment option of parents of preadolescents.

References

Abidin, R. R. (2012). *Parenting stress index* (4th ed.). Lutz, FL: PAR.

Achenbach, T.M., & Rescorla, L.A. (2001). Manual for the ASEBA School-Age Forms & Profiles. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Bratton, S., Dafoe, E., Swan, A., Opiola, K., McClintock, D., & Barcenas, G. (2017). *Play Therapy Outcome Research Database.* Evidence-based Child Therapy. Retrieved from: http://evidencebasedchildtherapy.com/research/

Carnes-Holt, K., & Bratton, S. C. (2014). The efficacy of child parent relationship therapy for adopted children with attachment disruptions. *Journal of Counseling and Development, 92*(3), 328-337. doi: 10.1002/j.1556-6676.2014.00160.x

Ceballos, P., Carnes-Holt, K., & Meany-Walen, K. (2020). CPRT Preadolescent Model. In Landreth, G. & Bratton, S. C. (Eds.). *Child Parent Relationship Therapy* (2nd ed.). New York, NY: Routledge.

Center for Play Therapy. (2020, June). *Child-Parent Relationship Therapy Certification Training*. https://cpt.unt.edu/child-parent-relationship-therapy-certification

Cornett, N., & Bratton, S. C. (2014). Examining the impact of child parent relationship therapy (CPRT) on family functioning. *Journal of Marital and Family Therapy, 40*(3), 302-318.

Doyle Buckwalter, K., Reed, D., & Mercer, D. (2018). Ghosts in the adoption: Uncovering parents' attachment and coping history. *Families in Society: The Journal of Contemporary Social Services, 98*(3), 225-234.

Guerney, B., Jr. (1964). Filial therapy: Description and rationale. *Journal of Consulting Psychology, 28*(4), 304–310. https://doi.org/10.1037/h0041340

Guerney, L., & Guerney, B. (1989). Child Relationship Enhancement: Family therapy and parent education. *Person-Centered Review, 4*(3), 344–357.

Landreth, G. L., & Bratton, S. C. (2006). *Child parent relationship therapy (CPRT): A ten session filial therapy model.* New York, NY: Routledge.

Landreth, G. L., & Bratton, S. C. (2020). *Child parent relationship therapy (CPRT): A ten session filial therapy model* (2nd ed.). New York, NY: Routledge.

Leathers, S. J., Spielfogel, J. E., Geiger, J., Barnett, J., & Vande Voort, B. L. (2019). Placement disruption in foster care: Children's behavior, foster parent support, and parenting experiences. *Child Abuse and Neglect,* 147-159.

Ni Chobhthaigh, S., & Duffy, F. (2018). The effectiveness of psychological interventions with adoptive parents on adopted children and adolescents' outcomes: A systematic review. *Clinical Child Psychology and Psychiatry,24*(1), 69-94.

Opiola, K., & Bratton, S. (2018). The efficacy of Child Parent Relationship Therapy for adoptive families: A replication study. *Journal of Counseling and Development, 96*(2), 155-166.

Parolini, A., Shlonsky, A., Magruder, J., Eastman, A. L., Wulczyn, F., & Webster, D. (2018). Age and other risk factors related to reentry to care from kin guardian homes. *Child Abuse and Neglect, 79,* 315-324.

Ray, D. C, & McCullough, R. (2015; revised 2016). Evidence-based practice statement: Play therapy (Research report). Retrieved from Association for Play Therapy website: http://www.a4pt.org/?page=EvidenceBased

Rolock, N., & White, K. R. (2016). Post-permanency discontinuity: A longitudinal examination of outcomes of foster youth after adoption or guardianship. *Children and Youth Services Review, 70*, 419-427.

Shirtcliff, E. A., Skinner, M. L., Obasi, E. M., & Haggerty, K. P. (2017). Positive parenting predicts cortisol functioning six years later in young adulthood. *Developmental Science, 20*(6).

Stover, L., Guerney, B., & O'Connell, M. (1971). Measurements of acceptance, allowing self-direction, involvement, and empathy in adult-child interaction. *Journal of Psychology, 77,* 261-269.

Swan, A., Bratton, S. C., Ceballos, P., & Laird, A. (2019). Effect of CPRT with Adoptive Parents of Preadolescents: A Pilot Study. *International Journal of Play Therapy, 28*(2), 107-122.

Swan, A., Bratton, S. C., Walker, K., Hughes, L., & Frawley, C. (in-review). What experiences prompted adoptive parents of preadolescents to self-refer for child-parent relationship therapy? *International Journal of Play Therapy.*

White. K. R. (2016). Placement discontinuity for older children and adolescents who exit foster care through adoption or guardianship: A systematic review. *Child and Adolescent Social Work Journal, 33,* 377-394.

Author's Note: Alyssa M. Swan, Counseling and Play Therapy Services, Bloomington, IL. Correspondence concerning this article should be addressed to Alyssa Swan, 1701 E. Empire St., Suite 360-30, Bloomington, IL (email: alymswan2@gmail.com).

Discrimination Model of Supervision: Adapted for LGBTGEQIAP+ Work

Sandra Gavin
Northern Illinois University

Abstract

Effective clinical supervision should promote the development of a supervisee's multicultural competencies (Bernard & Goodyear, 2019). Embedding LGBTGEQIAP+ competence throughout counselor training programs is insufficient because counselor educators frequently lack skills and knowledge to train counselors to be LGBTGEQIAP+ competent (Gess & Doughty Horn, 2018), and this gap needs to be addressed in supervision. More effective LGBTGEQIAP+ affirmative practices in counseling is essential since professional and ethical guidelines set by the American Counseling Association (ACA) requires LGBTGEQIAP+ competence to be infused in counselor education programs (Ginicola, Welfare, & Filmore, 2017). Further, development of counseling and supervision models designed to more effective promote those who have traditionally lacked a voice (Goodrich & Luke, 2011).The focus of this article highlights how to use Bernard's (1979) discrimination model that builds self-efficacy and competency of new counselors working with LGBTGEQIAP+ clients.

In recent decades, multicultural and social justice movements have enabled the development of counselor competency in a way that more effectively meets the needs of individuals and groups at large (Smith & Shin, 2008). Supervision offers a unique opportunity for counselors to grow and develop their clinical knowledge, awareness, and skills (Bidell, 2005; Goodrich & Luke, 2011). Inadequate preparation in counseling training programs has resulted in counselors and supervisors feeling unprepared or underprepared to meet the needs of lesbian, gay, bisexual, transgender and two-spirit, gender expansive, queer and questioning, intersex, agender, asexual, aromantic, pansexual, polygender, and all other sexual and gender identities *LGBTGEQIAP+* clients (Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2019); Case, Stewart, & Tittsworh, 2009). This gap within the training of counselors and supervisors may underserve this population because supervisors have failed to acquire the knowledge, awareness, and skills to assist their supervisees (Green et al., 2009; Messinger, 2007). Green and associates explored comfort levels of counseling practitioners working with LGBTGEQIAP+ clients. Participants identified having minimal training in their graduate programs and (46%) lacked addressing LGBTGEQIAP+ issues in clinical supervision (Green, Murphy, Blumer, & Palmanteer, 2009).

The Discrimination Model (DM) does not focus on LGBTGEQIAP+ persons and supervisors determine how to apply the model to help supervisees develop multicultural competencies; however, the current trend using this model lacks intentionality and does not effectively address the needs of this population (Goodrich & Luke, 2011). Currently there is limited research using the DM with new counselors working with LGBTGEQIAP+ clients. This article adapted Bernard's (1979) DM with more intentionality to improve counselor multicultural competencies to meet the needs of LGBTGEQIAP+ persons. This model is utilized over other

models of supervision since the DM is still one of the most widely use models of supervision (Bernard & Goodyear, 2019).

In an effort to be inclusive, another important term is gender non-conforming, which is defined as an individual who does not match the traditional norms of behaving and expressing masculinity or femininity which is set by society (Gess & Doughty Horn, 2018). Gender non-conforming describes a wide range of persons with non-traditional gender identities, and it is important to recognize this population faces unique challenges that differ from LGB (Farmer, Welfare, & Burge, 2013). Working with gender non-conforming clients in session is different than working with cisgender (a person whose gender aligns with their biological sex) individuals (Farmer et al., 2013). *New counselors* are defined as counselors who recently completed their counseling graduate school training. Previous research has demonstrated new counselors may self-perceive as unprepared and may question their own competency to work with LGBTGEQIAP+ (Graham, Carney, & Kluck, 2012). The first section of this paper examines new counselors' hesitations working with this population and its implications.

New Counselors Working with LGBTGEQIAP+ Clients

There has been a recent shift for counselors toward more affirmative and supportive practices when working with the LGBTGEQIAP+ population in the counseling profession (ALGBTIC, 2012; American Counseling Association [ACA], 2014; Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2013). Ethical guidelines strongly recommend that counselors be multiculturally competent and suggest that counselors have an ability to recognize diversity and embrace multicultural approaches that support individual client needs (ACA, 2014). Counselor education programs are not required to have separate LGBTGEQIAP+ courses. Most programs infuse this training and education however the program views appropriate. The lack of specific coursework focusing on LGBTGEQIAP+ client populations is one contributing factor to why graduate school training programs have not sufficiently prepared new counselors to work with LGBTGEQIAP+ clients. Green et al. (2009) surveyed counselors and stated only 65% of counselors reported learning about diverse sexual orientations and gender identities during their graduate school training. Largely, LGBTGEQIAP+ issues remain an under researched area of focus in counselor education (Dickey & Loewy, 2010) resulting in counselors experiencing low self-efficacy and reduced feelings of competencies in working with this client population (Case et al., 2009).

Counselors should be able to use counseling interventions which are affirmative and intended to build feelings of empowerment and positive identity development for LGBTGEQIAP+ clients (Ginicola et al., 2017). A more recent study found counselors have affirming attitudes toward the LGBTGEQIAP+ population, but they feel unequipped to work with LGBTGEQIAP+ clients in session (Farmer et al., 2013). Thus, accidental harm may occur when counselors are working with these clients due to limited training and inclusive experiences that are not present within counselor education programs (Goodrich & Luke, 2011). For example, Bryan (2018) indicated a reluctance of licensed counselors to counsel LGBTGEQIAP+ clients and this reluctance is shown through microaggressions within sessions. Microaggressions are verbal, nonverbal, slights or insults, that may intentionally or unintentionally communicate messages to target individuals based upon their identity (Bryan, 2018; Gess & Doughty Horn, 2018). Because microaggressions are often subtle and difficult to identify, it may be difficult for counselors working with LGBTGEQIAP+ clients to articulate if they are encountering biases or

prejudice. It is important to note the most recent ACA code of ethics prohibits counselors from refusing service to LGBTGEQIAP+ clients and referring out on the basis that they have inadequate skills without trying to seek training can negatively affect client access to counselors (ACA, 2014, Ginicola et al., 2017).

Research has shown community-based counselors display greater self-efficacy when working with LGBTGEQIAP+ clients compared to school counselors (Farmer et al., 2013). This might imply that LGBTGEQIAP+ youth are more likely underserved within school settings. To that end, LGBTGEQIAP+ adults generally seek counseling at higher rates compared to their heterosexual counterparts (Liddle, 1997). Numerous LGBTGEQIAP+ clients report dissatisfaction with their counseling experience (Finnerty, Kocet, Lutes, & Yates, 2017). Clinical supervision of new counselors is crucial because of the increased need for LGBTGEQIAP+ counseling, counselor's low self-efficacy, and poor counselor education program training to prepare counselors for LGBTGEQIAP+ work. The DM of Supervision could be an effective model that facilitates growth within supervisors and supervisees working to improve multicultural competencies, especially with LGBTGEQIAP+ clients.

Discrimination Model of Supervision

Clinical supervision is defined as the interaction between supervisor and supervisee that promotes development of the supervisee's clinical skills and assures that the skills are applied for the benefit of the client (Troomski-Klingshirn & Davis, 2007). Clinical supervision is effective in developing supervisee competence, and supervisors need to supervise with a guiding pedagogy to better understand counselor development and to ground their supervisory practices (Bernard & Goodyear, 2019). Generally, DM is a situation specific model that concentrates on three foci for supervision and three supervisor roles that can be utilized to assist with supervisee's growth. DM provides a focus on educational and relationship elements in clinical supervision (Bernard & Goodyear, 2019; Timm, 2015). Generally, the DM involves a dual role of assessing their supervisee's skills and choosing a supervisor role to address the supervisee's needs or goals (Crunk & Barden, 2017). Supervisors assess supervisee's skills or, foci, through: intervention (supervisee's observable interactions with clients), conceptualization (ability to conceptualize the issues), and or personalization (process of implementing a style of counseling) to determine needed growth (Bernard, 1979; Bryne & Sias, 2010; Crunk & Barden, 2017).

Once supervisors gauge an understanding of their supervisee's skill level within each foci area, the supervisor utilizing DM will assume one of three roles to address the need or goal: teacher (when structure and instruction is needed), counselor (when the supervisor wishes to enhance reflectivity or process supervisee's internal experiences), or consultant (when the supervisor wants the supervisee to trust their own insights, feelings about their work, and to act independently). Supervisors should consider all (i.e. 3 roles X 3 foci) choices before attending to the specific situation across and within sessions (Bernard & Goodyear, 2019). Thus, it is vital for supervisors to remain aware of the supervisee's needs in order to attend to his or her most pressing focus area and adopt the most appropriate supervisor role to address this need (Bryne & Sias, 2010; Crunk & Barden, 2017).

The DM is one of the most sought-after models of supervision utilized due to its nature of being a training model that is geared to meet the needs of the supervisee (Timm, 2015) and its efficacy is supported by considerable evidence (Bernard, 1997; Bernard & Goodyear, 2019; Luke, Ellis, & Bernard, 2011). DM is widely used as it fosters natural avenues to the supervisor

relationship and incorporates change-inducing roles that influences the relationship (Timm, 2015). Numerous studies have generally supported the model (Lazovsky & Shimoni, 2007; Luke et al., 2011). The DM can easily be adapted to better serve LGBTGEQIAP+ clients and new counselors, because it is empirically validated and provides an approach to conceptualize and implement interventions that benefit LGBTGEQIAP+ client needs (Goodrich & Luke, 2011). The focus of the following section is to highlight how to use DM in a way that builds self-efficacy and competency of new counselors to work with LGBTGEQIAP+ clients. It specifically applies Bernard's (1979) DM to new counselors working with this population and how supervisors can generally implement these strategies.

LGBTGEQIAP+ Adapted Discrimination Model of Supervision

LGBTGEQIAP+ Adapted Discrimination Model of Supervision was first designed to address LGBTGEQIAP+ concerns and needs, as well as the likelihood that practicing supervisors may not be prepared to identify or address these needs when appropriate (Messinger, 2007). The recommended adjustments to the DM model are not meant to completely change it, but to apply DM with more intentional multicultural competencies with supervisory work for LGBTGEQIAP+ clients. Because there is currently little to no adapted DM models to work with LGBTGEQIAP+ clients, besides one in group work by Goodrich and Luke (2011), this provides a rationale for utilizing the existing DM and modifying its use with LGBTGEQIAP+ populations. Goodrich and Luke (2011) adapted the DM to work with these populations and to meet the needs of group work. However, their model does not focus on the needs of supervisees at an individual level which may prevent practicing supervisors from utilization, hence the need for the present model.

Not having an effective supervisory framework for training new counselors to work with this client population negatively impacts services and quality of treatment provided to LGBTGEQIAP+ clients (Gess & Doughty Horn, 2018). Given the high volume of supervisors that use the DM, this new adapted model could be integrated into practicing supervisor's current approach to meet the needs of LGBTGEQIAP+ clients. Without this adapted model, supervisors may struggle to identify and address this population's needs and/or issues with their supervisees preventing supervisees from expanding upon their own knowledge, skills, and awareness, to provide quality services (Crunk & Barden, 2017; Gess & Doughty Horn, 2018). Overall, practicing supervisors will likely find LGBTGEQIAP+ Adapted Discrimination Model of Supervision to be intuitive and easy to incorporate into their current DM model because of its alignment with using multicultural competencies within the framework.

Like Bernard's (1979) DM, the LGBTGEQIAP+ Adapted Discrimination Model of Supervision, intentionally focuses on assessing supervisee's skills, choosing a supervisor role to address this need, and maintaining flexibility throughout clinical supervision are still relevant and essential when utilizing this adapted model. Bernard's foci area (i.e. intervention, conceptualization, and personalization) are replaced with multicultural counseling competencies to provide a more comprehensive focus on LGBTGEQIAP+ issues. Supervisors assess supervisee's skills or, foci, through: knowledge (supervisee's level of knowledge about their own worldviews, the cultural group he or she is working with, and understanding of macrolevel influences), skills (specific techniques and interventions needed when working with a specific group), and or awareness (supervisee's attitudes and beliefs, self-monitoring of biases and stereotypes, and a development of a positive mindset toward multiculturalism) to determine

needed growth in multicultural competencies (Bernard, 1979; Goodrich & Luke, 2011; Sue, Arredondo, & McDavis, 1992).

The LGBTGEQIAP+ Adapted Discrimination Model of Supervision specifically addresses the needs of LGBTGEQIAP+ clients, supervisors, and new counselors. Conceptualization is replaced with knowledge as both require supervisors to gain additional information about gender identity, gender expression, affectional, or sexual orientation of supervisee's clients. Intervention is replaced with skills since it speaks to unique worries and issues of LGBTGEQIAP+ individuals and helps the counselor navigate how to process these needs. Lastly, personalization is replaced with awareness as both involves the supervisor challenging their supervisees to reflect on personal experiences, assumptions, and prejudice that may impact their work with this population. This self-exploration process enhances connection with supervisee's internal self, their client, and the clinical supervision relationship (Goodrich & Luke, 2011). In the next section, the case of April is discussed, integrating tenets of the LGBTGEQIAP+ Adapted Discrimination Model of Supervision.

Case Illustration

April is a newly graduated master's student in clinical mental health counseling and she recently accepted starting working at a small private practice as a licensed professional counselor. April demonstrates competency across many clinical and professional domains. However, as a new counselor, she is currently struggling with a new client that identifies as transgender. Her supervisor has noticed that April tends to reflect client feelings well but is unable to deepen the conversation about the client's issues with their career. April seems to validate the client; yet, the conversation usually changes after a few minutes. This had led to April feeling stuck and unsure what to do with her client. Using the LGBTGEQIAP+ Adapted Discrimination Model of Supervision, her supervisor might follow the below strategies in supervision with April. The next segment applies the primary tenants to April's case. There are multiple avenues that can be applied within each clinical supervision session or across sessions.

Application Steps

First, supervisors should assess and choose an entry point needed to improve supervisee's LGBTGEQIAP+ competency of knowledge, skills, and or awareness. Next, the supervisor will decide which supervisor role would be most appropriate for delivery (i.e. teacher, counselor, or consultant). Third, the supervisor implements the intervention and monitors supervisee development.

Step 1: Pick Multicultural Competency Focus Area

The supervisor, along with the supervisee, must first choose which area of focus April needs development in for this specific situation (i.e. knowledge, awareness, and or skills). April may need to gain more LGBTGEQIAP+ multicultural competencies in more than one area; however, the supervisor should assess which one is most appropriate. Knowledge is one avenue where the supervisee may need to research and familiarize with the unique issues and developmental challenges common with someone who defines as transgender (i.e. work concerns, identity development). April may have a lack of knowledge about relevant historical

contexts, societal expectations or stigmas, or an understanding of LGBTGEQIAP+ identity development process.

Another point of entry could be enhancing supervisee awareness. April may be unaware of her own core beliefs and biases, unaware about how her worldviews impact the counseling relationship, and struggling with awareness and ability to identify her client's worldview (Goodrich & Luke, 2011). The goal of building personal and other awareness should encourage more LGBTGEQIAP+ affirmative counseling practices because the supervisee is honoring diversity and embracing a multicultural approach (ACA, 2014). Improved self and other awareness will build a strengthened foundation within the therapeutic relationship (Bernard & Goodyear, 2019). April may validate her client; however, she may struggle with personal awareness or her being empathetic towards her client's worldview during session.

The last option the supervisor has involves improving skill development. Just being self-aware and knowledgeable is not enough, a counselor must effectively use skills in a way that demonstrates understanding and validation of the LGBTGEQIAP+ individual's identity, culture, and their client's unique characteristics. Some examples April could use, but not limited to, are: April's ability to address differences in identities between the counselor and client, ability to give the client space to explore their diverse intersectional identities and how this relates to their career concerns, and the ability to help her LGBTGEQIAP+ client process their thoughts, feelings, and lived experiences within the counseling relationship (Ginicola et al., 2017; Goodrich & Luke, 2011). Although it is possible that there is more than one acceptable approach and area to focus on (Bernard, 1979: Bernard & Goodyear, 2019), April would benefit from enhancing her knowledge as an intervention. Next the supervisor chooses which role to facilitate this.

Step 2: Choose a Facilitation Role for Desired Intervention

Now the supervisor decides how to facilitate this intervention via teacher, counselor, or consultant. The first option/role, teacher, involves the supervisor taking an active role and requires direct instruction. Without that knowledge the supervisee would not be as effective (Bernard & Goodyear, 2019). The supervisor and supervisee could process new material or knowledge about societal expectations, various identities, up-to-date terminology, and other information to better inform the supervisee about the LGBTGEQIAP+ communities. One study demonstrated that psychoeducation and interactive interventions within clinical supervision can improve supervisee's multicultural competency. For instance, if April developed a stronger knowledge base about common career issues transgender clients may face and discussing how to approach this topic, would benefit all involved. Another important element to consider is psychoeducation being a vital component in preventing legal or ethical concerns that could potentially harm a client if not processed in supervision (Aruthur & Achenback, 2002).

The second role the supervisor could choose is counselor. Facilitation through a counselor role can assist with improving supervisee skills, knowledge, and or awareness. The supervisor using this role could enhance self-monitoring and self-awareness of their supervisee's which may not be in the forefront of the supervisee's awareness but can be brought to their attention (Goodrich & Luke, 2011). The supervisor using the counselor role, may intervene by helping the supervisee identify lived personal experiences of clients or help processing client's mixed emotions that could be impacting quality of services through microskills. That being said, this role is not providing personal counseling rather intentional direction toward ethical and

competent services. April and her client could benefit from April exploring her personal experiences, biases, and how this impacts their therapeutic relationship.

The consultant role is the last role the supervisor could choose to facilitate their intervention. The consultant role operates as if the supervisee already has a sense of independence and is more of a peer supervision method. The consultant can help with encouraging supervisees to follow their own feelings or insights about their work through empowerment (Bernard, 1979; Bernard & Goodyear, 2019). Accountability and responsibility are returned to the supervisee to use their experiences and expertise to make the most appropriate decision. This role is used more with experienced supervisees. Some examples April may find useful are brainstorming ideas on how to approach career concerns related to their identity, addressing stigma, and or how to process the "white elephant in the room" of the client's identity and their career. April seemed stuck even though she is validating the client, maybe she already has a foundation and needed the confidence to process the "white elephant." After exploring all options, the supervisor has chosen to increase April's knowledge through the teacher role because this provides April with a fuller understanding of how to start to explore, validate, and normalize her client's experiences more deeply.

Step 3: Implementation and Monitoring

The supervisor using the teacher role will provide direct instruction and process LGBTGEQIAP+ identity and common career related concerns with April. April will take feedback and incorporate into her counseling approach with that client. After the supervisor facilitates the intervention, there needs to be a growth check to determine if the intervention was successful. This could be immediate, after the supervisee had time to process new information provided, and or supervisor monitor work via live supervision or recorded sessions. Again, supervisors should consider all (i.e. 3 competency areas X 3 roles) choices before attending to the specific situation to improve knowledge, awareness, or skills to help supervisees grow and develop their multicultural self-efficacy skills. There are a number of ways to interventive to get a similar outcome. The next portion discusses other suggestions for better supervisory practices for new counselors working with LGBTGEQIAP+ clients.

Additional Practices to Better LGBTGEQIAP+ Work

Many clinical supervisors admitted to having inadequate training on how to work with LGBTGEQIAP+ clients (Case et al., 2009) which serves as an impediment to providing effective supervision with this population (Messinger, 2004). The lack of preparation could be harmful to the supervisory experience, so it is recommended that supervisors attend professional LGBTGEQIAP+ conferences, visiting reputable LGBTGEQIAP+ webpages, work on being a part of their local LGBTGEQIAP+ communities, and consult to better serve supervisees (Gess & Doughty Horn, 2018). Also, one-way supervisors can assess supervisees LGBTGEQIAP+ competency is to provide space for their supervisees to report their perceived self-efficacy. Another suggestion is for supervisors to monitor supervisee multicultural growth through the use of evidenced-based multicultural counselor competency scales. The highlighted scale is the Sexual Orientation Counselor Competency Scale (SOCCS) which measures self-reported counselor competency when working with sexual orientations in a way that provides more ethical and affirmative services for LGBTGEQIAP+ clients. Specifically, counselors self-report

attitudes, knowledge, and skills using a Likert scale (Bidell, 2005). Lastly, new counselors experience high anxiety with minimal exposures or interactions with LGBTGEQIAP+ communities which fosters continued lower comfort levels and low self-efficacy (Ginicola et al., 2017). New counselors who want to work with this population would benefit from exposure to the LGBTGEQIAP+ communities to decrease anxiety and increase perceived self-efficacy.

Limitations and Future Research

Largely, models of supervision are untested (Bernard & Goodyear, 2019). There is no "perfect" path to take with this application, the use of clinical judgement plays a major role in the supervisor's decisions. This adapted model may not be generalizable to all populations and there is still work to be done on continuing to adapt this model for work with LGBTGEQIAP+ populations. However, Sue et al. (1992), indicates knowledge, skills, an awareness shown to improve self-efficacy and multicultural competence working with diverse groups and individuals. More research is needed to understand the influence of using DM with supervisors, supervisees, and how this impacts LGBTGEQIAP+ clients. Future exploratory studies could compare using this application of DM compared to the traditional DM ideology on LGBTGEQIAP+ clients. Qualitative research could explore supervisor and supervisee perceptions of using this model. This model could be employed in counselor education and supervision training programs teaching supervisors-in-training how to use this model effectively with their supervisees because it provides a framework that is aimed at enhancing the multicultural competency of new counselors by improving their knowledge, awareness, and skills through the work of Bernard's (1979). The LGBTGEQIAP+ Adapted Discrimination Model of Supervision is an easy implementation method for clinical supervisors who are working toward bettering LGBTGEQIAP+ quality of services provided through affirming and strength-based approaches.

References

American Counseling Association. (2014). ACA Code of Ethics. Alexandria, VA: Author.

Arthur, N., & Achenback, K. (2002). Developing multicultural counseling competencies through experiential learning. *Counselor Education & Supervision*, *42*, 2–14.

Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling. (2012). ALGBTIC competencies for counseling lesbian, gay, bisexual, transgender, queer, questioning, intersex, and ally individuals. Retrieved from. http://www.algbtic.org/images/stories/ ALGBTIC_Comps_for_Counseling_LGBQQIA_Individuals_Final

Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling. (2019). LGBTGEQIAP+ initialism. Retrieved from. https://algbtic.org

Bernard, J. M. (1979). Supervisor training: A discrimination model. *Counselor Education and Supervision, 19*, 60-68.

Bernard, J. M. (1997). The discrimination model. In C. E. Watkins, Jr., *Handbook of psychotherapy supervision* (pp. 310–327). New York, NY: Wiley.

Bernard, J. M., & Goodyear, R. K. (2019). *Fundamentals of clinical supervision* (6th ed.). NY, NY: Pearson.

Bidell, M (2005). The sexual orientation counselor competency scale: assessing attitudes, skills, and knowledge of counselors working with lesbian, gay, and bisexual clients. *Counselor Education & Supervision 44*(4), 267-279. doi: 10.1002/j.1556-6978.2005.tb01755.x

Bryan, S. E. (2018). Types of LGBT microaggressions in counselor education programs. *Journal of LGBT Issues in* Counseling, 12(2), 1995-135. doi: 10.1080/15538605.2018.1455556

Byrne, A. M., & Sias, S. M. (2010). Conceptual application of the discrimination model of clinical supervision for direct care workers in adolescent residential treatment settings. *Child & Youth Care Forum, 39*(3), 201-209. Retrieved from http://search.ebscrohost.com/login.aspx?direct=true&db=eric&AN=EJ885435&site=ehost-live&scope=site

Case, K. A., Stewart, B., & Tittsworth, J. (2009). Transgender across the curriculum: A psychology of inclusion. *Teaching of Psychology*, *36*, 117–121.

Council for Accreditation of Counseling and Related Educational Programs. (2013). *CACREP accreditation standards and procedures manual*. Alexandria, VA: Author.

Crunk, E., & Barden, S. (2017, February 5). The Common Factors Discrimination Model: An integrated approach to counselor supervision. Retrieved from https://tpcjournal.nbcc.org/2017/02/05/the-common-factors-discrimination-model-an-integrated-approach-to-counselor-supervision/.

Dickey, L. & Loewy, M. (2010). Group work with transgender clients. *Journal for Specialists in Group Work*, *35*(3), 236-245. doi: 10.1060/01933922.2010.492904

Farmer, L. B., Welfare, L. E., & Burge, P. L. (2013). Counselor competence with lesbian, gay, and bisexual clients: Differences among practice settings. *Journal of Multicultural Counseling and Development, 41*, 194-209. doi:10.1002/j.2161-1912.2013.00036.x

Finnerty, P., Kocet, M. M., Lutes, J., & Yates, C. (2017). Affirmative, strengths-based counseling with LGBTQI+ people. In M. M. Ginicola, C. Smith, & J. M. Filmore (Eds.), *Affirmative Counseling with LGBTQI+ People* (pp. 109–125). Alexandria, VA: American Counseling Association.

Gess, J. M., & Doughty Horn, E. A. (2018) Queering counselor education: Situational analysis of LGBTQ+ competent faculty, *Journal of LGBT Issues in Counseling*, *12* (2), 101-118. doi: 10.1080/15538605.2018.1455554

Ginicola, M. M., Smith, C., & Filmore, J. M. (2017). *Affirmative counseling with LGBTQI people*. Alexandria, VA: American Counseling Association.

Goodrich, K. M., Luke, M. (2011). The LGBTQ responsive model for supervision of group work. *Journal for Specialists in Group Work, 36*(1), 22-40. doi: 10.1080/01933922.2010.537739

Graham, S. R., Carney, J. S., & Kluck, A. S. (2012). Perceived competency in working with LGB clients: Where are we now? *Counselor Education and Supervision*, *51*(1), 2–16. doi: 10.1002/j.1556-6978.2012.00001.x

Green, M. S., Murphy, M. J., Blumer, M. L. C., & Palmanteer, D. (2009). MFTs' comfort level working with gay and lesbian individuals, couples, and families. *American Journal of Family Therapy*, *37*, 159–168.

Lazovsky, R., & Shimoni, A. (2007). The on-site mentor of counseling interns: Perceptions of ideal role and actual role performance. *Journal of Counseling & Development*, *85*, 303–314.

Luke, M., Ellis, M. V., & Bernard, J. M. (2011). School counselor supervisors' perceptions of the discrimination model of supervision. *Counselor Education and Supervision*, *50*, 328–343.

Messinger, L. (2007). Supervision of lesbian, gay, and bisexual social work students by heterosexual field instructors: A qualitative dyad analysis. *The Clinical Supervisor*, *26*, 195–222.

Smith, L. C., & Shin, R. Q. (2008). Social privilege, social justice, and group counseling: An inquiry. *The Journal for Specialists in Group Work, 33*, 351–366.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development*, *70*, 477–486.

Timm, M. (2015). Creating a preferred counselor identity in supervision: A new application of Bernard's dis-crimination model. The Clinical Supervisor, 34, 115–125. doi:10.1080/07325223.2015.1021499

Troomski-Klingshirn, D. M., & Davis, T. E. (2007). Supervisee's perceptions of their clinical supervision: A study of the dual role of clinical and administrative supervisor. *Counselor Education and Supervision, 46*(4), 294-304.

Author's Note: Sandra Gene Gavin is a Licensed Professional Counselor and a Counselor Education and Supervision PhD student at Northern Illinois University. All correspondence should be sent to Z1853593@students.niu.edu.

MALE PERCEPTIONS OF SUPPORT AND ACADEMIC SELF-CONCEPT: A CORRELATIONAL STUDY

James Morris III
Lewis University

Abstract

This study examined differences in student perceptions of social support among male undergraduate students and explored the relationship between student perceptions of social support and academic self-concept. An investigation of the relationship of academic self-concept and the type of social support received by male undergraduates was also completed. The purpose of this study was three-fold, with the first goal being to promote awareness in the academic community and counseling profession of the perceptions of social support among male undergraduates in a social and academic context. Secondly, the researcher sought to examine the relationship between perceptions of social support and academic self-concept among male undergraduate students. Finally, the researcher aimed to investigate the relationship between the type of social support received and perceptions of academic self-concept. Results from the 76 participants revealed a significant relationship between academic self-concept and perception of social support for male students.

Society has made significant strides toward actively creating a culture of support and encouragement for girls and women at all levels of education, as well as in other areas of life (Eldred et al., 2014; Murtaza, 2012; Rao, 2014). The advent of Title IX of the Education Amendments Act in 1972 addressed the male-to-female representation ratio of 60% to 40% on university campuses and prompted the creation of a variety of programs to address this disparity, but the inverse now exists on university campuses. The purpose of Title IX was to address gender imbalances; it appears that such imbalances still exist, but now, in the opposite direction from when Title IX was enacted. Researchers have begun to suggest that the educational achievement and social-emotional well-being of boys and young men are areas of increasing alarm (Nuttall & Doherty, 2014; Santos, Galligan, Pahlke, & Fabes, 2013). Taken together, many of the successes and gains for girls and women appear to have come with increased concern about boys and young men across similar indicators for well-being. Understanding the psychology of young men, specifically young African American men, within the context of their educational experience serves as the focus of this research.

Problem Background

Student populations on college campuses currently average 56% female students to 44% male students (U.S. Department of Education, 2013). In the year 2015, only 40% of master's degrees were conferred to male graduate students (U.S. Department of Education, 2015). Cheng and Chan (2004) suggested that early adolescent girls seemed to have higher perceptions of support from their peers than did boys, with boys generally reporting less support from classmates when making the distinction between "close friends" and "classmates" (Rueger,

Malecki, & Demaray, 2010). While existing literature provides strong evidence for gender differences in how boys and girls perceive support (Elgoibar, Munduate, Medina, & Euwema, 2014), much less is known about perceptions of social support among undergraduate or graduate males (Tinajero, Martínez-López, Rodríguez, Guisande, & Páramo, 2015), especially African American males. It is possible that a real or perceived lack of social support for male students on college campuses affects their persistence and degree completion. Further, given the potential variations in perceived social support and persistence across different ethnic groups, the lack of focus on African American students presents another gap. Researchers should seek to fill the gap in the understanding of the current social and academic environment as experienced specifically by male undergraduate students, particularly African Americans.

According to the National Center for Education Statistics (2011), boys are expelled from school three times more often than girls. Boys are much less likely than girls to participate in student government, academic clubs, music, and various other student clubs (Kleinfeld, 2009). Adolescent boys tend to be more susceptible to behavior such as engaging in drinking, gambling, and quarrels with others (Le Grange et al., 2014). In addition, boys are reported to have twice the risk that girls have of developing learning disabilities (Haegele & Burns, 2015); furthermore, at least twice as many boys are diagnosed with ADHD (Pastor & Reuben, 2008). Some have suggested that there is something inherently "wrong" with boys, seemingly ignoring the systemic or environmental factors that may be contributing to their struggles (Brooks, Jones, & Burt, 2013; Strayhorn, 2014).

Social Support

Social support refers to the perception or reality that one is cared for, has assistance from others, and is a member of a supportive network (Thoits, 2011). Lakey and Orehek (2011) noted the link between social support and the reduction of psychological distress. Those with low levels of perceived social support reported more frequent occurrences of depression, anxiety, and even the development of panic and phobias in stressful situations than those with higher levels of perceived social support (Lakey & Orehek, 2011). My study examined perceived social support among undergraduate males.

Boundless (2016) identified four categories of support: emotional support (the presence, warmth, and nurturance that provides the individual with a sense of value, esteem, acceptance, or affection); tangible support (the offering of a material service that provides concrete assistance to another person); informational support (the provision of advice, guidance, or suggestions that enable individual problem-solving); and companionship support (the presence of another person, providing a sense of belonging and engagement). Boundless (2016) noted the importance of distinguishing between *perceived* support (i.e., subjective, personal experience or judgment that support will be offered) or *received* support (i.e., objective, specific action offered in a time of need). For this study, the researcher focused instead on the perceptions of male undergraduate students regarding their support systems.

In discussions of the factors involved in the current challenges faced by young men, perceived social support is one variable that is often linked to academic development. Hernandez, Oubrayrie-Roussel, and Prêteur (2015) pointed to the positive correlation between social support and academic achievement. Witkow and Fuligni (2011) reported findings indicating that adolescents of both genders who reported higher perceptions of support from friends and family had greater academic achievement. So critical is the role of social and

emotional support for students' development that the Illinois State Board of Education has included social/emotional standards in state learning requirements (Campbell, 2010).

Purpose of the Study

The purpose of this study was three-fold. First, the researcher intended to explore perceptions of social support among male undergraduates in an academic context. Secondly, the researcher sought to examine the relationship between perceptions of social support and academic self-concept among male undergraduate students. Finally, the researcher aimed to investigate the relationship between the type of social support received and perceptions of academic self-concept.

Given the gender-specific challenges faced by boys and young men, (Elgoibar et al., 2014; Tinajero et al., 2015).this research was intended to provide a multicultural context for counseling professionals working in academic and clinical settings to address the unique needs and challenges faced by these populations. There is much to be learned through research into these variables that might inform best practices for instructional strategies/training, counseling, academic advisement, and even university retention efforts. In regard to counseling, Kaplan, Tarvydas, and Gladding (2014) defined it as "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (p. 366). This research was designed, then, to aid the efforts of counselors to empower clients towards achievement of those goals.

Research Questions and Hypotheses

Research Questions

Three research questions guided this research study. The first question asked: What is the difference in student perceptions of social support among male undergraduates across different year levels in school? The researcher hypothesized that findings would reveal a significant difference. With the second question, the researched asked: What is the relationship between academic self-concept and student perceptions of social support among male undergraduates? The hypothesis for this question anticipated a finding of a significant positive relationship. The third and final research question asked: What is the relationship between academic self-concept and the type of social support received by male undergraduates? Regarding this question, the researcher hypothesized that findings would reveal a significant relationship between academic self-concept and types of social support received by the male undergraduates in the study.

Methodology

Research Design

The researcher used a correlational research design to examine the differences in student perceptions of social support among male undergraduate students across undergraduate academic levels. The researcher aimed to determine the relationship between perceptions of social support and academic self-concept and to investigate the relationship between academic self-concept and

the type of social support received by male undergraduates. For this study, the researcher used survey instruments to measure the variables of academic self-concept and student perceptions of social support, as well as to gather demographic information from the undergraduate students. A correlational research design was appropriate because the variables in the study could not be manipulated in a controlled experimental research setting (Goertz & Mahoney, 2012). Moreover, the selected research design was consistent with the research questions, which involved an examination of the relationships between multiple variables.

Participants

The sample population consisted of all undergraduate students at two private, Midwestern universities. The combined campus populations totaled approximately 5,000 undergraduates. The researcher sampled 357 male undergraduate students for this study, based on a 5% margin of error and a confidence interval of 0.95. The students were selected based on their responses to recruiting efforts and the sole inclusion criteria were that they were male and enrolled as undergraduates at the time the study was conducted. Sample size calculations addressed the question of sufficiency for the sample of 357 individuals in achieving the required statistical power for the quantitative analysis. A power of 0.80 is normal and usually used in quantitative research to ensure that statistical analyses can provide valid conclusions (Faul, Erdfelder, Lang, & Buchner, 2007). The power of the study reflects the probability of rejecting a false null hypothesis. The sample size computation was conducted using the G*Power sample size calculator. The highest number among three computations was 180 samples for the minimum required sample size to achieve the necessary statistical power of 80%. Thus, the 357 individuals targeted and recruited for this study were more than enough to achieve the statistical power of 80% for each of the three statistical analyses conducted for this study. Convenience sampling was used in recruiting participants in the study from classes taught by professors on the campuses of the two universities. Those professors were selected by the researcher based on the number and size of the classes they taught. Questionnaire packets that included cover letters and informed consent forms were distributed in class. Students filled out the questionnaires and returned them in the provided envelopes.

Instrumentation

The survey instruments used included the 40-item Academic Self-Concept Scale (ASCS) developed by Reynolds (1988), the 12-item Multidimensional Scale of Perceived Social Support (MSPSS) developed by Zimet, Dahlem, Zimet, and Farley (1988), and a demographic questionnaire. Cronbach's coefficient alpha was obtained for the scale as a whole, as well as for each subscale. The reliability of the total scale was .88 with the subscales of significant other, family, and friends demonstrating good internal consistency with values of .91, .87, and .85 respectively (Zimet et al., 1988). The ASCS inventory used a four-point Likert scale to measure student perceptions of competence within an academic realm, with higher scores generally indicating more positive academic self-concept. Questions included items such as: "Most courses are very easy for me," and "I am better than the average college student," with students responding on a scale from 1 (strongly disagree) to 4 (strongly agree). The MSPSS inventory measured subjective social support, using three subscales to address social support in the areas of family, friends, and significant other. Students responded on a seven-point scale ranging from 1

(very strongly disagree) to 7 (very strongly agree). Items included statements such as: "My family really tries to help me," and "I get the emotional support I need from my family." The researcher also used a demographic questionnaire to collect factors including ethnic background, age, sex, year in school, major, and self-reported grade point average.

The answers to the questionnaires produced the study variables. The independent variables included the type of social support received, gender, and year level in school of the undergraduate students. Dependent variables included academic self-concept and student perceptions of social support.

Limitations

The convenience sampling technique imposed the principal limitation of this study. Though not an ideal method of gathering samples, the method was necessitated by considerations of time and cost and is, nevertheless, an extremely common form of sampling. The sampling method specifically limits the ability to reveal characteristics from beyond the sample group (Acharya, Prakash, Saxena, & Nigam, 2013). A second limitation derived from correlational nature of the study results. Correlational research is suited for determining the level of the relationship between two variables and cannot directly establish a cause-and-effect relationship (McLeod, 2008). Furthermore, the selection of only two private universities in the Midwest is a limitation and limits the generalizability of the findings. Because of these limitations, it is worthwhile to think of the results as indicative of a potential relationship as opposed to proving some sort of a causal connection between academic self-concept and perception of social support. This limits the potential impact of the research, but understanding these limitations also facilitates a clear understanding, and there is certainly value in what is understood.

Data Processing and Analysis

SPSS statistical software was used for the analyses of collected data. Conducted analyses included: (a) a Pearson correlation to determine relationships between variables; (b) a univariate analysis of variance (ANOVA) of the data to determine whether the mean scores for the academic self-concept and perception of social support of the male undergraduate students with different year levels in school were significantly different from one another; and (c) a linear regression analysis to examine whether type of social support was related to the academic self-concepts of participants.

The researcher addressed the first research question using an ANOVA to aid in determining whether there were significant differences in student perceptions of social support among male undergraduates with different year levels in school. ANOVA was conducted for the different measures of student perceptions of social support (freshman, sophomore, junior, senior). If significant differences for the different measures of student perceptions of social support were found between the different groupings of year levels in school, then each of the year level groupings were compared to one another to determine where the group differences resided. A post-hoc test was conducted if significant differences were determined, using the effect size to measure the strength of the relationship between the variables by using Cohen's *f*-statistic.

To address the second research question, the researcher used a Pearson's correlation test to determine if there was a correlation between student perceptions of social support and

academic self-concept. Alpha was set at 0.05 to determine statistical significance. The researcher employed linear regression for the third research question, which investigated for a correlation between the type of social support received and academic self-concept. For the first dummy variable, participants who received social support from family were represented as 1, while participants who had not were represented as 0. For the second dummy variable, participants who received social support from friends were represented as 1, while participants who had not were represented as 0. For the third dummy variable, participants who received social support from a significant other were represented as 1, while participants who had not were represented as 0. The dependent variable was the perceptions of the academic self-concepts of the participants.

Results

Of the 357 students surveyed, 86 returned completed surveys for a response rate of 24.1%. Eight of the 86 responses were removed for incomplete data. Two responses were removed because respondents had not reported their gender as male. Total valid responses totaled 76. With Research Question 1, the researcher sought to determine whether male students' academic self-concept varied based on their current class standing (i.e., freshman, sophomore, junior, senior). A Kruskal-Wallis test revealed this was not the case, and thus the null hypothesis (that academic self-concept would not vary by year level) failed to be rejected.

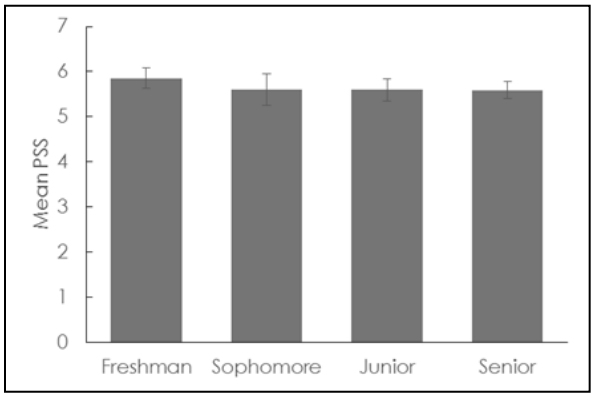


Figure 1. Mean perceived social support for each year level (error bars represent -/+ 1 S.E.M.).

With Research Question 2, the researcher inquired as to whether male students' academic self-concepts were related to their perceived level of social support. A Kendall's Tau correlation analysis demonstrated the greater a student's academic self-concept, the greater he perceived his social support to be. Thus, the null hypothesis (that academic self-concept and perceived level of social support would not be related) was rejected.

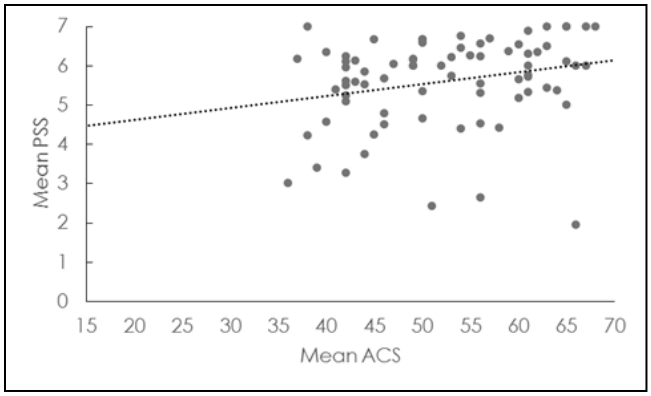


Figure 2. *Mean academic self-concept by mean student perceptions of social support.*

Finally, the researcher used Research Question 3 to determine the relationship between types of social support and academic self-concept. A multiple regression analysis revealed that the three types of social support significantly predicted academic self-concept, but none of the individual predictors explained a significant amount of the variance in academic self-concept when controlling for the other types of social support. Therefore, a tentative interpretation is that better social support – regardless of the source – is associated with higher academic self-concept.

Table 1.
Regression Coefficients for a Linear Regression Model of Predictor Variables and Outcome Variable

Variable	*B*	*SE*	*P*
(Intercept)	39.615	5.263	< .001
Significant other support	-1.158	1.092	.169
Friend support	1.831	1.503	.227
Family support	1.899	1.196	.117

Conclusions, Implications, and Recommendations

Study findings revealed: (a) that academic self-concept did not demonstrate statistically significant variance by grade level, (b) that the higher a student's academic self-concept, the greater his perceptions of social support, and (c) that the three types of social support delineated by the researcher, when aggregated, had significant, predictive relationships with academic self-concept. These findings affirmed the idea that perceptions of social support are related to male students' academic self-concept. These findings were broadly in line with the limited scholarship on the subject, reinforcing the growing hypothesis that social support and perceptions of social support have an impact on academic performance (Hovey, Hurtado, Morales, & Seligman, 2014; Demaray & Malecki, 2002; Thoits, 2011).

As a result of this project, it can be said with greater clarity that there is a relationship between academic self-concept and social support. Results also supported the need for more discussion of the types of social support that potentially influence academic self-concept for young men. It may be the case that differences exist in the ways that boys receive and use social support, confirming findings in existing literature that show young men tending to perceive less

social support than women (Altermatt, 2007; Rueger, Malecki, & Demaray, 2010). According to some scholars, society has lost a sense of its responsibility relative to academic failures among young men (Brooks et al., 2013; Strayhorn, 2014). The findings from this study provided a possible rationale for a relationship between the support young men receive and their abilities to succeed academically. Findings also reinforced the role of society in influencing academic success of young men (Lakey & Orehek, 2011; Thoits, 2011).

This study's findings strengthened current research on social support, particularly supporting a substantial range of implications about the broader benefits of social support. The recognition that social support improves health in a number of ways adds to the advantages of a tight-knit relationship between academic self-concept and social support (Galatzer-Levy, Burton, & Bonanno, 2012; Kong, Zhao, & Yu, 2012; Lakey & Orehek, 2011; Pirutinsky et al., 2011). The implications increase in importance when considering all of the ways in which health in its many forms can be augmented. It is also important to note that these findings affirmed current published findings emphasizing the importance of social support for happiness and success. Finally, this research added to the slim collection of scholarship confirming the benefit of academic self-concept and social support for academic achievement (Curtin, Stewart, & Ostrove, 2012; Skaalvik & Skaalvik, 2013).

Implications for Practice

Although there is substantial extant research regarding the challenges facing women and girls in academia (Eldred et al., 2014; Murtaza, 2012; Rao, 2014), much less recent research has addressed the academic barriers for men and boys despite growing evidence of the need to address them (Nuttall & Doherty, 2014; Santos et al., 2013). The affirmation that perceived social support affects academic self-concept provides an opportunity to explore the findings and relationships established in previous research and consider them through this framework. Furthermore, there is potential for developing approaches to the academic engagement of young men through approved perceptions of social support.

As an example, a reciprocal relationship between self-concept and achievement was suggested by these findings. In turn, the relationship between social support and self-concept and how those affect academic achievement is suggested. It may be the case that a lack of social support leads to underachievement, or that robust social support enhances it.

This research specifically distinguishes between the presence of social support and the perception of the presence of social support. That perception may be as important as social support itself. This finding is implied by the results of this study and may be generally applicable to other student populations; more research is needed in this area.

Several studies revealed differences between the perceived competencies of males and females in various academic areas of study (Jansen, Schroeders, & Lüdtke, 2014; Richardson, Abraham, & Bond, 2012; Sáinz & Eccles, 2012; Stankov, Lee, Luo, & Hogan, 2012). Combining these observations with affirmation of the relationship between academic self-concept and perceived social support suggests the possibility of developing a strategy to create equilibrium in fields of study to minimize gender differences. For example, in a class that is more often daunting for women than men or for boys than girls, supports could be put in place to reassure the group in question. Measures to enhance gender equality in classrooms should include adjusting for gender differences in learning, assuming such differences are conclusively

identified. Moreover, social support can be measured and evaluated for both male and female students in terms of its effect on academic achievement.

This study also proved relevant regarding the implications for African American men and boys. While the existing body of research clearly delineated a number of obstacles for African American students (Jones, Irvin, & Kibe, 2012; Strayhorn, 2014; Wallace, 2013), there is good reason to hypothesize that some of these obstacles could be ameliorated with social support (Williams & Chung, 2013). Further, because research supports social identity as a significant influence among African American students, social support and the perceptions thereof could be surmised to have a significant influence on the capacities of African American students to navigate academic challenges (Williams & Chung, 2013). Of course, this could be the case for students of other ethnicities as well.

Recommendations for Research

This study explored the relationship between academic self-concept and the perception of social support among male students in academic settings. That relationship should be further studied in different contexts, with populations and settings. Findings point to the need for replication under alternative sampling techniques and more specific populations. Future researchers also could make inquiry into the three types of social support, specifically examining their differences and similarities in regard to academic self-concept. Implications for future research related to gender and race are also substantial. For example, the research could be replicated with women as the center of the research, or with men of various ethnicities. Future scholars could seek to deepen their understanding of the relationship between perceived support and academic performance, building out specific aspects and implications.

Additional recommendations are that studies could be conducted regarding the approaches used by counselors who counsel young men. When a student is referred to a counselor due to academic issues, a fruitful line of initial inquiry could be the student's perceived social support. This could be evaluated during the initial stages of assessment/interview process. This research suggests that perceptions of social support may affect a male student's academic performance; therefore, further research should explore how that inquiry could be utilized during initial counseling evaluations to inform treatment planning.

Furthermore, such evaluations can and should include inquiries about the student's lived experiences that shaped his perceptions of social support. Qualitative inquiry would be valuable to find out this information as the focus of future research and in clinical settings. Given the linkage between perceptions of social support and academic performance, it may be possible to identify life experiences of young men that positively or adversely affect their academic performance due to enhancing or reducing their perceptions of social support.

References

Acharya, A. S., Prakash, A., Saxena, P., & Nigam, A. (2013). Sampling: Why and how of it. *Indian Journal of Medical Specialties, 4*(2), 330–333.

Altermatt, E. R. (2017). Academic competence perceptions moderate the effects of peer support following academic success disclosures. *Social Development, 1*, 1–16.

Boundless. (2016, May 16). *The value of social support in managing stress*. Retrieved from https://www.boundless.com/psychology/textbooks/boundless-psychology-textbook/stress-and-health-psychology-17/coping-with-and-managing-stress-89/the-value-of-social-support-in-managing-stress-339-12874/

Brooks, M., Jones, C., & Burt, I. (2013). Are African-American male undergraduate retention programs successful? An evaluation of an undergraduate African-American male retention program. *Journal of African American Studies, 17*(2), 206–221.

Campbell, M. (2010). Academic and social support critical to success in academically rigorous environment. *The Education Digest, 76*(1), 61–64.

Curtin, N., Stewart, A. J., & Ostrove, J. M. (2012). Fostering academic self-concept: Advisor support and sense of belonging among international and domestic graduate students. *American Education Research Journal, 50*(1), 108–137.

Demaray, M. K., & Malecki, C. K. (2002). The relationship between perceived social support and maladjustment for students at risk. *Psychology in the Schools, 39*, 305–316.

Eldred, J., Robinson-Pant, A., Nabi, R., Chopra, P., Nussey, C., & Bown, L. (2014). Women's right to learning and literacy: Women learning literacy and empowerment. *Journal of Comparative and International Education, 44*(4), 655–675.

Faul, F., Erdfelder, E., Lang, A-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39*, 175–191.

Galatzer-Levy, I. R., Burton, C. L., & Bonanno, G. A. (2012). Coping flexibility, potentially traumatic life events, and resilience: A prospective study of college student adjustment. *Journal of Social and Clinical Psychology, 31*(6), 542–567.

Haegele, K., & Burns, M. K. (2015). Effect of modifying intervention set size with acquisition rate data among students identified with a learning disability. *Journal of Behavioral Education, 24*(1), 33–50.

Hernandez, L., Oubrayrie-Roussel, N., & Prêteur, Y. (2015). Educational goals and motives as possible mediators in the relationship between social support and academic achievement. *European Journal of Psychology of Education, 31*, 193–207.

Hovey, J. D., Hurtado, G., Morales, L. R., & Seligman, L. D. (2014). Religion-based emotional social support mediates the relationship between intrinsic religiosity and mental health. *Archives of Suicide Research, 18*(4), 376–391.

Jansen, M., Schroeders, U., & Lüdtke, O. (2014). Academic self-concept in science: Multidimensionality, relations to achievement measures, and gender differences. *Learning and Individual Differences, 30*, 11–21.

Jones, M. H., Irvin, M. J., & Kibe, G. W. (2012). Does geographic setting alter the roles of academically supportive factors? African American adolescents' friendships, math self-concept, and math performance. *Journal of Negro Education, 81*(4), 319–337.

Kaplan, D. M., Tarvydas, V. M., & Gladding, S. T. (2014). 20/20: A vision for the future of counseling: The new consensus definition of counseling. *Journal of Counseling and Development, 92*, 466–472.

Kleinfeld, J. (2009). The state of American boyhood. *Gender Issues, 26*(2), 113–129.

Kong, F., Zhao, J., & You, X. (2012). Emotional intelligence and life satisfaction in Chinese university students: The mediating role of self-esteem and social support. *Personality and Individual Differences, 53*(8), 1039–1043.

Lakey, B., & Orehek, E. (2011). Relational regulation theory: A new approach to explain the link between perceived social support and mental health. *Psychological Review, 118*(3), 482.

Leedy, P. D., & Ormrod, J. E. (2010). *Practical research* (9th ed.). New York, NY: Pearson.

Le Grange, D., O'Connor, M., Hughes, E. K., Macdonald, J., Little, K., & Olsson, C. A. (2014). Developmental antecedents of abnormal eating attitudes and behaviors in adolescence. *International Journal of Eating Disorders, 47*(7), 813–824.

McLeod, S. (2008). Correlation. *Simply Psychology*. Retrieved from https://www.simplypsychology.org/correlation.html

Murtaza, K. F. (2012). Women empowerment through higher education in Gilgit-Baltistan. *International Journal of Academic Research in Business and Social Sciences, 2*(9), 343–367.

National Center for Education Statistics. (2011). *Digest of education statistics*. Retrieved from http://nces.ed.gov/pubs2012/2012001.pdf

Nuttall, A., & Doherty, J. (2014). Disaffected boys and the achievement gap: 'The wallpaper effect' and what is hidden by a focus on school results. *The Urban Review, 46*(5), 800–815.

Pastor, P. N., & Reuben, C. A. (2008). Diagnosed attention deficit hyperactivity disorder and learning disability: United States, 2004 – 2006. *Vital and Health Statistics, Series 10*, 1–14.

Pirutinsky, S., Rosmarin, D. H., Holt, C. L., Feldman, R. H., Caplan, L. S., Midlarsky, E., & Pargament, K. I. (2011). Does social support mediate the moderating effect of intrinsic religiosity on the relationship between physical health and depressive symptoms among Jews? *Journal of Behavioral Medicine, 34*(6), 489–496.

Rao, D. P. (2014). Women empowerment as a tool for enhancement of values in education: An historical analysis. *Journal of Human Values, 20*(1), 85–93.

Reynolds, W. M. (1988). Measurement of academic self-concept in college students. *Journal of Personality Assessment, 52*(2), 223-240.

Richardson, M., Abraham, C., & Bond, R. (2012). Psychological correlates of university students' academic performance: A systematic review and meta-analysis. *Psychological Bulletin, 138*(2), 353.

Rueger, S. Y., Malecki, C. K., & Demaray, M. K. (2010). Relationship between multiple sources of perceived social support and psychological and academic adjustment in early adolescence: Comparisons across gender. *Journal of Youth and Adolescence, 39*(1), 47–61.

Sáinz, M., & Eccles, J. (2012). Self-concept of computer and mathematics ability: Gender implications across time and within ICT studies. *Journal of Vocational Behavior, 80*(2), 486–499.

Santos, C. E., Galligan, K., Pahlke, E., & Fabes, R. A. (2013). Gender-typed behaviors, achievement, and adjustment among racially and ethnically diverse boys during early adolescence. *American Journal of Orthopsychiatry, 83*(2pt3), 252–264.

Silverman, D. (2010). *Qualitative research*. Thousand Oaks, CA: Sage.

Skaalvik, E. M., & Skaalvik, S. (2013). School goal structure: Associations with students' perceptions of their teachers as emotionally supportive, academic self-concept, intrinsic motivation, effort, and help seeking behavior. *International Journal of Educational Research, 61*, 5–14.

Stankov, L., Lee, J., Luo, W., & Hogan, D. J. (2012). Confidence: A better predictor of academic achievement than self-efficacy, self-concept and anxiety? *Learning and Individual Differences, 22*(6), 747–758.

Strayhorn, T. L. (2014). What role does grit play in the academic success of Black male collegians at predominantly White institutions? *Journal of African-American Studies, 18*(1), 1–10.

Thoits, P. A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior, 52*(2), 145–161.

Wallace, L. (2013). *The relationship between racial identity, perceived racial discrimination, and the academic self-concept of African American college men: A mixed-methods examination* (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses database. (3567789)

Williams, W. S., & Chung, Y. B. (2013). Do cultural attitudes matter? The role of cultural orientation on academic self-concept among Black/African college students. *Journal of College Counseling, 16*, 228–242.

Witkow, M. R., & Fuligni, A. J. (2011). Ethnic and generational differences in the relations between social support and academic achievement across the high school years. *The Journal of Social Issues, 67*(3), 531.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment, 52*(1), 30-41.

Author's Note: Dr. James Morris III is an Assistant Professor in the Graduate Counseling Program at Lewis University. All correspondence should be sent to professorjmiii@gmail.com.

Acceptance and Commitment Therapy for College Students with Traumatic Experiences

Mike Caverly
Northern Illinois University

Abstract

Traumatic experiences can impact the development of a positive therapeutic alliance and, thus, render treatment ineffective. The literature suggests that Acceptance and Commitment Therapy (ACT) can be useful in treating traumatic experiences. ACT targets event centrality and experiential avoidance, which are key constructs for treating clients with a history of trauma. The literature is reviewed, a case study is presented, conclusions are drawn, and practical implications are provided.

Keywords: Acceptance and Commitment Therapy, College Counseling, Trauma

ACT Theoretical Presentation

Acceptance and Commitment Therapy (ACT) originates from the cognitive school of thought and was formed from a branch of philosophy called *functional contextualism* (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). ACT is a constructivist approach to managing problems as it views problems in the greater context of the events currently happening for clients (Harris, 2017). Simply put, ACT does not aim to change behavior and cognition in order to change the emotion. Instead, ACT attempts to change the broader context that links these constructs together (Hayes, Levin, Plumb, Villatte, Pistorello, 2013). The six ACT tenets are values, committed action, acceptance, cognitive defusion, self-as-context, and remaining present (Boals & Southerd-Dobbs, 2020). However, these tenets are not linear, and the time spent on each tenet in counseling will most likely vary (Brady & Whitman, 2012).

Values. Values are what we value in our lives, our social relationships, or our career (Polk & Tengalia, 2019). Values are not goals that can be obtained, but rather, they are a guide to what is important for the client.

Committed action. Committed action is acting on these values. The client takes action to fulfill a value. For example, a client enrolls at a university because they value education (Polk & Tengalia, 2019).

Acceptance. Acceptance encourages the client to actively embrace their own history without any attempts to alter the form or frequency of the experience (Hayes et al., 2006; McClean & Follete, 2016). It is important to note here, that in the context of traumatic experiences, "acceptance" does not explicitly mean, nor does it mean to implicitly suggest, that the traumatic experience is somehow acceptable (McClean & Follete, 2016). Acceptance is also cultivated to manage experiential avoidance, which is, the unwillingness to remain engaged in the present moment (Hayes et al., 2013; McClean & Follett, 2016). Acceptance is created as the alterative to experiential avoidance. Acceptance, as the name of the theory would imply, is ultimately the goal of ACT (Harris, 2017).

Cognitive defusion. Cognitive defusion allows a client to alter an emotional memory, unhelpful behavior, thought, or emotional experience (Hayes et al., 2013). This alteration in the emotion, behavior, or thought, can create a psychological distance from the dysfunctional psychosocial experience. For example, ACT counselors encourage clients to repeat the thought out loud multiple times, in order to change the way the client interacts with that thought (Hayes et al., 2006). A new relationship can then be created with the presenting problem, as the client says, "I am having the thought that I am not worthy." A new relationship involves a psychological distance from it. In other words, there is an alteration in the emotional experience of that thought (McClean & Follett, 2016).

Psychological flexibility is not a tenet, but rather, it is technique in ACT that falls along the same lines of cognitive defusion. It is depicted by the capacity to continue with positive behaviors, despite the presence of negative emotional states (Polk & Tengalia, 2019). Such psychological flexibility create the conditions for change to exist (Hayes et al., 2006; McClean & Follete, 2016; Polk & Tengalia, 2019). For example, a client can learn "I'm anxious about, being anxious." The psychological distance from the emotional experience of anxiety creates a new relationship with anxiety (Harris, 2017). That new relationship is the result of psychological flexibility and cognitive defusion. Psychological inflexibility, on the other hand, is the inability to engage the present moment, and an assumption that the client holds about themselves as the source of psychosocial dysregulation (Hayes et al., 2013). In other words, a client becomes anxious about being anxious, and assumes they are the problem rather than the relationship they have with anxiety.

Self-as-context. Self-as-context is an abstract construct related to Buddhist mindfulness. Self-as-context is the ability to observe one own's cognitive and/or emotional experience, from an outside perspective, without negative self-judgment (Harris, 2017; Hayes et al., 2013). This creates a new perspective of seeing oneself that is much more than the negative emotional states or negative thought patterns (Boals & Murrell, 2016; McClean & Follett, 2016). Explaining ACT in metaphors during counseling is encouraged and common (Harris, 2017). This tenet of ACT may be best explained via a chess metaphor. The client is a chessboard, the negative experiences are the blue pieces and the positive experiences are the red pieces, and the pieces move around while the chessboard stays the same (Boals & Southerd-Dobbs, 2020).

Remaining present. It may be implicit that the last ACT tenet, remaining present, is a common theme throughout acceptance, self-as-context, cognitive defusion, and psychological flexibility. Remaining present is related to mindfulness, best defined by Kabat-Zinn (1994, p. 4), as "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally." This tenet of present moment awareness is a cornerstone of ACT (Hayes et al., 2013). However, in the context of counseling clients who have experienced a traumatic event, mindfulness may cause harm to the client (Treleaven, 2008). Thus, it will not be explored in depth in the following case study. Next, in order to provide additional context to the case study, the prevalence of students presenting to university counseling centers with a history of traumatic experiences will be explored.

Traumatic Experiences in College

An annual report, conducted by the Center for Collegiate Mental Health (CCMH), studied College Students (CS) that attended counseling at university counseling centers in the United States and found that 41.4% of CS experienced at least one traumatic event and most

(60.8%) experienced the traumatic event within the last one to five years (CCMH, 2019). Further, Boyraz, Horne, Armstrong, & Owens (2015) found 52.2% of CS were exposed to at least one traumatic event during their lifetime, and only 5.2% of those CS sought counseling following exposure to the traumatic event.

ACT can be effective at university counseling centers. Studies support ACT for CS with social anxiety (Block & Wolfort, 2000), depression and anxiety (Foreman, Herbert, Moitra, Yeomans, Geller, 2007) in promoting mental health and school engagement (Gregoire, Lachance, Bouffard, & Dionne, 2017). Multiple studies suggest ACT can be effective for clients with a history of traumatic experiences (Bean, Ong, Lee, & Twohig, 2017; Boals & Murell, 2016; Boals & Southard-Dobbs, 2020; McLean & Follette, 2016).

ACT to Treat Trauma

Bean et al. (2017) conducted an empirical review on ACT to treat Post-Traumatic Stress Disorder (PTSD). The review included a single subject design, three case studies, one case series, and two randomized clinical trials. Batten and Hayes (2005) found significant clinical cut-offs following 12 months of ACT counseling for a client diagnosed with PTSD and substance abuse. Twohig (2009) found clinical cut-offs for a client diagnosed with PTSD following a 21-week trial of ACT.

ACT seems to be effective for treating PTSD because of the way it targets event centrality via self-as-context (Bean et al., 2017; Boals & Murrell, 2016; Boals & Southard-Dobbs, 2020). Other work suggests that ACT can be effective for treating PTSD and trauma because of how acceptance and experiential avoidance are affected by ACT (Hayes et al., 2013; Kashdan & Kane, 2011). Next it is important to explore these issues in depth to set the stage for the case study.

Event Centrality and ACT

Event Centrality (EC) is to what extent, if any, a client defines themselves based on the traumatic event (Bean et al., 2017; Boals & Murrell, 2017; Boals & Southerd-Dobbs, 2020). EC is not exclusive to ACT, but self-as-context and acceptance are core tenets of ACT, and psychological flexibility, acceptance, and self-as-context directly targets EC. Targeting EC seems to ameliorate PTSD symptoms in the literature (Bean et al., 2017; Boals & Southerd-Dobbs, 2020).

Boals and Murrell (2016) conducted a randomized controlled study on 97 clients that completed four ACT sessions and four treatment-as-usual sessions. Four hour-long ACT counseling sessions were done with clients that have experienced abuse and/or domestic violence. The counseling sessions were focused on the concept of EC. The logic here, was that ACT targets EC through the concept of self-as-context, acceptance, and psychological flexibility. The results concluded the ACT group had significant positive changes pre-to-post treatment of EC, symptoms of PTSD, and symptoms of depression. PTSD symptoms were mediated by the positive changes in EC. Finally, the authors concluded that this was the first study of its kind to explore how EC is manipulated by ACT, and how ACT can effectively reduce EC, which mediates PTSD symptoms (Boals & Murrell, 2016)

The reason that ACT may be effective in treating PTSD and traumatic experiences is because of how ACT targets EC via self-as-context, acceptance, and psychological flexibly

(Boals & Murrell, 2016; Boals & Southerd-Dobbs, 2020). This logic is not without its issues, as the relationship between EC and PTSD symptoms is complex, thus more studies are needed and these results may not generalize to the general population (Boals & Murrell, 2016; Boals & Southerd-Dobbs, 2020). Despite that, the basis of ACT is to effectively change the relationship the client has to the presenting problem (Hayes et al., 2006) and to broaden the greater context of the client's self-concept. This new context can create a new relationship that the client may have with the traumatic event in order to reframe the event, which may lead to acceptance (Boals & Southard-Dobbs, 2020; Boals & Murrell, 2016). This occurs in opposition to the client defining themselves based off the traumatic experience (e.g., event centrality; Bean et al., 2017). Instead, they can function in the context of negative emotional states by seeing themselves in the context of the traumatic event, via psychological flexibly and self-as-context (Boals & Southard-Dobbs, 2020; Boals & Murrell, 2016**;** McClean and Follete, 2016; Polk & Tengalia, 2019). In other words, clients can see the whole chess board, rather than just the negative parts.

Experiential Avoidance and ACT

Experiential avoidance is common in those managing a traumatic experience (Bishop, Ameral, & Palm Reed, 2017) and avoidance is a criterion to diagnose a client with PTSD (Diagnostic and Statistical Manual V, American Psychological Association, 2013). ACT seems to target experiential avoidance (Harris, 2017; McLean & Follette, 2016) which effectively moderates PTSD symptoms (Kashdan & Kane, 2011). Experiential avoidance is a key construct that maintains PTSD symptoms and avoidance can serve as a barrier to positive psychological functioning (Bean et al., 2017; Hayes et al., 2013). Avoidance is key to trauma treatment, as it may pave the way for the counseling to be effective and it moderates post traumatic growth (Kashdane & Kane, 2011). Again, experiential avoidance is when clients are "unwilling to remain in contact with particular private experiences" (Hayes et al., 1996, p. 1154).

McClean and Follete (2016) argue that ACT provides a new lens for addressing experiential avoidance during counseling. This is similar to the notion of psychological flexibility, a technique in ACT, which is the capacity to persist in behaviors despite the presence of negative emotional states (McClean and Follete, 2016; Polk & Tengalia, 2019). Such psychological flexibility and the changes in the way clients interact with their thoughts create the conditions for change to exist (Hayes et al., 2006; McClean & Follete, 2016; Polk & Tengalia, 2019).

A metaphor can be used to explain experiential avoidance, which is encouraged in ACT counseling (Harris, 2017). The "Sushi Train Metaphor" is when a client pictures a conveyer belt at a restaurant with plates of food on it. The chef behind the door in the kitchen is creating the dishes (e.g., the mind), some of the plates of sushi are appealing (positive thoughts and behaviors) and some are not appealing (negative emotional states or memories). ACT teaches clients to metaphorically step back from the conveyer belt and watch the unappealing plates drift by. Clients can also learn not to jump up (e.g., avoidance) to take the appealing dishes (Harris, 2017). This is an example of the experiential avoidance of certain thoughts, memories, or emotions. Psychological flexibility, which allows negative emotional states to occur rather than avoiding them, can combat experiential avoidance and lead to a broader sense of self (e.g., self-as-context; Harris, 2017). Next these topics will be explored in a case study to provide specific clinical examples.

Case Presentation

Anika, pseudonym, was a 23-year-old cisgender female that attended a small southern university in the United States. Anika was originally from India and she reported she moved to America at age 11 and was fluent in English. Anika presented with social anxiety and relationship issues with her male partner. She reported in session one that she had sought counseling before with multiple clinicians but did not find it helpful. She also reported in session one that "this thing happened, but we're not going there yet."

Psychological Safety and Experiential Avoidance during Counseling

The initial therapeutic goal, which is common in counseling, was to establish psychological safety and a positive therapeutic alliance (Score, 2012; Siegal, 2012). Psychological safety is critical to a trauma case (Schore, 2012; Siegal, 2012). Tone is also important when discussing safety in the therapeutic alliance, and it is added to provide depth to the dialog presented below. The counselor blends a Humanistic approach with techniques from ACT.

Psychological safety can help manage avoidance in counseling (Schore, 2012). Anika was petrified to discuss the traumatic event, because of the very nature of trauma, as it was too intimidating for her to feel vulnerable enough to discuss the event with the counselor (Schore, 2012). Providing a psychologically safe environment was key to this case, because of the role of experiential avoidance (Hayes et al., 2013; Kashdan & Kane, 2011; McLean & Follette, 2018). This dialog at the end of the first session is outlined below for counselors that are new to ACT and/or Counselors-in-Training.

> (Anika): "So, what is *this* [emphasis added] counseling like? Do I just talk about my problems? I've been in counseling before, but it always seems a little bit different" (breaks eye-contact).
> (Counselor): My goal is to make this room safe for you, you will have complete control over what, *and when* [emphasis added] we talk about whatever it is you want to talk about (full eye contact, spoken in soft and slow tone).
> (Anika): None of my counselors have said that before (no eye-contact)
> (Counselor): I'm a little surprised to hear that, but again, it's your call Anika, when we talk about stuff, and how long we talk about stuff. You just let me know. Say, 'Mike, I'm not ready for that one yet' (full eye contact, spoken in soft and slow tone).
> (Anika): That's good, I really like that (eye contact; soft tone without pressure in voice)

During session two, Anika reported that she has felt anxious since the event occurred but did not want to discuss the event yet (suggesting she would like to continue counseling after session two). She stated multiple times during session two that she did not want to talk about what happened, she stated "I'm shattered by it, it has destroyed me – but I'm not ready to talk about it yet." Again, the premise of safety is key here because the counselor must establish a strong therapeutic alliance in order to create the conditions for Anika to feel vulnerable enough to psychologically engage the emotional experience of the traumatic event (Schore, 2012).

Event Centrality and Self-as-Context

The phrases "I'm shattered by it and it has destroyed me" may suggest that she may be defining herself based off this traumatic event. This statement suggests that she may not be able to function because she is "shattered" and "destroyed" by the event. Here, an ACT counselor can use self-as-context to target and treat event centrality (Boals and Southard-Dobbs, 2020). Making self-as-context explicit in the case is key to facilitating acceptance, psychological flexibility, cognitive defusion, and to access a transcendent sense of self (Harris, 2017). Thus, Anika was challenged to understand herself in broader context of her core self, even the part of her sense of self that experiences avoidance and emotionally re-experiences the traumatic event. The following metaphor was used to explicitly explore self-as-context, cognitive defusion, and psychological flexibility with Anika. This metaphor reflects a client picturing themselves standing on a bridge, above a stream, watching the leaves float by underneath.

> "Notice there are two parts of you involved in this. There's your thinking self (or "your mind"), that's doing a few different things: creating imagery of the stream and the leaves, creating thoughts, putting those thoughts onto the leaves, and probably creating judgments or other thoughts about the exercise itself and how you're going with it. And there's another part of you that's noticing all of that." (Harris, 2017, p. 8)

Here, the ACT counselor is using a metaphor to explain self-as-context explicitly, to set the stage for acceptance, cognitive defusion, psychological flexibility, and access to the transcendent self that goes beyond the negative psychological functioning (Harris, 2017). This technique creates the conditions for Anika to change the relationship she has with the traumatic experience. This technique also creates psychological distance between negative emotional states and Anika's self-concept (McLean & Follette, 2016).

Experiential Avoidance and Psychological Flexibility

During session four, Anika again reported that she has "felt anxious since the event occurred but did not want to discuss the event yet." The avoidance that Hayes et al. (2013) described is also key to this case. In Anika's case, she reported she was terrified to discuss the event and a strong therapeutic alliance was needed to create the conditions to begin to process the event and manage this avoidance, wherein ACT can be helpful (McLean & Folette, 2016; Score, 2012).

Towards the end of session four, Anika appeared less anxious when describing the event. She reported in an emotional cathartic release (evidenced by pressured and loud tone, tearfulness, and protective body posture with crossed arms). "Why did I let him beat me?!" This occurred at the end of the fourth session and the counselor validated the traumatic event and resulting emotion. The counselor simply stated, "I'm so sorry to hear that Anika, but I'm so glad you felt ok to tell me." This willingness to explore the event may be due to Anika's trust in the counselor (Schore, 2012). As the conditions were set for psychological safety, she began to process the event, something Anika reported she was terrified of in the first two sessions.

In Anika's case, the experiential avoidance was maintaining the post-traumatic distress (McLean & Follette, 2016). Further, this avoidance was managed via psychological flexibility (Hayes et al., 2013). During session four, Anika demonstrated psychological flexibility,

suggesting she felt safe enough to psychologically engage the traumatic event during counseling. Despite her reported fear in session one, she was willing to "contact the present moment as a conscious human being, fully and without defense, as it is, and not what it says it is" and that is the very definition of psychological flexibility (Hayes et al., 2006, p. 138).

Experiential Avoidance and Acceptance

During subsequent sessions, Anika chose to discuss her academics for most of the sessions. This might have been evidence of avoidance, as she began by shifting the sessions back towards her academics and away from the traumatic event. Anika seems to define herself based on this traumatic experience (e.g., event centrality), evidenced by her statement: "I'm destroyed by it." She also may have been insinuating that she was at fault for the physical assault. Given the nature of the traumatic experience, it makes sense that Anika may want to avoid these emotional experiences (Kashdane & Kane, 2011). Little was achieved in session five to seven according to Anika. During session eight, Anika demonstrated psychological flexibility, and returned to the emotional experience of the physical assault, and the following interaction occurred:

> (Anika): Damnit, Mike, I feel like it will always define me! (said in an agitated tone, with pressured speech, and loud volume)
> (Counselor): Anika, you're more than that experience (said in an agitated tone, with pressured speech and loud volume, to meet the intensity of the client's emotional state).
> [long pause from client as she sits back in chair]
> (Anika) "…end of the day, it's not what describes me."

Acceptance

The technique of challenging the notion that the traumatic event defines her, alters the contextual nature of this negative cognition (Bean et al., 2017; Boals & Murrell, 2016; McLean & Folette, 2016). It affects the greater emotional and cognitive context surrounding the traumatic experiences (Hayes et al., 2013). According to the ACT counselor, this is why the challenging statement worked so well. This challenging statement began to change how Anika defined herself, evidenced by her statement "I haven't thought about it like that." This has affected the way that she defined the physical assault in her personal history. This positive clinical outcome led to acceptance and seeing herself-in-context of the traumatic event, rather than the traumatic event defining her (Bean et al., 2017; Boals & Murrell, 2016; Boals & Southerd-Dobbs, 2020). This clinical outcome also encouraged engagement in the present moment and committed action towards a valued life and value of relationships with future partners (Hayes et al., 2006). During the final session, Anika reported that she began to perceive the physical assault differently and has started a more positive intimate relationship with a male partner.

Conclusion

Anika's case is a typical case of a client that experiences avoidance due to a traumatic event and who may define herself based off the traumatic experience (Boals & Southerd-Dobbs, 2020; Kashdane & Kane, 2011). This case was presented to provide some context of how to use

ACT, the techniques of teaching psychological flexibility, and targeting event centrality via self-as-context. This case may provide more evidence that ACT can be effective in treating CS with traumatic experiences. Future research should consider the role of event centrality and how ACT, specifically, self-as-context, can ameliorate PTSD symptoms (Boals & Southerd-Dobbs, 2020). Future research should also consider randomized controlled studies, as Bean et al. (2017) found only two studies on ACT recently. Overall, this case is an example of how to use ACT with a traumatized university student.

References

American Psychological Association (2013). *Diagnostic and statistical manual of mental disorders (5th Ed.). Arlington, VA: American Psychiatric Publishing.*

Batten, S. V., & Hayes, S. C. (2005). Acceptance and commitment therapy in the treatment of comorbid substance abuse and post-traumatic stress disorder: A case study. *Clinical Case Studies, 4*(3), 246–262. doi: 10.1177/1534650103259689

Bean, R., Ong, C., Lee, J., & Twohig, M. (2017). Acceptance and commitment therapy for PTSD and trauma: An empirical review. *The Behavior Therapist, 40,* 145-150.

Bishop, L., Ameral, V., & Palm Reed, K. (2017). The impact of experiential avoidance and event centrality in trauma related rumination and post-traumatic stress. *Behaviour Modification,* 1-23. Doi: o0r.g1/107.171/0771/40514544545151771774477287

Block, J. & & Wolfort, E. (2000). Acceptance or change: treating socially anxious college students with ACT or CBTG. *The behavior analyst today,* 1(2), 3-10.

Boals, A. & Murrell, A. (2016). I am > trauma: Experientially reducing event centrality and PTSD symptoms in a clinical trial. *Journal of Loss and Trauma, 21*(6), 471-483. doi: 10.1080/15325024. 2015.1117930

Boals, A., & Southerd-Dobbs, S. (2020). A call for intervention research to reduce event centrality in trauma-exposed individuals. *Journal of Loss and Trauma,* 3-25. DOI: 10.1080/15325024.2020.1734744

Boyraz, G., Horne, S. G., Armstrong, A. P., & Owens, A. C. (2015). Posttraumatic stress predicting depression and social support among college students: Moderating effects of race and gender. *Psychological Trauma: Theory, Research, Practice, and Policy, 7*(3), 259-268. doi:10.1037/a0037967

Brady, V. P., & Whitman, S. M. (2012). An acceptance and mindfulness-based approach to social phobia: A case study. Journal of College Counseling, 15, 81–96. doi:10.1002/j.2161-1882.2012.000007

Center for Collegiate Mental Health. (2019, January). 2019 Annual Report (Publication No. ST17-74).

Foreman, E., Herbert, J., Moitra, P., Yeomans, P., Geller, P. (2007). A randomized controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression. *PubMed,* 5(5). Doi: 10.1177/0145445507302202.

Gregoire, S., Lachance, L., Bouffard, T., & Dionne, F. (2017). The use of acceptance and commitment therapy to promote mental health and school engagement in university students: a multisite randomized controlled trail. *Behaviour Therapy*, 49(3), 15-33. Doi: 10.1016/jbeth.2017.10.003

Harris, R. (2017). Making self-as-context relevant, clear, and practical. Retrieved from: https://www.actmindfully.com.au/upimages/Making_Self-As-Context_Relevant,_Clear_and_Practical.pdf

Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64,* 1152–1168. doi:10.1037/0022- 006X.64.6.1152

Hayes, S., Luoma, J., Bond, F., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. Behaviour Research and Therapy, 44, 1-25. Doi: 10.1016/j.brat.2005.06.06

Hayes, S. C., Levin, M. E., Plumb-Vilardaga, J., Villatte, J. L., & Pistorello, J. (2013). Acceptance and commitment therapy and contextual behavioral science: Examining the progress of a dis- tinctive model of behavioral and cogni- tive therapy. *Behavior Therapy, 44*(2), 180–198. doi: 10.1016/j.beth.2009.08.002

Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditations in everyday life.* New York, NY: Hyperion.

Kashdan, T., & Kane, J. (2011). Posttraumatic distress and the presence of posttraumatic growth and meaning in life: Experiential avoidance as a moderator. *Pers Individ Dif, 50*(1), 84-89. doi: 10.1016/j.paid.2010.08.028

Lang, A. J., Schnurr, P. P., Jain, S., He, F., Walser, R. D., Bolton, E., ... Chard, K. M (2016). Randomized controlled trial of acceptance and commitment therapy for distress and impairment in OEF/OIF/OND veterans. *Psychological Trauma: Theory, Research, Practice, and Policy*, 1–12. doi: 10.1037/tra0000127

Lambert, M. J. (2013). Outcome in psychotherapy: The past and important advances. *Psychotherapy*, 1(50), 42-51. DOI: 10.1037/a0030682

Leong, F. T. L., & Lau, A. S. L. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research, 3,* 201-214. doi: 1522-3434/01/1200-0201/0

Marx, B. P., & Sloan, D. M. (2005). Peritraumatic dissociation and experiential avoidance as predictors of posttraumatic stress symptomatology. *Behaviour Research and Therapy*, 43 (5), 569–583 doi: 10.1037/a0023927

McLean, C., & Follette, V. (2016). Acceptance and commitment therapy as a nonpathologizing intervention approach for survivors of trauma. *Journal of Trauma & Dissociation, 17*(2), 138-150. doi: 10.1080/15299732.2016.1103111.

Merwin, R. M., Rosenthal, M. Z., & Coffey, K. A. (2009). Experiential avoidance mediates the relationship between sexual victimization and psychological symptoms: Replicating findings with an ethnically diverse sample. *Cognitive Therapy and Research*, 33(5), 537–542. doi: 10.1007/s10608-008-9225-7

Muller, R. (2018). *Trauma and the struggle to open up: From avoidance to recovery and growth.* W.W. Norton: NY, NY.

Orsillo, S. M., & Batten, S. V. (2005). Acceptance and Commitment Therapy in the Treatment of Posttraumatic Stress Disorder. *Behavior Modification, 29*(1), 95-129. doi: 10.1177/0145445504270876

Polk, K., & Tengalia, P., (2020). The ACT matrix with Dr. Kevin Polk and Phil Tengalia, M.A [Audio podcast]. Retrieved from: *https://shrinkrapradio.com/678-the-act-matrix-with-dr-kevin-polk-and-phil-tenaglia-m-a/*

Twohig, M. P. (2009). Acceptance and commitment therapy for treatment- resistant posttraumatic stress disorder: A case study. *Cognitive and Behavioral Practice, 16*(3), 243–252. doi: 10.1016/j.cbpra. 2008.10.002

Schore, A., (2012, June). Modern attachment theory; the enduring impact of early right-brain development. Symposium conducted at the UCLA Center for Culture, Brain, and Development. Los Angeles, California.

Siegal, D. (2012). *Pocket guide to interpersonal neurobiology: an integrated handbook of the mind.* NY, NY. W. W. Norton & Company.

Treleaven, D. (2018). Is mindfulness safe for trauma survivors. Retrieved from: https://www.neuropsychotherapist.com/is-mindfulness-safe-for-trauma-survivors/

Author's Note: Mike Caverly is a Counselor Education and Supervision PhD student at Northern Illinois University. All correspondence should be sent to mcaverly@niu.edu.