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FROM THE EDITOR

Greetings to you all! I am grateful for the opportunity to present you with Volume 36 of the Virginia Counselors Journal (VCJ). I would like to thank all of those who submitted their work to this outlet and the many authors who have contributed to the content in this Volume. The quality of the journal is dependent on your willingness to share your work through this outlet. In addition, I would like to acknowledge the work of the VCJ Editorial Board and thank them for taking their time to offer valuable feedback and suggestions to authors and for identifying and recommending articles to include in this edition of the VCJ.

There have been changes in the makeup of the editorial board and editors over the past year. Thank you for your patience during this transition. I would like to extend my gratitude to Linda Grubba for inviting me to take on the role of editor and to Drs. Kevin Doyle, Rip McAdams, and Nadine Hartig for providing guidance as I transitioned into this new role. In addition, I would like to thank the VCA Board for ongoing support and Vicky Wheeler for all of the work she does to make this publication come to fruition. It takes many individuals working together in a variety of roles to make this journal a reality. I am honored to be a part of this process.

In order to meet the needs of authors and reviewers, I am seeking additional Editorial Board members. If you have interest in serving on the VCJ Editorial Board please contact me and share your interest and experience. I look forward to hearing from you. In addition, if you have a manuscript ready for publication, I encourage you to consider submitting your work to VCJ for review.

Carrie Sanders

Editor, The Virginia Counselors Journal

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Advance Directives: A Tool for Social Justice Advocacy

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Abstract

Of the estimated 9.8 million individuals living in the U.S. with serious mental illness (SMI), approximately 40-50% experience routine coercive or involuntary treatment (Center for Behavioral Health Statistics and Quality, 2015; Montgomery & Kirkpatrick, 2002). Research suggests that coercive treatment negatively impacts client recovery (Swartz, Swanson & Hannon, 2003). Advance directives (ADs) are a legal innovation theorized to empower individuals, improve clinical outcomes, and reduce coercion among clients with SMI (Backlar, 1999). Although demand for these legal documents is high, few clients have ADs due to clinical and operational barriers (Wilder et al., 2013). This integrative review provides practicing counselors with an understanding of ADs, their benefits, as well as how clinicians can work to address the systemic obstacles hampering the widespread use of these legal and clinical innovations.

Keywords: *advocacy, advance directives, serious mental illness*

Introduction

The American Counseling Association (ACA) Code of Ethics (2014) specifies that clients have the freedom to choose whether to enter into or remain in a counseling relationship. The principle of informed consent further ensures that clients are meaningfully involved in their treatment, and can specify a course of action that is consistent with their values. Backlar (1995) argues, however, that the individual rights protected by informed consent (freedom, liberty, and autonomy) are predicated on the assumption that a person has the capacity to make rational choices. O'Connell points out that assumptions of "incapacity and dependency [continue to] taint our understanding and approach to treatment of persons with mental illness" (2015, p. 104). When individuals are assumed

to not have the capacity for rational choice, their right to refuse treatment is legally waived through the civil commitment process, which varies from state to state. In Virginia, individuals who are at risk of harm due to their illness are often subject to mandatory interventions such as involuntarily hospitalization or mandated outpatient treatment (McGarvey, Leon-Verdin, Wanchek, & Bonnie, 2013).

It is generally accepted by both the legal and medical communities that this temporary infringement of individual autonomy is balanced out by the principle of beneficence, or working for the good of the individual and society (ACA, 2014). In other words, the ends (preventing future harm) justify the means (coerced treatment). However, empirical studies suggest that this approach may not be as beneficent as it seems. Research shows that 36% of individuals with SMI report avoiding mental health treatment out of fear of coercion (Swartz, Swanson, & Hanson, 2003). Other studies have found that coercion may be experienced as traumatic, counter-therapeutic, and stigmatizing (Swanson et al., 2003; Swartz et al., 2003; Theodoridou, Schlatter, Ajdacic, Rössler & Jäger, 2012). These findings have fueled interest in advance directives, which advocates argue could reduce the need for coercion through client empowerment (Bonnie, 2012; Scheyett, Kim, Swanson, & Swartz, 2007; Swanson, Tepper, Backlar, & Swartz, 2000).

Advance directives (ADs), or psychiatric advance directives (PADs), are legal documents that allow individuals to express their wishes and desires regarding potential future psychiatric care (Bonnie, 2012). ADs¹ also allow individuals to legally authorize a proxy who can make healthcare decisions on their behalf when they are in crisis. The advanced instructions (AI) and proxy designations (also known as Health Care Power of Attorney or HCPA) within ADs are designed to help individuals with serious mental illness (SMI) manage future psychiatric crises.

In a 2010 article, Van Dorn, Scheyett, Swanson, and Swartz drew a direct connection between social justice advocacy and the goals of advance directives. Citing prior research on the benefits of ADs, Van Dorn et al. (2010) argued that these legal documents support client empowerment through increased

¹ For the purpose of this article, ADs and PADs will be used interchangeably to refer to the psychiatric care instructions. Medical advance directives, legal documents that govern medical treatment or end-of-life care, will be referred to using this specific term.

individual autonomy, improved clinical outcomes, and a reduction in the use of coercive practices (Scheyett et al., 2007; Swanson, Swartz, Ferron, Elbogen, & Van Dorn, 2006; Swanson et al., 2008). Despite demonstrated benefits, studies also indicate that ADs are largely underutilized among individuals with SMI (Swanson et al., 2006b; Wilder et al., 2013). As one of the fastest growing professions in the provision of mental health services, counselors are well poised to encourage greater use of ADs across the state (Bureau of Labor Statistics, 2015). In order to do so, however, counselors must educate themselves on the use of these legal tools. This integrative review seeks to provide practicing counselors with an understanding of ADs, research on their benefits, as well as recommendations for using the ACA Code of Ethics (ACA, 2014) and ACA Advocacy Competencies (Lewis, Arnold, House, & Toporek, 2003) to address barriers hampering the widespread use of these promising legal and clinical tools.

The Revolving Door

Individuals with SMI are a marginalized, stigmatized, and often voiceless population of mental health consumers (Corrigan, 1999). In 2014, there were an estimated 9.8 million adults aged 18 or older in the United States with serious mental illness (SMI) such as bipolar disorder, schizophrenia, or major depressive disorder (Center for Behavioral Health Statistics and Quality, 2015). This number represents 4.2% of all U.S. adults. Individuals with SMI often experience periods of stability between episodic or acute crises (Bonnie, 2012). During these times of crisis, individuals may become incapacitated such that they are unable or unwilling to make health care decisions to protect themselves from undue harm and may be subject to involuntary treatment (Backlar, 1999).

Involuntary or coercive treatment, however, is associated with the “revolving door” (Davis, 1975). The revolving door describes a population of chronically mentally ill individuals frequently readmitted to psychiatric units due to noncompliance following discharge. Features of certain disorders, such as impaired reasoning and judgment, poor insight, and decisional incapacity can intensify the likelihood of poor follow-through (Zelle, Kemp, & Bonnie, 2014). The revolving door has a high cost to individuals, their families, and society (Insel, 2008).

Those affected by the revolving door die an average of 25 years earlier than the general population due to treatable medical conditions (Parks, Svendsen, Singer, Foti, & Mauer, 2006), and an increased risk of suicide and interpersonal violence (Alia-Klein, O’Rourke, Goldstein, & Malaspina, 2007). These negative outcomes are especially pronounced among those with co-occurring substance disorders (Adams & Scott, 2000). The revolving door is also financially costly. Estimates suggest that SMI costs the American economy \$193.2 billion each year (Insel, 2008).

Coercive Treatment

For the most part, the systemic response to the revolving door syndrome has been to expand coercive treatment through legal means (McGarvey et al., 2013). Many states have expanded coercive treatment laws twice over the past decade, once in 2008 following the Virginia Tech Shooting, and then again in 2014 following the Creigh Deeds tragedy (Bonnie, Reinhard, Hamilton, & McGarvey, 2009; Vozzella, 2016). In the wake of the Deeds tragedy, Virginia passed major changes to its civil commitment laws (Vozzella, 2016). These changes included an extension of the emergency custody order period (ECO) from six to eight hours, an increase in the time period from 48 to 72 hours for a temporary detention order (TDO), and guaranteed last resort beds at state psychiatric hospitals private facilities (Virginia Department of Behavioral Health and Developmental Services, 2016). From November 2013 to January 2016 there was a 20% increase in seasonally adjusted TDOs (Larocco, 2017), which some researchers have dubbed the *Deeds Effect* (Kunkle, 2015).

In addition to new civil commitment laws, coercive treatment practices have also expanded in more informal ways. For instance, many states require evidence that an individual’s condition poses a threat of “imminent danger” for the courts to override objections to mental health intervention (McGarvey et al., 2013). Yet in practice, treatment objections by individuals with SMI are overridden even in instances where there is no imminent danger (Hashmi, Shad, Rhoades, & Parsaik, 2014). Researchers argue that this gap between the law and its practical execution is not due to clinical error (Turkheimer & Parry, 1992). This informal expansion of involuntary treatment is due to a lack of less restrictive alternatives, such as outpatient crisis stabilization centers (Turkheimer & Parry, 1992).

Unfortunately, studies suggest that the routine use of legal coercion to treat seriously ill individuals can have adverse consequences (Swartz et al., 2003). As mentioned in the introduction, coercion may be experienced as traumatic, stigmatizing, and may further discourage those with mental illness from seeking the treatment needed to manage and recover from acute psychiatric episodes (Swartz et al., 2003). The deprivation of choice through coercion has also been associated with quality of life implications, including higher poverty rates, lower education levels, increased mortality rates, and increased unemployment (Colton & Manderscheid, 2006; Kosciulek, 1998; Priebe et al., 2009). In total, repeat experiences with treatment imposed over objection appear to thwart the healthy development and recovery of individuals with SMI.

Advance Directives

Advance directives (ADs) offer a promising approach to the revolving door syndrome by providing a platform for collaborative treatment planning (Srebnik & Fond, 1999). With an AD, individuals can specify their treatment preferences when they are well and have full capacity for decision-making (Scheyett et al., 2007; Swanson et al., 2000). Then, in the event of a psychiatric emergency, consumers can expect that the health care system will acknowledge and honor their stated treatment preferences. By specifying these wishes in a legally binding document, ADs empower individuals with SMI to retain as much control as possible over their lives and their psychiatric care. It is speculated that ADs could also play a significant role in reducing coercion (Bonnie, 2012; Swanson et al., 2000) and improving long-term clinical outcomes for individuals with SMI through better treatment engagement and improved therapeutic alliance (Scheyett et al., 2007; Swanson et al., 2000).

When a person is unable to indicate his or her preferences or give consent due to incapacity, treatment decisions are typically given over to family members, health care providers, or the legal system. Medical advance directives emerged as a way for individuals to retain control in situations of incapacity following two high-profile legal cases, involving Karen Ann Quinlan (*In re Quinlan*, 1976) and Nancy Cruzan (*Cruzan v Director, Mo. Dept. of Health*, 1990). Karen Ann Quinlan was a 21-year-old woman in a persistent vegetative state. After several months of deterioration, Quinlan's family requested to discontinue the use of a ventilator so she could die naturally. Initially, the

hospital refused this request. The New Jersey Supreme court asserted that in the absence of any conclusive evidence of Quinlan's wishes, her rights to privacy and choice could be "asserted on her behalf by her guardians" (*In re Quinlan*, 1976, p. 34). Citing self-determination, best interests, and equality, the court recognized that patients have a constitutional right to refuse treatment even if they are unable or incompetent to make the decision.

The Quinlan decision influenced the outcome of the Cruzan case over a decade later. *Cruzan v. Director of Missouri Department of Health* (1990) involved Nancy Cruzan, a 25-year-old in a persistent vegetative state following a motor vehicle accident. After a period of deterioration without improvement, Cruzan's family requested that her feeding tube be removed. This request was based on a conversation between Ms. Cruzan and a friend, in which Cruzan stated that she would not want to be kept alive through artificial means without the hope of recovery. Initially, the Missouri Supreme Court denied the request based on the requirements of informed consent. The U.S. Supreme Court eventually upheld the state court's decision, ruling that the Due Process Clause allowed for treatment refusal by competent adults, but not by incompetent or incapacitated adults in the absence of *clear and convincing evidence* of the person's wishes (*Cruzan v Director, Mo. Dept. of Health*, 1990).

Van Dorn et al. (2010) point out that the Cruzan decision did not mandate that patients' wishes be written, but did highlight the challenge of meeting the *clear and convincing* standard with only a verbal conversation. In response to these court decisions, Congress passed the Patient Self-Determination Act (PSDA) in 1990, which required hospitals and other health care organizations to inform patients of their rights to create medical advance directives (Van Dorn et al., 2010). Although the Quinlan and Cruzan decisions focused on medical advance directives, these cases also provided a framework for the development of psychiatric advanced directives (Van Dorn et al., 2010). Applebaum wrote of ADs in the *New England Journal of Medicine*, stating, "The idea's undoubted appeal in medical settings is exceeded only by its potential utility on the psychiatric ward... It would permit rational treatment based on a patient's own rational wishes" (1979, p. 788).

ADs in Virginia

While federal law distinguishes between medical advanced directives and psychiatric advance directives, Virginia makes no distinction between the two (Zelle et al., 2014). Since the passing the Health Care Decisions Act in 2009 (HCDA), Virginians have been able to create a single, integrated document that specifies medical, psychiatric, and end-of-life directions. Virginia's integrated AD includes instructions and/or designation of a health care proxy who can make medical decisions for the person during periods of incapacity (Zelle et al., 2014). These advance care documents may also contain individualized, patient-centered plans to prevent crises, as well as to manage and recover from these acute symptomatic episodes. While consumers can specify their treatment preferences, physicians in Virginia retain the power to override the AD in situations where a person has specified contra-indicated interventions (for example, refusing all psychiatric treatment).

Virginia's HCDA also includes an enforceable "Ulysses Clause," in which a patient gives advance consent to hospitalization over his or her own future objection (Zelle et al., 2014). The so-called Ulysses Clause is taken from a famous scene in Homer's *Odyssey*, in which Ulysses tied himself to the ship's mast while instructing his men -- whose ears are filled with wax -- to ignore whatever he says as they sail by the maddening sirens (Finley, 1978). These instructions are analogous to the protestation or Ulysses Clause in advance directives: *when I have a crisis, I want you to follow the instructions I am writing now while I am capable of making informed decisions, and not follow my objections later when I am incapable of making informed decisions* (Mental Health America of Virginia, 2016). Unlike other aspects of the AD, a physician or a clinical psychologist who can testify that the consumer was competent and understands the implications of their consent to future treatment must sign the Ulysses Clause (Zelle et al., 2014).

The state of Virginia requires little for an advance directive to be considered legally binding (Zelle et al., 2014). While there are pre-made forms available online to help consumers make decisions in organized ways, they are not required to make the document legal. The only requirement is that the person signs the documents with two adults present to witness the signature. Consumers do not need an attorney to complete an AD, nor do they need a treating provider's

consent unless they add a protestation provision (i.e. Ulysses Clause). After completing an AD, consumers are encouraged to provide copies of this document to their health care providers. It is recommended that consumers also upload these documents onto the Virginia Department of Health (VDH) Advance Health Care Directive Registry and the US Living Will Registry. Storing the document in these registries ensures that if someone has a mental health crisis away from their home hospital or provider, the treating facility will have access to their AD (Mental Health America of Virginia, 2016)

Research on ADs

At present, there is no mention of advance directives in the counseling literature. However, legal, psychiatric, social work, and psychology researchers have published a number of studies examining aspects of ADs over the past two decades. Outcome research suggests that ADs offer both clinical and quality of life benefits. Several studies found that ADs increase consumer motivation to follow-up with treatment following a hospital discharge (Elbogen et al., 2007). Increasing follow-up can improve treatment adherence, which may reduce the frequency of future relapses, particularly those sparked by noncompliance (Elbogen et al., 2007). ADs also appear to improve the therapeutic alliance (Theodoridou et al., 2012). Researchers have found that the conversation around treatment preferences between the client and provider appears to improve the strength of the relationship (Swanson et al., 2006b). Other studies have suggested that ADs can reduce the use of future coercive crisis interventions, such as involuntary hospitalization (Swanson et al., 2008). ADs also appear to increase client empowerment, which has been associated with gains in self-confidence, social support, self-esteem, and quality of life (Linhorst, 2006; Nelson, Ochocka, Janzen, & Trainor, 2006).

ADs appear to be largely underutilized in the provision of mental health services despite high demand for ADs among consumers. A national survey found that the majority of people with SMI indicated an interest in completing an advance directive (Swanson et al., 2006b). Demand for ADs appears to be even higher among specific SMI populations, including women, non-whites, those with a history of self-harm, arrest, or an overall decreased sense of personal autonomy (Elbogen et al., 2006; Swanson et al., 2006b). These findings suggest that ADs could be

particularly powerful for individuals whose experience of marginalization in the mental health care system is compounded by gender, race, or justice-involved status. Despite high demand, only 7% of these same individuals (N=1,011) in the national survey executed an AD (Swanson et al., 2006b). A follow-up study in Virginia, however, found that 49% of consumer respondents (N=40) reported having completed an AD (Wilder et al., 2013). The authors of this study, however, recognized that there were low response rates among mental health consumers and possibly high selection bias among the respondents in this survey. As a result, the authors raised questions as to the generalizability of this study.

Among other stakeholder groups, such as families, advocacy groups, and clinicians, demand for advance directives is varied. In one study surveying 600 clinicians by Elbogen et al. (2006), less than half of the providers believed that advance instructions would be helpful to individuals with SMI. However, this study suggested that attitudes were more favorable when survey respondents were also aware of laws that enable clinicians to override advance instructions that were incompatible with standard practice (Elbogen et al., 2006). In another study on clinician experiences with ADs, only 13% of clinicians indicated that they had worked with a client who had either Health Care Power of Attorney (HCPA) or advance instructions (Van Dorn et al., 2006). The same study, however, found that family members and consumers were less concerned with empowerment, and tended to focus on the proscriptive and prescriptive benefits of the AD, such as avoiding being treated against one's will or being able to obtain much-needed treatment (Van Dorn et al., 2006). Despite the positive support for ADs among different stakeholder groups, the use of these documents remains low due to the significant barriers to implementation (Shields, Pathare, Van Der Ham, & Bunders, 2014).

Studies examining barriers to implementation identified two main hurdles to more widespread use of ADs, including issues surrounding consumer competency in the completion advance directives, and clinician misinformation or lack of awareness (O'Connell & Stein, 2005). The disparity between the anticipated benefit of ADs (empowerment, improved clinical outcomes, reduced coercion) and their low utilization rates prompts a social justice imperative for

counselors to address the barriers inhibiting the use of advance directives.

Implications for Counselors

The ACA Code of Ethics (2014) and the ACA Advocacy Competencies (Lewis et al., 2003) provide an ethical framework for counselors considering the use, or in this case, underuse of advance directives. In section A.2.d., the Code of Ethics (ACA, 2014) specifies that when working with incapacitated adults, counselors must "seek the assent of clients to services and include them in decision-making as appropriate" (ACA, 2014, p. 4). In this sense, advance directives are highly consistent with the ethics of the counseling profession. Similarly, ACA Advocacy Competencies encourage counselors to engage in forms of social justice advocacy across individual, systems, and societal domains (Toporek, Lewis & Crenshaw, 2009). These competencies expand the role of the counselor to include empowerment and advocacy practices aimed at addressing roadblocks that inhibit healthy human development.

As mentioned earlier in this article, demand for ADs is high while use remains low. Researchers attribute this disparity to two sets of barriers: consumer completion and clinician misinformation (Shields et al., 2014). Using the ACA individual empowerment competencies, counselors can help minimize the first barrier by providing assistance to consumers with the completion of an AD. Prior research suggests that structured AD facilitation is associated with numerous benefits, with the most important being that this type of assistance can lead to higher completion rates (Swanson et al., 2006a). In a randomized control trial, Swanson et al. (2006a) found that 61% of participants (N=469) in the treatment group receiving facilitation services completed an AD as compared to 3% in the control group. Facilitation also helps consumers think through their choices more thoroughly, provide more useful instructions, and remember their AD in a crisis situation (Swanson et al., 2006a). Requirements to become an AD facilitator vary from state to state. More information can be obtained through the Bazelon Center's MacArthur Foundation-funded Advance Directives Project (www.bazelon.org/Where-We-Stand/Self-Determination/Advance-Directives.aspx) (Bazelon Center, 2014).

The second factor that researchers have identified as a barrier to AD use is clinician misinformation or

lack of awareness (Shields et al., 2014). Studies have demonstrated the great clinical and consumer benefits of advance directives; yet, in actual practice, very few clinicians have ever used an AD. In this sense, there appears to be a gap between research and practice. Some scholars have argued that this “diffusion of innovation” issue can be overcome when the presenter of new ideas resembles the recipient of the new information (Rogers, 1983; Sanson-Fisher, 2004). In other words, counselors listen to other counselors and are more likely to adopt an innovation recommended by an LPC than one recommended by a social worker or a psychiatrist (Sanson-Fisher, 2004). Counselors can use the systems advocacy competencies (Lewis et al., 2003) to address this barrier. Strategies for fostering greater use among clinical mental health counselors could include providing in-service training on ADs, integrating ADs into agency procedures, or sharing AD resources through consultation (Shields et al., 2014). Counselors can also work on behalf of clients within their agencies to make advance directives part of the treatment planning process. As advanced directives become more commonplace among working clinicians, research suggests this will increase the likelihood that these documents will be accessed and followed in crisis settings (Scheyett et al., 2007).

Conclusion

Individuals with SMI are a marginalized and stigmatized population of clients. Many with SMI may face additional forms of oppression due to coercive practices in the mental health system. The revolving door of care is costly, both in the financial and personal sense, to these individuals, their families, our communities, and society-at-large. Advance directives offer a promising way of remediating systemic oppression by empowering individuals, improving clinical outcomes, and decreasing the use of coercive treatment. At present, the potential of ADs is untapped due to systemic barriers that inhibit more widespread utilization. As vital mental health professionals, counselors can take an active role in minimizing these barriers by utilizing the ACA Code (2014) and the ACA Advocacy Competencies (Lewis et al., 2003) to educate colleagues and clients about the use of ADs. Through advocacy and empowerment, counselors can support the increased use of ADs across the state.

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Mental Health Care for the Homeless: Best Practice and the Counseling Profession

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Abstract

This paper concerns the delivery of mental health care services to homeless people. We critically examine service delivery models of service delivery, with emphasis on roles for counselors. While deinstitutionalization in the 1980s led to community-based models of service delivery, the patchwork of approaches available now does not serve the needs of homeless persons with mental health problems. We conclude that a best practice approach combines the concept of housing first with peer navigated, integrated community services in primary care, mental health counseling, and social support.

Keywords: *homelessness, mental illness, counseling, shelters, housing first, treatment first*

Homelessness is a significant and persistent problem in the United States. In 2017, on any given night there were an estimated 553,742 people without housing nationwide, 6,067 of whom live in Virginia. (U.S. Department of Housing and Urban Development, 2017). For the first time in seven years, this figure is higher than the previous annual survey. People who are homeless are at elevated risk for substance abuse, mental illnesses, and other physical and social problems (Babidge, Buhrich, & Butler, 2001; Kasproff & Rosenheck, 2000). Approximately 1 in 10 persons seeking substance abuse or mental health treatment in the public health system in the United States is homeless (Substance Abuse & Mental Health Service Administration [SAMHSA], 2013).

This paper reviews current research on homelessness and mental health, explores the public policy response, and reviews the spectrum of treatment models. We augment this with interviews, highlighting participants' direct experiences at homeless shelters. With this background, we identify best practices in delivering mental health services to chronically homeless persons, and highlight the roles

that counselors can play in delivering mental health care to persons who are homeless.

Counselors are in a strong position to help develop and promote best practices when it comes to working with homeless clients with mental illness. The professional counselor approaches this problem with an integrated, wellness-oriented view of helping clients resolve their issues. The unique set of issues this population confronts represents both a problem and an opportunity for counselors to fill gaps in the institutional safety nets.

Overview of Homelessness

Homelessness and Mental Illness

Homelessness and mental illness are connected (Lippert & Lee, 2015). A study conducted by Greenberg and Rosenheck (2010) found that exposure to personal violence, substance use disorders, and other psychiatric illnesses raise the probability of homelessness. The rates of combined homelessness and mental illness are high. One study estimates that up to 60% of chronically homeless persons have mental health problems (Burt, Aron, Lee, & Valente, 2001). Within that group, serious mental illness (SMI) is found in approximately 25–33% of the homeless population (U.S. Department of Housing and Urban Development, 2011; Fischer & Breakey, 1991), and these rates likely have increased over time (North, Pollio, Perron, Eyrich, & Spitznagel, 2005). Among people with SMI, the risk of homelessness is 10–20 times that seen in the general population (Susser et al., 1997). In one study of patients with SMI treated in a public mental health system, 15% of patients were homeless at some point during a 12-month follow-up period (Folsom et al., 2005).

There is also strong evidence that the risk and severity of mental illness are correlated with the duration and number of episodes of homelessness (Lippert & Lee, 2015). The “accumulation of risk” perspective supports the observation that chronic exposure to stress increases the probability of resulting mental health issues. Greater severity of symptoms, increased vulnerability, and other elevated risk factors stem from the traumatic experience of homelessness (Castellow, Kloos, & Townley, 2015). The authors equate the impact of homelessness to adverse outcomes common to those experiencing post-traumatic stress disorder. In addition to these stressors, increased susceptibility to substance use disorder is also an important risk factor, given its high prevalence among

the homeless. As mentioned earlier, homeless episodes increase the incidence of psychiatric disorders, substance use disorders, and lead to lower rates of recovery (Castellow, Kloos, & Townley, 2015).

Given this accumulation of risk factors, it is not surprising that homeless individuals with mental health conditions were more likely than housed individuals with mental illnesses to pay return visits to hospital emergency departments and be readmitted (Chun, Arora, & Menchine, 2016). Hospital psychiatric wards have limited inpatient capacity, and homelessness creates a cascading effect on the behavioral health care system's ability to handle emergencies. So long as emergency rooms are the homeless community's primary care access point, there will be friction among users and providers of care.

The Trauma of Homelessness

Reflecting on the experience of homelessness helps counselors to understand how it contributes to mental illness. This can guide us in building a response that is both pragmatic and wellness-oriented. Shelter is a basic physiological need, but a home serves higher, existential needs as well. Being released from an institution without a place to live, aging out of foster care, losing the resources to maintain a home are all traumatic experiences. There is scant research on the phenomenology of homelessness, with virtually no studies conducted on the experience of becoming homeless. However, it is clear that counselors working with the homeless will need to be mindful of unmet needs in employment, social support, health care, and housing as the primary concerns of this population (McBride, 2012).

Counselors should also be aware that homeless people enter a cycle of drudgery which has the effect of draining self-esteem. The task of satisfying basic physiological needs is often an all-encompassing effort. Because people who are homeless often have comorbid physical conditions, scant resources, and are itinerant within their communities they most often do not know how to access or seek mental health care.

"Escape Velocity": Key Findings on Breaking the Cycle

It is important to describe what successful "escape velocity" from homelessness looks like, so that counselors can build delivery systems with the highest odds of success. Rayburn (2013) observes that "most

multiply troubled individuals in their early 30s are still multiply troubled individuals 20 years later, still people who struggle with addictions, unstable employment, troubles with the law, and presumably homelessness" (p. 9). Significantly, he found that individuals who successfully escaped this cycle of homelessness and mental illness did so with the help of social bonds, with marriage and employment indicated as strong supporters of creating and maintaining escape velocity.

A meta-analysis of homelessness and mental health care in Great Britain found that permanent housing is associated with reduced rates of mental illness in populations that were previously homeless (Smith, 2005). While housing alone may not suffice, the lack of a home is a major barrier to recovery. One way to conceptualize escape velocity is as a social process that incorporates personal agency, life quality, and attention to a person's individual needs, an approach that agrees well with the counseling ethos (Watson, 2012). This is distinct from the medical or clinical perspective; which, by defining recovery as the end of an illness, implies a normative state of being.

Public Policy: The Road from Deinstitutionalization

When exploring how counselors can be part of the solution to homelessness, it is important to consider how we got here. The 1980s began an era of deinstitutionalization in the mental health care field. Large, state run hospitals were systematically downsized and patients were disbursed into community mental health networks. Perhaps it was predictable that in the wake of deinstitutionalization, many people with SMI dropped out of the behavioral health care system and ended up chronically homeless.

As a public policy response to this unintended consequence, two initiatives, Programs for Assistance in Transition from Homelessness (PATH) and Access to Community Care and Effective Services and Supports (ACCESS) were launched in the 1990's with the support of the Substance Abuse and Mental Health Services Administration (SAMHSA). The ACCESS program was effective in reaching and providing services to homeless people with mental illnesses (Lam & Rosenheck, 1999). The PATH program continues to be a source of direct federal funding, through SAMHSA, to the state level. SAMHSA also serves as an information hub and training resource through the Homelessness and Housing Resource Network. Aside from these initiatives, individual states have developed

outreach programs, each of which has its own set of policies and practices (Rowe, Styron, & David, 2016).

A related, and lasting response to the impact of deinstitutionalization was the Health Care for the Homeless (HCH) initiative. This initially private, but later federally-sponsored program began in the 1980s, and now supports over 200 sites nationwide (Zlotnick, Zerger, & Wolfe, 2013). Many of the care models under review have emerged from HCH pilot programs.

President Barack Obama launched two major initiatives addressed at homelessness and mental illness. In June 2010, his administration released “Opening Doors: Federal Strategic Plan to Prevent and End Homelessness” (Interagency Council on Homelessness, 2010). One aspect of this program is the improved provision of behavioral health care to the homeless. Four years later, the Affordable Care Act of 2014 (ACA) opened new avenues to extend primary and mental health care to the homeless. Of note, states that chose to expand Medicaid as part of the ACA covered 22% more of their homeless population, compared to 4% in non-expansion states (DiPietro & Zur, 2014).

Although federal and state programs to extend care to homeless people have been in place for decades, it is questionable how well they reach their intended populations. To this point, one study found that while people experiencing homelessness were just as likely as housed individuals to have their needs for medical and dental care services met, those who were homeless were less likely to access mental health care services (Zur & Jones, 2014). They studied users of Federally Qualified Health Centers (FQHC). Many of these centers are eligible for HCH subsidies, and in many communities, they are the primary methods of health care delivery for homeless people. Despite this, individuals using this delivery method report significant gaps in their access to care.

The Counseling Profession and Homelessness

The counseling profession is in a strong position to address the complexity of homelessness. Complicated problems require an integrated response, a hallmark of counselor training. The pernicious combination of homelessness, poverty, medical, and behavioral issues can drive a wedge between caregivers and clients. Unfortunately, there is a persistent pattern of mutual avoidance between the community of caregivers and homeless individuals released from psychiatric

hospitals (Drury, 2003). This mutual avoidance is understandable but unhelpful in breaking the cycle of institutionalization, homelessness, and mental health problems.

Currently, a dearth of information exists related to effective mental health treatment for people who are homeless. In one study examining effective counseling services for the homeless, Baggerly and Zalaquett (2006) used a social justice framework to call counselors to action to reduce the gaps in mental health services to the homeless. The authors highlight the need for on-site mental health care providers to offer care over extended periods. They urged counselors to increase their awareness of homelessness, to support people experiencing homelessness with wellness and goal-oriented counseling, and to advocate on behalf of mental health care access for the homeless.

The Spectrum of Service Delivery Models

There is a debate in the helping community over where to start in addressing the problem. At one end of the spectrum lies Treatment first (TF) models of care, and Housing first (HF) models are on opposing poles. The treatment first approach is medically-oriented, with a focus on seeking to diagnose, treat, and monitor progress of the mental illness. Conversely, the housing first model is a consumer-oriented approach. Clients get a permanent roof over their heads, and then they decide which services to utilize. In practice, the spectrum of service delivery models is a continuum from bare bones TF models through hybrid models and back around to purist HF programs.

The CSB Referral Model

A basic approach to extending mental health services to a homeless person is a referral from an emergency clinic or shelter to the local community services board (CSB). This modality falls on the treatment first end of the spectrum, as the CSB focus is primarily on behavioral health. In practice, there are multiple logistical and administrative barriers to successful referrals from shelters to CSBs. The initial referral to a CSB can be problematic. Page (2007) reported that 45% of survey respondents reported “major barriers” in transferring clients to CSBs. In searching for ways to improve access to care, those involved in working with the homeless have developed several improvements on the basic referral model. These are outlined below.

The Assertive Outreach Model

The assertive outreach model can be thought of as a supply-driven TF approach. Trained clinicians and/or helpers reach out to create relationships with clients where they find shelter and spend their time. One study by Rowe et al., (2016) followed six outreach programs in Connecticut, and identified four critical success factors in keeping the teams engaged. They found that cohesive care teams, a broad menu of service options, support in navigating service systems, and a good working and training environment were strong motivating forces for these helpers.

Assertive outreach has been in use for over 20 years, is largely left to individual states to design, implement, and monitor, and often is conducted primarily by paraprofessionals who are supervised by clinical directors. The published research on these programs consistently points to the importance of “connectors.” These individuals, be they agency staff, case managers, or peer navigators, are critically important as links to and advocates for people who are homeless.

Co-Located Primary and Behavioral Health Services

Further along the spectrum, there are models of care that might be conceptualized as more demand-driven. In search of services, many people experiencing homelessness seek primary care at emergency rooms, free clinics, or urgent care centers. The comorbidity of homelessness, mental health issues, and physical maladies has led to efforts to combine primary and mental health care at facilities that are convenient for people who are homeless. SAMHSA points to what they call the Comprehensive, Continuous, and Integrative System (CCIS) as their recommended model (Harrison, Moore, Young, Flink, & Ochshorn, 2008). This integrative and overlapping approach brings elements from social work, counseling, psychiatric services, dental, and mental health together to serve homeless populations. An examination of one such program identified “system-level change, efficient use of existing resources, incorporation of best practices, and integrated treatment philosophy” as the key elements of the CCIS model (Harrison et al., 2008, p. 257). Their study indicated improved client outcomes as a direct result of program design and systematic application.

Continuity of Care

On the treatment first side of the debate, continuity of care (CoC) is a long-established approach to rehousing people with mental illness, particularly substance use disorders. Often referred to as the “abstinence model,” CoC is a stage-based approach with emphasis on care at the outset (Watson, 2012). Shelter is a provisional reward for compliance with the care regimen. Detox and “dry” shelters are often the first stages in this model. With compliance comes the opportunity to move to a halfway house. These temporary homes are characterized by a rules-based structure, regular drug testing, and mandatory attendance at counseling sessions. Despite their label, continuity of care programs are generally limited in duration and often are not connected to permanent housing agencies. This creates a gap when clients reach the end of their permitted stay in temporary housing. The jarring transition between unstructured life on the streets, the discipline of halfway houses, and the burden of finding permanent housing is often too much for people who have been chronically homeless.

Residential Recovery Homes

Another modified TF model is the residential recovery home. In a recent study, Polcin (2016) pointed to promising results coming from such programs as Oxford House. In this model, substance abusers who are homeless and/or dealing with other mental health issues live in a shared home, with support from peers and community health workers. Polcin noted some of the same limitations in residential recovery homes. Such facilities are often not connected to permanent housing, are time-limited, and require abstinence.

Housing First Models

At the other side of the divide over housing vs. treatment, the housing first philosophy embraces a low threshold approach to availability, coupled with belief in the client’s personal agency as to how to address substance abuse and/or mental health problems. Housing first programs provide a residence largely without conditions, either in apartments or group facilities. This permissive approach may be particularly helpful to persons who are chronically homeless (generally defined as longer than one year) and persons with chronic psychiatric conditions (Padgett, Gulcur, & Tsemberis, 2006). For people who are averse to formal treatment programs, housing first is an alternative

that resolves a major piece of their struggle—finding a stable residence.

The housing first model is a consumer-based approach, in contrast to the TF models that assume a normative threshold for screening individuals into rehousing programs (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005). This idea challenges traditional ways of conceptualizing care. Viewed from the Adlerian standpoint, the idea of personal responsibility and freedom as powerful tools lends support to solving the housing problem first. When these investigators sought to establish a direct link between choice, mastery, and improved mental health (measured via self-report), they found an association between these factors, but noted that mental health issues have etiologies that are not explained solely by homelessness Greenwood et al. (2005).

While it is useful to understand the treatment first vs. housing first debate, the findings do not tell us about hybrid or integrated models that take the best of both worlds. The following sections focus on such models.

The Mental Health Home Model

One interesting approach when homelessness and mental illness present together is the “mental health home,” which is informed by the success of the medical home model (Smith, Sederer, Smith, & Sederer, 2009). The mental health home is not so much a specific place as a locus of coordinated and comprehensive care, a successful delivery system for at-risk patients. In the case of seriously mentally ill and homeless people, their conditions render them not only without housing, but also medically homeless. The mental health home incorporates diagnosis and medication, along with preventative and primary care, advocacy, case management, and housing. The objective is reintegration onto community. Client self-determination, engagement, and partnership with the treatment team guide the process. In their suggestions for best practice, Smith et al. (2009) proposed that a non-medical clinician lead the treatment team, working with psychiatrists as expert consultants. Counselors, perhaps working with counselors-in-training, would seem to be well-suited for this role.

Bridging the Gap: An Integrated Approach

There are treatment models that appear to have sidestepped the TF-HF debate. One pilot program in the Philadelphia area that combines the medical home

and housing first models has shown promising results (Weinstein et al., 2013). This initiative integrates housing, primary medical and psychological care, and community support. As with the mental health care home model, it is interesting to consider whether counselors could be trained to fill the key coordinating role, with physicians and psychiatrists serving on the treatment teams.

The results of this Philadelphia pilot were corroborated by outcomes of a statewide initiative in California. In 2004, voters approved a proposition known as the Mental Health Services Act (Gilmer, Stefancic, Ettner, Manning, & Tsemberis, 2010). Assessing three years of this broad initiative in San Diego, the authors reported a 67% decrease in the mean number of days homeless, a rise in outpatient mental health visits and a decrease in emergency, inpatient, and justice system usage (i.e. detention or incarceration), and an increase in housing and outpatient costs that was 82% offset by crisis-oriented service costs.

Conclusion and Suggestions for Best Practice

Nearly forty years have passed since the dual challenge of homelessness and mental illness became a public policy priority. In the intervening decades, a range of theoretical frameworks and applications has been tested, enhanced, and woven into public health care across the country. Today, there are reasons to be optimistic. The combination of public policy support, integrative delivery models, appropriate conceptualization of care, and motivated counseling resources presents a positive outlook for raising the level and quality of mental health care services for the homeless. More research is needed to identify organizational models and career pathways for helping professionals who choose to make this important population their life’s work.

That having been said, there are several best practices in building community-based services for this population. First, assertive outreach is helpful in meeting clients where they are. Second, peer navigators are a bridge to connect this population with clinical resources and formal programs. Third, the psychosocial needs of this population are best satisfied through a low-barrier, housing first orientation. Fourth, housing alone is insufficient to systematically address the primary, mental health, and substance dependency issues faced by this population. Fifth, an integrated approach that provides the consumer with

sustained housing, and options to receive primary care, mental health, and social advocacy services has the highest likelihood of helping these individuals break the vicious cycle of homelessness and mental illness. Putting this together, best practice combines the concept of housing first with peer navigated, integrated community services in primary care, mental health counseling, and social support.

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A Contextual Framework for Counseling Immigrant and Refugee College Students

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Abstract

As the number of immigrant and refugee college students continues to increase, the services available through colleges and universities still remains low. Immigrant and refugee students experience unique barriers related to language, adjustment, financial stressors, and academics which can impact their academic performance and overall well-being. Due to cultural beliefs, perceived limited access, and misinformation regarding counseling and therapy, immigrant and refugee students are less likely to seek mental health support. This article explores how college and university counseling centers can provide culturally sensitive services for immigrant and refugee college students.

Keywords: *immigrant, refugee, college student, college counseling*

Introduction

The United States has been an immigration magnet since its inception. Immigrants began flocking to this country in hopes of pursuing a new and better life. The United States continues to welcome immigrants from all over the globe. Immigrants make up approximately 13.5% of the U.S. population, standing at an average of 43.3 million individuals (Zong, Batalova, & Hallock, 2018). In most recent years, an average of 1.3 million persons immigrated to the U.S. from other countries (Zong et al., 2018). Data from the National Center for Educational Statistics (Arbeit, Staklis, & Horn, 2016) indicated that 24% of undergraduate students in the United States are immigrants or children of immigrants. First generation immigrant students comprise 8-10% of undergraduates enrolled in U.S. colleges and universities (Arbeit et al., 2016).

Data from the U.S. Census Bureau (2016) suggests that 65% of jobs in the United States by 2020 will require post-secondary education or training. In Virginia, one in six workers is an immigrant and two fifths of adult immigrants have a college degree or

more (American Immigration Council, 2017). This leads to the critical role that counselors can play in promoting the adjustment of immigrant and refugee college students by assisting them in attaining higher education and training.

When referring to immigrant and refugee college students, it is critical to be mindful of their pre and post-migratory experiences. Factors in their pre-migration, such as access to education in country of origin, family, and socio-economic status will have an impact on acculturation and adjustment (Oppedal et al., 2017). Similarly, post-migratory factors such as acculturative experiences, access to services, financial barriers, family conflict, and university climate have similar impacts on well-being and psychological health (Baum & Flores, 2011; Blanchet-Cohen, Denov, & Bilotta, 2017; Núñez & Gildersleeve, 2016).

For the purpose of this article, the word “immigrant” will be used to describe any foreign-born college student who has immigrated to and currently resides in the U.S. This term will encompass those who have immigrated to the United States for the sole purpose of receiving education as well as those who immigrated for other reasons and are currently attending a U.S. university. This term will also include any immigration status. In this article, we examine the current literature to offer a contextual understanding for counseling immigrant and refugee college students.

Acculturation and Identity Development

Although adjustment to college can be a stressful process for many students, immigrant college goers in particular have unique additional stressors (Rodriguez, Myers, Morris, & Cardoza, 2000). Perceived prejudice, for example, was found to be experienced by South Asian immigrant college students and is a predictor of depression (Rahman & Rollock, 2004). Acculturation is a process that all immigrants undergo when they arrive to the United States. It is also found to be related to mental and emotional well-being among immigrant college students. Acculturation is defined as the cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture (Acculturation, n.d.). High levels of acculturation among immigrant Asian American college students were associated with better mental health (Miller et al., 2011).

Language Factors

Another aspect related to the acculturation process is language. Transitioning to college entails multiple adjustments that can include a change in the academic standards and expectations. There is a change in the way a student may think, write, and speak. These changes can be particularly difficult for refugee or immigrant students who may be at different levels of English proficiency. As more refugee and immigrant students are attending four-year institutions in the United States, more programs are being created to provide linguistic support. Unfortunately, there are still some institutions and professors who are not understanding of the linguistic adjustment that causes stress for these students. This stress can result in anxiety regarding doing well academically and achieving success (Kanno, 2010). Particularly, this can negatively impact a student's confidence in the ability to write, speak, or understand different academic assignments.

The language barrier may also impact refugee and immigrant students' ability to interact socially with peers, faculty, and staff. Students may lack the confidence in their English proficiency to initiate conversations with others (Noels, Pon, & Clément, 1996). This can limit a student's social support, thus creating a sense of isolation. Students may feel that no one understands them due to the language barrier and feel that it may be easier to avoid interactions.

Language acquisition and English proficiency are critical in the overall success of college students in the United States. Interestingly, greater self-perceived proficiency in English is linked with self-esteem, suggesting that immigrants with higher self-esteem have more perceived proficiency in the English language (Noels, Pon, & Clément, 1996). Language proficiency is also linked with academic success in immigrant college students (Li et al., 2017). Despite self-esteem and level of language preparation that characterize immigrants before arriving in the United States, language can still serve as a unique barrier. Immigrant Chinese students have reported that the colloquial English used in their university is much faster than what they had expected and prepared for before coming to the United States (Li et al., 2017).

Immigration Status

Immigration status can play a vital role in the adjustment and continued success of immigrant college students. The status label of college students

as "immigrants" was found to have an interaction with hopelessness, as well as familial acculturative stress (Lane & Miranda, 2018). This is a unique aspect of the identity of immigrant college students that is not found in their non-immigrant counterparts. For undocumented immigrant students, fear of arrest, deportation, as well as racism and discrimination, can play a role in whether a student is able to successfully obtain a college degree (Borjian, 2018). Many undocumented college students are not able to obtain work in the United States after college (O'Neal et al., 2016).

Given the current political uncertainty of Deferred Action for Childhood Arrivals (DACA), as well as U.S. refugee policy, one can infer the added stressor placed on this particular subset of immigrant college students. In a study conducted by Borjian (2018), students reported that pro-immigrant public policy, as well as institutional processes and support, are critical aspects in their academic success. Counselors should be aware of their immigrant client's perceived prejudice as it has been found to be a factor related to adjustment to college (Rahman & Rollock, 2004). Holding immigrant status also deserves attention related to familial factors and finances. Immigrants often have financial barriers related to their immigration status and this can play in role in their success in post-secondary education (Baum & Flores, 2011). This suggests that financial access as related to immigration status is a factor in educational attainment among immigrant and refugee college students.

Family Factors

Recent literature on the experiences of immigrant and refugee college students suggests the need for universities and staff to explore different ways of understanding unique factors influencing academic adjustment and success within and beyond the university setting. This includes an important focus on familial background and relationships contributing to academic adjustment (Chhuon, Vichet, & Hudley, 2008). A focus on familial background and relationships provides a holistic understanding of the unique challenges and needs immigrant and refugee students face in higher education (Vasquez-Salgado, Greenfield, & Burgos-Cienfuegos, 2015; Smith & Khawaja, 2011). However, the predominant strategy used in higher education of attending to post-migratory experiences ignores pre-migratory education quality related to

country of origin and socioeconomic status (Baum & Flores, 2011), as well as the impact of the institutional values and post-migration acculturation on family conflict and strong family bonds (Blanchet-Cohen, Denov, & Bilotta, 2017).

Researchers have found immigrant families with a previously high-income level in their country of origin will have a greater likelihood of obtaining and accessing higher education than immigrant families with a low-income level in their country of origin (Baum & Flores, 2011). The limited access to higher education largely attributed to an immigrant family's socioeconomic status perpetuates disadvantage across generations. For example, immigrant students who have parents with college degrees are more likely to be better prepared for academic expectations, compared to immigrant students that are first generation college students. Immigrants who are first-generation college students from families with low-income levels typically have limited knowledge and resources needed for post-secondary academic preparation, which results in low rates of degree completion (Baum & Flores, 2011). This creates an inherent obstacle to obtain social mobility for immigrant families with a low-income level. Therefore, universities and college counseling centers cannot only focus on post-migratory experiences affecting academic success, access, and adjustment, but must also explore pre-migratory experiences. Additionally, universities need to examine the impact of institutional values and compounded stressors influencing family intergenerational conflict and psychological well-being.

Researchers have reported the transition to higher education as a specific time with increased acculturative stress and family intergenerational conflict for immigrant or refugee college students (Tseng, 2004). While enrolled in college, these students experience dichotomizing values, such as the value of independence by the surrounding dominant culture compared to the familial value of interdependence. The value of independence over interdependence in the academic setting amplifies an experience of cultural mismatch that hinders academic success and increases acculturative stress for students by emphasizing differentiating from family, rather than maintaining social support and sense of community (Baranik, Hurtst, & Ebby, 2018; Stephens, Fryberg,

Markus, Johnson, & Covarrubias, 2012). Furthermore, the different familial and institutional values can result in a cultural conflict that increases intergenerational family conflict (Lazarevic, 2017).

An increase of intergenerational family conflict impacts immigrant and refugee college students' psychological well-being (Singh, McBride, & Kak, 2015) by increasing the students' bicultural management difficulty (Hou, Kim, & Wang, 2016). The bicultural management challenge results in a heightened internal struggle from navigating between home and school values (Vasquez-Salgado, Greenfield, & Burgos-Cienfuegos, 2015). Researchers have found that parental distress and intergenerational family conflict exacerbate acculturative stress, psychological distress, and lowered social support (Lui, 2015; Singh et al., 2015). Family support buffers experienced discrimination on campus and lack of a sense of belonging (Chhuon & Hudley, 2008). Although researchers have identified the educational outcomes and mental health disparities for immigrants (Hou, Kim, & Wang, 2016; Lui, 2015) and refugees (McBrien, Dooley, & Birman, 2017), there remains a gap in the research that explores the effects of pre-and post-migratory experiences and the subsequent longitudinal impact on family functioning, mental health, academic success in higher education.

Academic Adjustment and First-Generation Issues

Self-efficacy is an important component in a student's self-confidence. Bandura (1997) stated, "Perceived self-efficacy is a better predictor of intellectual performance than skills alone" (p. 216). In a study done by Multon, Brown, and Lent (1991), self-efficacy was found to impact a student's perceived ability to perform academically. Refugee and immigrant students face difficult challenges that may not be experienced by their non-immigrant American counterparts. These challenges may cause students to struggle academically and impact their self-efficacy (Soria, 2013). Based on a student's cultural background, high academic performance may be an expectation for both oneself and one's family. This adds a level of stress on a student which may cause anxiety about high academic achievement. If a student does not perform well, this can also lead to depressive symptoms and feelings of worthlessness (Kumaraswamy, 2013).

Cultural Adjustment & Identity Development

Cultural adjustment can be both a positive and negative experience for refugee and immigrant students. Students have the opportunity to learn about the American culture and integrate different values and beliefs that feel appropriate. This can also pose a challenge for immigrant students in remaining true to their family, community, and homeland (Kim, 2009). As students begin to adopt a new culture, they may feel shame and guilt regarding leaving certain aspects of their culture behind. Immigrant students are in the process of entering adulthood and often living on their own for the first time. Potochnick and Perreria (2010) found that they reported their migration experience as a stressor in moving to the United States. Students identified different stressors, including discrimination, documentation, family support and involvement. If students perceived these experiences as negative, their ability for a positive cultural adjustment and overall wellbeing are at risk.

Identity development is a critical point in any student's life. There are many transitions and life events happening during this time. Students may question who they are, piecing together elements of themselves learned in their home country, as well as new elements related to acculturation learned while in America. As a result, they can experience depressive symptoms in struggling to merge different cultures and identities together while still navigating the new role of being a college student (Kim, 2009).

First Generation College Student

First generation students not only experience college for the first time but also are the first in the family to attend college. Some refugee and immigrant students also face this challenge in unique ways as their external support may be many miles away. They are encountering many firsts, such as moving to another country, signing up for classes, making living arrangements, and dealing with dietary changes alone (Potochnick, 2010). The many difficulties associated with this role can result in first generation immigrant students being at a higher risk for anxiety and depression.

Mental Health Concerns

Assuming the identity of a college student is a difficult task for anyone leaving home for the first time. This can be especially difficult for an immigrant

or refugee student traveling to another country and leaving family to attend college. In addition to becoming accustomed to a different environment and way of living, students also face the challenge of integrating different cultural beliefs and values (Mori, 2000). Gallagher and Tyler (2014) surveyed college counseling centers across the United States and found anxiety, depression, relationship problems, suicidal ideation, self-injury, and alcohol use as the most prevalent concerns of college students. Although these presenting concerns may be experienced by refugee or immigrant students, there are also several additional difficulties associated with the cultural adjustments. These challenges may include language barriers, academic stress, cultural adjustments, being a first-generation student, and identity development (Pérez-Rojas et al., 2017).

Barriers to Treatment

Counseling may be perceived differently amongst refugee and immigrant students based on cultural background. Some students may come from a country where counseling is perceived as acceptable while others may hold a stigma. Students may also be unaware of the process of counseling in a college environment. Stigma presents as a major barrier in immigrant students seeking counseling. Students may believe that counseling is for individuals who are "sick" and may fear "losing face" and appearing weak (Han & Pong, 2015). Students may have been taught to deal with certain mental health issues internally or within their family.

Students may be unaware of the resources available and the process of seeking counseling. There is a vast amount of information immigrant students are receiving regarding their relocation and entry into college. They may not know that counseling services are offered and for what issues they may address with a clinician. Based on the counseling center protocol, it may be difficult for immigrant students to set up an appointment. For example, they may believe that counseling through the University is expensive and have limited financial means. Immigrant students may also prefer a counselor who is knowledgeable of their cultural background and language. Students may feel that a counselor who shares the same cultural background may share similar values and beliefs (Han & Pong, 2015). This may help build a strong therapeutic alliance and trust within the relationship. The counselor may also be the student's main support

during acculturation and serve as an advocate for obtaining resources on the college campus.

Although more universities are beginning to offer more resources for immigrant and refugee students, there may still be difficulty in bridging student access. Language barriers cause several challenges for students as they transition. Students are still learning the English language and may not know certain words or phrases needed to articulate their need to access specific services. This can impact their ability to receive mental health support as they may not know exactly how to express their need, leaving them to self-isolate or perhaps feel embarrassed. With the language barrier limiting their social interactions students may miss forming relationships with peers, faculty, or staff. This unintended isolation eliminates the opportunity for students to consult with social support in seeking and accessing mental health resources. Finally, immigrant students may not have access to the same resources available to American students. This specifically applies to resources that may be available within the community for those with a specific immigration status.

Recommendations for Counselors and Future Research

First, focus on resilience. Despite the challenges and barriers faced by immigrant and refugee college students, research has suggested that there are several factors in the successful adjustment and academic success of this population. A personal characteristic that serves as a protective factor for immigrants is resilience; which is typically fostered during an individual's upbringing and can have high association with cultural social norms and beliefs (Arnetz, Rofa, Arnetz, Ventimiglia, & Jamil, 2013). Resilience is defined as having a pattern of positively adapting in the context of current or past adversity (Wright & Masten, 2009). Resilience among refugees is associated with less psychological distress (Arnetz et al., 2013). Borjian (2018) suggested that resilience requires much more than sheer personal determination, but that it is an interconnected system of support which includes the family, community, and institution. Echterling, Presbury, and McKee (2018) conceptualize resilience as a characteristic of individuals, families, groups, and communities. Moreover, it is the result of four factors: social support, meaning making, affect regulation,

and successful coping. These factors are important to consider when working with immigrants and refugees in a college setting.

Second, consider multiculturalism. Although the counseling field continues to move towards being multiculturally competent there is still more that needs to be done related to refugees and immigrants. Although immigrant students experience more mental health problems than their American counterparts, they still underutilize counseling services (Mori, 2000). Currently, there is a gap in the research as it relates to immigrant college students' experience and attitudes towards mental health counseling. More research and discussion needs to take place to help college counselors better understand the difficulties experienced by this population. This would also provide an opportunity to train culturally competent counselors and create new techniques that are culturally appropriate based on clients' cultural backgrounds.

Lastly, thoroughly understand and be mindful of the university climate and its systemic impact. The continued focus on post-migration and society's deficit view of refugees and immigrants in higher education promotes a narrow individualistic perspective, rather than the post-migration socio-cultural context that impacts psychosocial adjustment, higher education access, and academic success (Núñez & Gildersleeve, 2016; Oppedal, Guribye, & Kroger, 2017). Researchers have found that post-migration acculturation impacts the psychosocial adjustment for refugee young adults more than pre-migratory traumatic experiences in some cases (Oppedal et al., 2017). This indicates a need to examine factors in the larger sociocultural contexts impacting the psychosocial adjustment of immigrant and refugee college students. One factor may be the societal expectation of assimilation and how cultural values may conflict upon arrival that influence loss or weakening of ethnic identity (McBrien et al., 2017). Through the loss of ethnic identity, immigrant and refugee students experience lowered levels of social support and further alienation from relationships that buffer from acculturation stressors (Hou et al., 2016). Similarly, the loss of identity and stigma experienced by refugee and immigrant young adults, contributes to inhibited growth and coping abilities (Baranik, Hurst, & Eby, 2018; O'Neal et al., 2016; Wehrle, Klehe, Kira, & Zikic, 2018). Therefore, college campuses and university personnel must become aware of the sociocultural norms and expectations influencing psychosocial

adjustment and academic success for all immigrant and refugee students (Núñez & Gildersleeve, 2016).

To adequately address the impact of acculturation stressors amongst refugees and immigrants on college campuses, university personnel must become aware of the dominant cultural norms reinforced in the university setting, such as the value of independence over interdependence, and promote necessary social support through intercultural understanding and a sense of community (Rasheed & Munoz, 2016; Vickers et al., 2017). Professors and university staff can build a sense of community and enhance intercultural understanding across college campuses through peer mentoring programs, pedagogical practices that promote intercultural competence (i.e., engaged reflection and perspective-taking), and a collective approach to learning that increases academic expectations and linguistic support for immigrant and refugee college students (Andrade, Evans, & Hartshorn, 2014; Vickers et al., 2017). Similarly, by emphasizing a sense of community and providing social support networks via informal and formal opportunities, university settings mitigate the cultural mismatch of individual. This is in comparison to interdependence that hinders immigrant and refugee college student success, as well as model inclusion policies rather than the current socio-political policies of exclusion (Duranczyk, Franko, Osifuye, Barton, & Higbee, 2015).

The differences and similarities observed within immigrant or refugee college student academic success and adjustment relate not only to familial background and pre-migratory experiences, but also to the systemic barriers faced upon arriving to the United States (Baum & Flores, 2011; Vickers, McCarthy, & Zammit, 2017). For example, undocumented immigrants compared to documented immigrants report higher drop-out rates due to financial stressors, lack of social support due to fear communicating with university personnel, and inability to access higher education because of exclusionary policies and law (O'Neal, 2016). The inability to access higher education and discriminatory policies experienced by immigrant and refugee students indicates university personnel must acknowledge and critically examine the socio-political reality facing their students (Reyna Rivarola, 2017).

To critically examine and acknowledge the socio-political context impacting access to higher education and the psychosocial adjustment of immigrant and refugee college students, university officials need to

explicitly state and practice inclusionary policies, as well as provide institutional validation, such as student support centers, for undocumented immigrant students (Reyna Rivarola, 2017). Institutional validation provides undocumented and refugee students a feeling of acceptance that is contrary to the larger anti-immigration and anti-affirmative action policies in the dominant socio-political reality. Furthermore, university staff, advisors, and counselors need to be aware of generational disadvantage amongst immigrant and refugee students to appropriately respond to each unique student's need and ability to obtain higher education (Núñez & Gildersleeve, 2016).

Conclusion

The United States is a land founded on immigration. Immigrant and refugee college students have shown to have unique barriers and strengths. It is recommended for college counseling centers to focus not only on the post-migratory experiences of immigrant and refugee college students, but also on factors in their pre-migration, such as access to education in country of origin, family, and socio-economic status. The literature points to resilience as a factor linked to the successful experiences of immigrants and refugees (Borjian, 2018), as well as a protective factor for mental health concerns (Arnetz et al., 2013). Research suggests the importance of interconnectedness between student, family, community, and university in order to foster support and increase resilience (Borjian, 2018). This is confirmed throughout the literature (O'Neal, 2016; Reyna Rivarola, 2017), pointing to the critical role of counselors as facilitators of this process as well as advocates for this marginalized group of students. Immigrant and refugee college students will continue to play a critical role in enriching the heterogeneity of American society and college counselors are on the forefront of professionals who can assist in the adjustment and success of this population.

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Counseling Refugees: A Trauma-Informed Model and Toolkit for Practitioners

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Abstract

Refugees have endured enormous challenges. In their countries of origin, their life circumstances included overwhelming, even traumatic, stressors that forced them to flee their homelands. Moreover, their desperate journeys of seeking refuge confronted them with life-threatening dangers, overcrowded and underfunded camps, and demoralizing bureaucratic regulations. Finally, even if they were successful in attaining asylum in the U.S., refugees often must deal with severely limited financial resources, barriers in assimilating into the host culture, daily acts of microaggression and marginalization, and even overt hostility from community residents. Counselors can play a vital role in providing essential therapeutic services to these refugees by assisting them in healing from their past traumas, promoting their resilience, and helping them in their successful assimilation into a new and complex culture. Fortunately, there are resources available to counselors in carrying out their important work. This article describes specific modalities and tools, including the Refugee Services Toolkit and the Multi-Level Model, that can assist counselors providing services to refugees. The modalities integrate strategies that include mental health education, traditional Western counseling, indigenous healing practices, and cultural empowerment.

Keywords: *refugees, trauma, counseling*

Counseling Refugees: A Trauma-Informed Model and Toolkit for Practitioners

On nearly a daily basis, the news media include heartrending images of desperate adults and children

seeking refuge from devastating, oppressive, and dangerous circumstances in their countries of origin. Refugees are immigrants who have been forced to flee their home countries in order to escape the ravages of war or the horrors of persecutions due to race, ethnicity, political opinion, or religion (American Immigration Council, 2014). Many immigrants may be seeking greater economic opportunities by coming to the United States, but refugees, in contrast, are unable to return to their home countries because of well-founded fears for their own lives and for those of their loved ones. The purpose of this article is to provide counselors with a practical model and helpful toolkit for addressing the needs of refugees who are resettling in Virginia communities.

Current Status of Refugees

The United Nations High Commissioner for Refugees (UNHCR) (2018) estimated that there are 68.5 million forcibly displaced people worldwide. Of that total population, about 25.4 million, or over 37%, are refugees. During 2016 alone, 26 countries admitted over 105,000 refugees to be resettled within their borders, with the United States admitting 73,000. However, from January to December 2017, the current White House administration accepted only 29,022 refugees, the lowest number since at least 2002 (Gomez, 2018). The reduction in admissions will likely continue in the future because the administration has established an annual cap of 45,000 refugees a year, the lowest cap since Congress created the Refugee Resettlement Program in 1980 (Connor & Krogstad, 2018). In recent years, Virginia regularly has resettled between 1900 and 2600 refugees each year (Virginia Department of Social Services, 2013). The majority of those refugees were originally from either Iraq or Bhutan.

Refugees have practical, social, and spiritual needs after arrival that are more extensive than other immigrants. Arriving refugees need assistance, particularly the older and less educated, whereas the young and educated refugees are more likely to fare well in the American economy. We also learn from history how injurious the politicization of refugee admissions can be, subjecting newcomers to unwarranted hostility and misunderstanding. (American Immigration Council, 2015).

Before they are able to gain admission into the United States, refugees undergo a comprehensive,

lengthy, and detailed screening process that evaluates their overall health, assesses their security status, and reviews their criminal records (United States Department of State, 2015). If applicants successfully pass these intensive screenings, they may then be allowed to connect to Resettlement Support Centers to arrange travel to the United States. Once in the United States, private voluntary agencies collaborate with the State Department to offer basic services for refugees and their families. These services include providing food, housing, clothing, employment counseling, health screenings, and other related assistance. The process of resettlement can take as long as two years, depending on the time required to complete extensive background checks.

The political and social conditions that compel refugees to flee their homes with virtually no resources are often horrific, oppressive, and life threatening. Therefore, it is not surprising that refugees would be much more likely to have Posttraumatic Stress Disorder (Lopez-Quintero, Neumark, & Tobin, 2012). Moreover, their desperate journeys of seeking refuge have confronted them with life-threatening dangers, overcrowded and underfunded camps, and demoralizing bureaucratic regulations. Finally, even if they are successful in attaining asylum in the U.S., refugees often must deal with severely limited financial resources, barriers in assimilating into the host culture, daily acts of microaggression, marginalization, discrimination, social stigma, and overt hostility from community residents. The countless stressors that refugees experienced in their home countries, throughout their perilous journeys to seek refuge, and during their stays in their host communities form the perfect storm for developing mental health disorders. Such overwhelming challenges require services that are comprehensive, integrative, and culturally sensitive.

Unfortunately, the current political climate has led many American politicians and citizens to question our nation's commitment to addressing the plight of refugees. Nevertheless, no matter where one stands on the question of national policies regarding immigrants and refugees, a counselor has an ethical responsibility to uphold the ideal of beneficence by respecting the dignity and promoting the welfare of clients (American Counseling Association, 2014). The reality is that refugees are already in the United States, and the Commonwealth of Virginia's counselors are

called to provide services that are clinically appropriate and culturally sensitive to their presenting concerns.

A Psychosocial Model for Counseling Refugees

Recently, a resilience-focused approach has been developed that includes four evidence-based strategies for implementing successful crisis counseling (Echterling, Presbury, & McKee, 2018). Applying this approach specifically to refugees, this model has integrated the work of Bemak, Chung, and Pederson (2003), who designed a psychosocial model for planning counseling interventions to address the specific needs of refugees. This model has two foundational elements that are necessary for successful implementation. The first is *cultural competence*. Effective counselors have a deep appreciation for the worldviews of their refugee clients, along with a commitment to honor their cultural heritages. Successful counselors are knowledgeable about the sociopolitical conditions from which their clients have fled. At the very least, they become thoroughly familiar with the specific experiences that their clients personally endured as refugees. Given that most refugees in Virginia have fled countries of collectivist cultures, the predominant individualist culture of the United States is only one of the dramatic differences that refugees encounter here. Counselors should also recognize the countless other challenges and barriers that refugees face in adapting and adjusting to their current circumstances. Finally, successful counselors of refugees need to design and implement their interventions with a deep and abiding commitment to cultural sensitivity.

The second important element is providing a *trauma-informed environment* (Steele & Malchiodi, 2012). A trauma-informed environment is one that provides a safe haven for refugees and is an essential foundation for productive counseling of traumatized survivors (Kinzie & Fleck, 1987). The core values of respect, cooperation, and kindness permeate throughout the counseling setting and are expressed in multiple ways through the physical and interpersonal environment. For example, counselors can respectfully design their offices to reduce triggers for trauma by muffling the intrusive sounds of sirens and nearby construction, painting walls in soothing colors, and posting artwork depicting peaceful scenes and celebrating a variety of cultures (Bemak, Chung, & Pederson, 2003). Effective counselors make an explicit point of welcoming refugees, honoring their

customs, adhering carefully to traditional practices regarding touch and social distance, and respecting their worldviews.

The value of cooperation in a trauma-informed environment highlights the commitment to a sense of community and an appreciation for interdependence, which are prerequisites for reducing the profound distrust that traumatized clients often have developed as a necessary survival mechanism to navigate their perilous journeys. Kindness is rarely mentioned in counseling texts, but recent studies have documented that acts of thoughtful generosity release the neuropeptide oxytocin in the recipients of such kind gestures (Echterling, Presbury, & McKee, 2018). Oxytocin, which enhances interpersonal trust (Bartz, Zaki, Bolger, & Ochsner, 2011), is an essential hormonal byproduct of successful counseling. Researchers have found that oxytocin increases significantly when individuals experience an empathic relationship (Feldman, 2012).

Communicating cultural sensitivity and providing a trauma-informed environment comprise the foundational elements of this psychosocial model that includes education, counseling, cultural empowerment, and the integration of both Western and indigenous approaches to healing.

Education

Education, the first component of this model, involves offering refugees from different cultures the additional information they need to understand adequately the complexities and nuances of the U.S. mental health system (Bemak, Chung, & Pederson, 2003). This task includes building a relationship through open communication about what to expect without making any assumptions about what the client actually knows.

A sample case highlights the vital importance of educating refugees about the mental health system. A certain client, a child who had experienced countless traumas in the Middle East, was actively self-harming while at school. The school counselor explained to the student the school's protocol for intervening when self-harm is involved and immediately scheduled a meeting with the family. The student's parents indicated through a translator that he was receiving counseling services through the local Community Services Board (CSB), and the counselor asked if they would be willing to fill out a release of information

permission form in order to collaboratively develop a plan for safety with colleagues at the CSB. The parents became frantic and expressed to the translator their fears that if they signed the document, it would mean that the counselor could "send our child away." After the counselor clarified the purpose of the release of information form, the relieved parents were happy to sign the document. As a result, this vitally important clarification helped to connect the child in need with a staff who collaborated to design an appropriate treatment plan.

Counseling

The second component of this psychosocial model is counseling. A variety of evidence-based interventions, such as trauma-focused cognitive behavioral therapy, child-centered play therapy, medication, group modalities, and family therapies (Schottelkorb, Dumas, & Garcia, 2012) have been found to be effective with refugees. For example, the client described above participated in wraparound services with the CSB, along with intensive in-home counseling, which was focused on family connection and skill building. The client also received therapeutic day treatment services through the school to help with skill building. Throughout the state of Virginia, Refugee Resettlement Offices, which are sponsored by Church World Service, facilitate groups for families to help process their experience as refugees and help with acculturation (R. Sprague, personal communication, September 25, 2015).

Cultural Empowerment

Advocacy is an important consideration when offering cultural empowerment to refugee families. In addition to providing direct counseling services, you can work with community partners to share vital information regarding the needs of refugee clients. Bemak, Chung and Pederson (2003) stated:

Thus, we strongly believe that mental health professionals must be attuned and highly sensitive to the difficulties inherent in adapting to a new culture and expand beyond traditional roles to provide case management-type assistance, guidance, and resource information that will empower the refugee. (p. 57)

As a counselor who has trusting and empathic relationships with refugees, you are in a unique position to serve as a knowledgeable advocate for

meeting their basic needs, such as housing, food, medical services, career counseling, and financial assistance. Addressing these immediate concerns can have a powerful therapeutic impact on refugees, who may have been struggling for years with a profound sense of abandonment.

In Virginia, promising community partners now include Trauma Informed Care Networks (TICN). The purpose of a TICN is to encourage collaboration between local agencies to provide increased awareness of the impact of trauma, and educate the public on best practices in working with people experiencing trauma. Another example of a local community partner is the Refugee Resettlement Office in Harrisonburg, which works with Harrisonburg High School to facilitate a peer-mentoring program designed to help refugee students with cultural empowerment. Within this program, students are exposed to different community programs and services through presentations and experiential learning opportunities. They gain essential information about the public transit system, academic programs, health services, and other supports, both inside the school and in the broader community. The mentors in this program are students who act as cultural brokers, helping refugees connect to these services and supports in culturally sensitive ways. For example, presenters speak with mentees about using academic supports available, and then mentors engage with their mentees in tutoring sessions so they can connect with these supports.

Integration of Western and Indigenous Healing Practices

The fourth component of the psychosocial model involves integrating traditional Western approaches to healing with methods that are culturally sensitive to refugee clients. If refugees express a desire to involve their religious and spiritual leaders, then collaborating with indigenous healers can add to the therapeutic power of your work as a counselor. For example, in conjunction with family counseling, a trusted sheik may provide devout Muslim parents and children with a special ceremony involving the Koran as a healing ritual. Many counselors already have integrated Eastern methodologies, including meditation and yoga, into their general practices as a way to work more effectively with their American clients with PTSD (Shallcross, 2012).

In the following section, a promising and practical instrument for counselors, the Refugee Services Toolkit (NCTSN, 2015) is described. This toolkit is web based, and uses easy-to-follow prompts to help organize assessment and intervention. The toolkit utilizes a linear model in terms of evaluating stressors that a client may be experiencing, to help simplify the planning and implementation of potential interventions.

Refugee Services Toolkit

The Refugee Services Toolkit (NCTSN, 2015) is a practical assessment procedure to assist counselors in designing and implementing the most effective treatment plans for refugee clients. The Toolkit, which is web-based (<http://learn.nctsn.org/course/view.php?id=62>) and free of charge, prompts a counselor to rate the intensity of four core stressors that often confront refugees: traumatic events, acculturation challenges, resettlement issues, and ongoing conditions of isolation. The counselor then receives immediate feedback from the Toolkit, along with recommended interventions for refugee clients, their primary caregivers, and other interested parties.

Traumatic Events

The Toolkit focuses on trauma events as the first core stressor by sharing sample questions that might be asked of a client. These open-ended questions explore for previous and current traumatic events and conditions, possible changes in mood or behavior, difficulties in relationships in the home or school, and any current support network. Depending on the answers to these questions, the counselor then rates the client's overall level of traumatic exposure as low, moderate, or high. Based on these results, the counselor then receives specific recommendations for potential interventions to prevent issues, promote strengths, and address concerns. These strategies include connecting families to community activities, counseling services, or other community resources (NCTSN, 2015).

Acculturation Challenges

The Refugee Services Toolkit's second core stressor focuses on the challenges of acculturation. This portion assesses how families are navigating the host community and integrating its culture with their own culture of origin. Some sample questions that the Toolkit provides to assess this domain involve

exploring the parents' perceptions regarding their children's acceptance of the host culture, checking if the adults rely on the children to serve as translators, and inviting the family to discuss what values of the host culture they appreciate, and what values of their culture of origin are they committed to maintaining. Based on the assessment results, the interventions recommended by the Toolkit include connecting with other refugee families, providing educational materials about adjusting to a new culture, and coordinating with schools and other agencies that provide cultural orientation (NCTSN, 2015).

Resettlement Issues

This core stressor is related to helping refugees become more culturally empowered. This core stressor asked questions related to the family's ability to provide resources that are integral in daily functioning. These resources included the basic needs of food, shelter and clothing, as well as financial and healthcare needs. The interventions included helping the family access agencies that help provide resources, including local departments of social services, food pantries, resettlement agencies, or other public or private entities. (NCTSN, 2015).

Isolation

The final core stressor addressed in the Toolkit is that of isolation, which may be due to a variety of reasons, including discrimination, geographic distances, interpersonal loneliness, or sense of cultural isolation. Some interventions designed to ameliorate this stressor include connecting refugees with volunteers who welcome them into the local community, referring families to support groups that promote sharing among refugees, involving other religious organizations that reach out to refugees, and advocating for celebrations of the cultural richness that refugees bring to a community.

One common theme across many of the intervention strategies is the emphasis on the crucial role of cultural brokers, those individuals who provide an emotional link to the home country from which the refugees had to flee. Such cultural brokers are quickly trusted and serve as essential links between the refugees and the services available in their host communities.

Conclusion

With the great number of traumatized refugees who have sought a safe haven in Virginia, counselors must be prepared to respond to their mental health needs. Refugees may present with a variety of concerns, which can adversely affect acculturation (Lopez-Quintero et al., 2012). The Multi-Level Model can assist counselors in providing services to refugees. The modalities integrate strategies that include mental health education, traditional Western counseling, indigenous healing practices, and cultural empowerment. The Refugee Services Toolkit (NCTSN, 2015) aids counselors in treatment planning with refugees. Counselors can rely on the Toolkit as an important aid in working within a multi-level model, where their roles include advocate, change agent, consultant, adviser, and facilitator. The Multi-Level Model integrates the recommendations of the Toolkit into a useful framework that incorporates education, counseling, cultural empowerment, and connecting Western and indigenous healing methodologies to assist refugees.

In Virginia, there are a number of resettlement agencies that provide assistance to refugee families throughout the different facets of the resettlement process. Using these resources and collaborating with other professionals, counselors can play a vital role in providing essential therapeutic services to refugees.

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Experiences of International Students in US Counseling Programs: An Advocacy Approach for Counselor Educators and Supervisors

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In the 2014, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) reported that 5.08% of the students enrolled in counselor education doctoral programs and 0.76% of the students enrolled in counseling education master's programs were international students for the 2014-2015 academic year (CACREP, 2014). According to Behl, Laux, Roseman, Tiamiyu, & Spann (2017), of the 32,698 students enrolled in CACREP-accredited programs for the 2013-2014 academic year, 311 were international students. This number increased by 20% in the following year (Behl et al., 2017).

The importance of attracting international students in counseling programs lies in the potential to invest in knowledge and skills that will serve diverse populations in and beyond the USA. In the context of education, international students bring a perspective to the classroom, their peers, and their instructors' views that could otherwise be missed. Once these students graduate, they can go back to their home countries and serve their communities to help alleviate their suffering and promote mental health wellness more effectively. Alternatively, international graduates who decide to stay in the US may serve better their respective communities, whether it is through counseling services for the people in their communities or training/mentorship for newer international students (Behl et al., 2017). In both cases, adequate training of international students is an important investment and route to the internationalization of the counseling profession.

Ng and Noonan (2012) discuss several concepts regarding the internationalization of the counseling profession, including themes such as:

- The nurturance of a global perspective in counseling scholarship, through teaching, research, and service;

- The facilitation of collaboration among counseling professionals globally, in practice, research, and training; and
- The indigenization of the counseling profession in local settings and discovering the cultural-specific elements that are central to practice in one own's region.

These themes refer to goals that inevitably involve the participation of international counseling professionals, including international graduates from US counseling programs. These goals are important in that Cross-cultural research can inform culturally appropriate training and adequate service to diverse nations and communities worldwide. Consequently, international students who graduate from counseling programs in the US represent a labor force that is well fitted to engage in this task, namely training, research, and service, in ways that are adapted and responsive to local cultural sensitivities.

The areas of training, research, service, and leadership/advocacy are domains where international graduates will most likely engage in as they return home. Subsequently, for them to serve in ways that are adaptive and sensitive to their respective cultures, they must be immersed in cultural-sensitive training from their counselor educators and supervisors in US institutions. This is a perspective that educators, supervisors, and academic advisors should keep in mind and strive for when training international students (and indigenous students as well). In fact, multicultural competence when teaching and supervising requires weaving the many cultural aspects into learning opportunities, research projects, and practice. With such training, international students are then able to serve diverse populations in ways that are both research-informed and culturally sensitive.

Moreover, international students in counseling programs are not only the hope for the development of the internationalization process of the counseling profession. They are also the hope for millions of people with mental illness that do not have access to treatment. In fact, according to the World Health Organization (WHO), up to 85 percent of people with severe mental illness in low and middle-income countries receive no treatment (WHO, 2013). To challenge these statistics, WHO (2013) launched a 2013-2020 comprehensive mental health action plan, with four major objectives, namely:

- Strengthen effective leadership and governance for mental health
- Provide comprehensive, integrated and responsive mental health and social care services in community-based settings
- Implement strategies for promotion and prevention in mental health
- Strengthen information systems, evidence and research for mental health.

To think that 85 percent of people with mental illness in developing countries find no treatment available to them is alarming. From a standpoint of a future counselor educator, training diverse student populations in teaching, research, and quality service is a task that comes with a sense of urgency. As mentioned earlier, international students who graduate from master's and doctoral counseling programs are an important asset in the counseling profession that will serve toward this purpose.

With this purpose in mind, one can appreciate the importance of the presence of international students in US counseling programs, as well as the necessity of adequate training. Consequently, appreciating the importance of international students also involves looking more closely into their unique experiences. This paper pulls from previous literature and discusses what research has found to be the needs of international students in counseling programs. We will also look at different ways for counselor educators and supervisors to consider advocating for this student population to facilitate a smoother learning process and a meaningful experience.

The Needs of International Students

To date, there are only three articles published about international students in the counseling programs in US. One looks at needs and acculturative stress of international students in CACREP programs (Behl et al., 2017), the second looks at challenges faced by this student population (Lee, 2013), and the third looks at coping strategies in supervision training for international doctoral students in counselor education (Woo, Jang, & Henfield, 2015). Both the first and second articles suggest that the needs and challenges of counseling international students can be summed up in four categories: Language barriers, academic and career concerns, cultural adjustment issues, and financial problems. Lee (2013) points out that international students face enormous difficulties,

and yet it is a population that has received little clinical, research, and educational attention.

Language Barriers

Research has found that international students experience difficulty with English, both oral and written, as well as with certain terminologies (e.g., fall behind, get caught up, etc.), idioms (e.g., pick someone's brain, beat around the bush, etc.), and acronyms (Behl et al., 2017). This limitation has its effects on international students' confidence, quality of interaction with students and faculty, and even on their grades. I, as an international graduate student, have personally experienced the language difficulty described above. The amount of concentration required in the classroom for fear of losing track of discussion, the audacity to ask clarifying questions, and hesitation to speak up are but a few of the challenges that I went through. My experience is that peers and faculty are often unaware of these challenges, which can add to the intensity of this barrier.

Another important aspect about the language barrier that Lee (2013) points out is the accent. The authors note that past research has shown that nonnative accent influences how listeners evaluate speakers' competence, intelligence, education, social status and attractiveness, and personality. Speakers are almost immediately downgraded due to their accent (Lee, 2013). This degrading, accent-based perception, along with negative perception based on other cultural differences is ground for perceived discrimination that international students have reported in the past, which can contribute in low academic performance (Behl et al., 2017).

Academic and Career Concerns Needs

Behl et al. (2017) notes that international students are more concerned with their academic and career needs than they are with their social needs. The educational system in the US can represent drastic differences from what these students are familiar with. The amount of classroom engagement, readings and assignments outside class, the interactional nature of graduate courses, group activities, etc., have the potential to throw international students off course at first and contribute in a rough transition into adjustment to US teaching/learning methods (Behl et al., 2017). As a result, international students are also prone to experiencing guilt and shame from the resulting academic low performance.

Further, international students also face career challenges. Students on a student visa status must face employment restrictions during and after their course of education. For instance, these students are only allowed to work on campus for 20 hours a week (Lee, 2013). There are only two contexts for off-campus work authorization that international students can manage to find employment: Curricular practical training (CPT), which typically provides a part-time position that must be in their field of study and be related to their academic program (Lee, 2013).

The other option is the optional practical training (OPT), which provides a full-time position for a period of twelve months, beyond which international students are required to return to their home country, unless they find an employer who is willing and capable to sponsor them for a work visa application lottery (Lee, 2013). For many international counseling graduates, a twelve-month work period is not enough to acquire all the experience needed to go back and serve adequately. Particularly, for international counseling graduates in their pursuit of residency hours in Virginia, this twelve-month period is not enough to attain licensure and depart as a licensed professional.

In fact, licensed professionals departing the US to return in their home countries where licensure regulation might not be present yet would contribute in two main ways. First, through their research work, training, advocacy, and quality service, experienced professionals, as opposed to freshly graduates, would play a significant part in promoting recognition for professional counseling abroad. Second, they would contribute in enhancing counselor professional identity development for novice counselors in their home countries. It is important to note that both these roles represent a significant part of advocacy for the counseling profession as it continues to develop an international presence.

This is a reality that adds difficulty to the lives and experiences of international students. As an international student, I can say that it is already hard enough to find your place in any competitive society where people look for what is more familiar and comfortable to them; to this, adding the fact of being a foreigner, with some language barriers, academic challenges, and restrictive employment guidelines creates even more challenges in obtaining relevant professional experience.

Financial Problems

Employment restrictions, alongside other requirements, such as having to keep a full-time course load, place serious limitations in international students' financial means, adding to their stress. Many of these students have reported having to rely on an outside source of financial support, such as family members (Behl et al., 2017). This implies that international students with wealthy families are the ones who will most likely make it to a US higher education institution unless they manage to find an international loan or scholarship. An additional financial stressor is that financial aid and loan opportunities are highly limited for international students, despite the fact that tuition rates and the overall cost of life are much higher than in their home countries (Lee, 2013). Some students have had to leave and return home half-way through the program (Behl et al., 2017).

Cultural Adjustment

Arriving international students go through an incredible amount of cultural change and adjustment within their new American environment. Cultural change is present in nearly all interactions and activities they engage in, both academically and socially. International students must work to find an affordable place to live, determine what food to buy and where, figure out how local transportation works, understand their healthcare coverage and its limitations, adjust to a new climate, etc. (Lee, 2013). They must also learn and practice communicating in a new language for every sought service or interaction, learn about and engage in "Western" relationships with faculty, peers, and the community they live in, deal with homesickness, loneliness, and feelings of incompetence. Needless to say that facing all these challenges may have an adverse consequence on students' mental and emotional wellness, which might then affect their academic performance (Lee, 2013).

Advocating for International Students in Counseling Programs

Research has shown that international doctoral students develop personal, proxy, and collective agencies of support (Woo, Jang, & Henfield, 2015). Personal agency of support refers to the effort international students make to assimilate with the US culture and engage in self-reflection (Woo, Jang,

& Henfield, 2015), to understand and interact better with faculty, peers, clients, and supervisees. Proxy agency refers to the support and care provided by mentors (Woo, Jang, & Henfield, 2015). Unfortunately, international doctoral students in supervision have reported lack of cultural sensitivity and support from faculty supervisors (Woo, Jang, & Henfield, 2015). This population then tends to seek out mentorship from faculty in their home countries. International students also engage in collective agency as they seek out networking with other international students and graduates (Woo, Jang, & Henfield, 2015). The remainder of this paper will focus on ways that counselor educators and supervisors might engage in advocating for international students through Gibson (2014) model of advocacy competency for clients/students.

Advocacy Competency Domains

In her chapter, Gibson (2014) elaborates different advocacy domains that counseling professionals can engage in to meet the needs of their clients or students. For the sake of the focus of this paper, international students' advocacy will be tailored to this model. Gibson (2014) suggests guidelines for each advocacy domain. We will review these guidelines as they pertain to the advocacy domains of interest for this subject:

International students' empowerment strategies.

- Identify their strengths and resources
- Identify the social, political, economic, & cultural factors that affect them
- Recognize signs that reflect their responses to systemic and internalized oppression
- Help them identify external barriers that affect their development
- Train them in self-advocacy skills
- Help them develop self-advocacy strategies
- Assist them in carrying out these strategies

International students' advocacy strategies.

- Negotiate relevant services on behalf of international students
- Help them gain access to needed resources
- Identify barriers to their well-being
- Develop strategies to confront these barriers
- Identify potential allies for confronting the barriers
- Carry out the strategies

Effective advocacy for international students starts with awareness of their needs and challenges, as well as awareness of one's own biases about this different group of students, their different learning and communication styles (Lee, 2013). Advocacy also requires educators and supervisors to be open and willing to connect and immerse themselves into the different culture through discussions and experiences to acquire empathic understanding of international students' experiences, as well as knowledge and insight about factors that hinder their healthy development (Gibson, 2014; Lee, 2013). This level of faculty involvement may require training for educators, advisers, and supervisors that is specifically oriented toward meeting the needs of international students. To meet this goal, the university office for international students and scholars could take a more proactive stance and initiate as well as carry out such training.

As mentioned in the guidelines for student empowerment, educators and supervisors can empower international students by namely identifying their strengths and resources, provide them with relevant information that can help them navigate specific challenges, and train and assist them in being more assertive in self-advocating for their rights (Gibson, 2014). For instance, educators and supervisors can, with genuine interest, explore together with international students, what aspects of their cultures, personalities, and thought processes can contribute to quality service and further their professional development. Such advocacy strategies could be helpful to domestic students as well and could generally be considered good practice.

Such student empowerment is particularly important in that in their effort to succeed academically, international students may seek to assimilate with the dominant culture and engulf the learned theoretical orientations without considering their own cultural identity or striving for their authentic and unique professional development. One of the downfalls for this learning process is that once these students graduate and return to their home countries, they will encounter challenges as to how to effectively apply what they have learned in their respective cultures because they have solely reflected and applied the learned knowledge in a "Western" context. To prevent this challenge, faculty members and supervisors can encourage and help create a

space within the curriculum and training experience for international students to feel empowered to speak up about possible limitations or considerations that would be relevant as students go to home countries and regions to practice.

Furthermore, educators and supervisors can also provide these students with information regarding, for instance, financial aid/loan opportunities and follow up with them in the process. It cannot be stressed enough how important it is that counselor educators and supervisors familiarize themselves with resources available to international students in their respective developmental levels. For trainees who are in their internship/employment search phase, educators and supervisors can assist them with culturally appropriate communication when working with clients or preparing for interviews.

Further, they can help them find available resources, provide them with recommendations, collaborate with decision-makers and negotiate relevant opportunities on their behalf. Faculty advisors should also consider themselves advocates for these students. Sometimes, problematic situations can arise that are unique for international students where a word from a faculty advisor can go a long way in disentangling the predicament in favor of the student. In this sense, it is not enough to point the student to where he or she needs to go find resources. Faculty advocates will also follow up with them, provide them with tips and ideas, and if necessary take appropriate action on their behalf.

Overall, it is important to note that international students need intentional, genuine, and practical assistance from their educators and supervisors for them to successfully navigate the many and unique challenges they face on their educational journey while away from their home and familiar systems. Educators and supervisors should also keep in mind that in providing adequate training and assistance to international students in the counseling program, they are making a valuable and long-term investment at an international level, hopefully one that will contribute in helping alleviate mental illness worldwide by providing adequate treatment to the 85% of people with mental illness in developing countries who are not fortunate to have no such access (WHO, 2013).

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Using Bloom's Taxonomy Learning Objectives as a Theory for Teaching and Learning in Research and Program Evaluation in Counseling

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Abstract

Discussed in this article is how counselor educators can integrate teaching the required CACREP-core research and program evaluation in counseling course within an established pedagogical framework of learning objectives by utilizing the cognitive domain of Bloom's taxonomy. More specifically, the authors describe how to organize and guide a capstone class group project using the cognitive domain of Bloom's taxonomy as a guiding principle and set of learning objectives to help counseling students gain a stronger understanding and sense of utility in how research and program evaluation can be applied in the counseling profession. First-year counseling students were guided in the development of a program evaluation survey which they administered to second-year counseling students regarding their impressions of the counseling program after one year. Implications for counselor educators are discussed.

Keywords: *counselor education, pedagogy, teaching and learning theory, research and program evaluation in counseling*

Research and program evaluation in professional counselor education training programs has remained one of the eight original common core curricular experiences since the inception of CACREP (Council for Accreditation of Counseling and Related Educational Programs) standards in 1981. While the specific curricular experiences have evolved over the years, and integration of research and program evaluation has been incorporated within the specialty areas, the basic requirement has been that counseling students receive foundational knowledge, practice, and skills in this important common core curricular experience regardless of specialty area.

Despite research and program evaluation having a long history of importance in the training of professional counselors and counselor educators, the course has nevertheless often been associated as a source of anxiety for both counseling students and counselor educators. In fact, even as far back as 1986, Yager and Wilson (1986) concluded that since counseling research included statistics, many students' fears and anxieties were associated with feelings of inadequacy in mathematics. The authors further concluded that many counseling programs tended to rely on other departments and programs to teach research. In doing so, it devalues the importance of research being a necessary skill in the counseling profession, and removes the counselor educator's ability to reinforce the important juncture between counseling skills and scientific methodology (Yager & Wilson, 1986).

In higher education, most faculty are held accountable for teaching, research (i.e., scholarship), and service; and depending on an institution's particular focus, these three domains may rank in importance and priority. Specifically related to counselor education, recent study trends reveal that counselor educators are not only reporting increasing teaching loads, but also more time spent preparing for teaching in comparison to research and service responsibilities (Davis, Levitt, McGlothlin, & Hill, 2006; Magnuson, Norem, & Lonneman-Doroff, 2009; Malott, Hall, Sheely-Moore, Krell, & Cardaciotto, 2014). With such reports of increased teaching loads and time spent preparing for teaching, it might seem logical that counselor educators would turn to the counseling literature to gain insights on instructional strategies for particular courses. However, further research in the pedagogical teaching practices grounded in effective teaching and learning theories, as it pertains to counselor education, has been sorely lacking (Barrio Minton, Wachter Morris, & Yaites, 2014; Malott et al., 2014). More specifically, Barrio Minton et al., (2014) conducted a content analysis of 230 peer-reviewed counseling articles pertaining to teaching and learning practices appearing in journals of the American Counseling Association and its divisions between 2001 and 2010. Their findings indicated that slightly less than 15% of the published articles were clearly grounded in learning theory or instructional research, and only 12% were minimally grounded. Of the remaining articles, approximately 45% were found to only be "...grounded in

counseling literature, theories, or research rather than learning theories or instructional research” (p. 171); approximately 15% had no identifiable pedagogical foundation; and approximately 13% did not use foundation rooted in applicable learning sciences or theories (Barrio Minton et al.). More poignantly, of the instructional research that does exist in counselor education, the authors found that core areas such as assessment, career development, and research and program evaluation were nonexistent; while more emphasis was placed in multicultural and clinically oriented competencies and content (Barrio Minton et al., 2014; Malott et al., 2014).

Given that research and program evaluation in counseling remains a CACREP-core curricular requirement in all specialty areas, student and faculty anxiety with the course, and the dearth of pedagogical strategies grounded in teaching and learning theories in counselor education journals, it is of value for counselor educators to promote teaching strategies for research and program evaluation that are grounded in learning theoretical frameworks. To assist with meeting this need, the authors of this article propose an example of how to integrate this required course within an established pedagogical framework of learning objectives utilizing the cognitive domain of Bloom’s taxonomy (Bloom et al., 1956).

Bloom’s Taxonomy: A Primer

Originally named after Benjamin S. Bloom, who served as the committee chair for educators that developed the taxonomy in the 1950s, the overall objective of a taxonomy was to establish a “framework for classifying statements of what we expect or intend students to learn as a result of instruction” (Krathwohl, 2002, p. 212). While Bloom’s overall taxonomy contains a set of three hierarchical domains for classifying educational learning objectives into increasing levels of complexity (e.g., cognitive, affective, and sensory domains), it is the cognitive domain that is the primary focus of most traditional education, and the specific domain applied later here in the presented example. To sum up a definition of the cognitive domain, Adams (2015) succinctly states “Bloom’s taxonomy contains six categories of cognitive skills ranging from lower-order skills that require less cognitive processing to higher-order skills that require deeper learning and a greater degree of cognitive processing” (p. 152). The final and original draft of the taxonomy was published in 1956 under

the title, *Taxonomy of Educational Objectives: The Classification of Educational Goals. Handbook I: Cognitive Domain* (Bloom, Engelhart, Furst, Hill, & Krathwohl, 1956).

Bloom’s taxonomy formulates the foundation of many pedagogical philosophies (Anderson & Krathwohl, 2001; Krathwohl, 2002), including those grounded in constructivism, in which increasing responsibility is placed upon the learner to actively create (i.e., construct) and apply meaning from knowledge rather than simply being a passive recipient of information from the teacher/instructor (Glasersfeld, 1989). This delivery method of instruction is typically focused on an integration of *guided practice* and *scaffolded* pedagogy with students, using increasing levels of complexity to guide, build and achieve higher levels of cognitive skill development through the creation and application of knowledge (i.e., the six categories of the cognitive domain in Bloom’s taxonomy). Guided practice refers to learners being given opportunities to apply and practice skills they are learning, under the direction of the instructor. During this process, learners receive instructor guidance to demonstrate and produce a correct performance (Seels & Glasgow, 1998). Relatedly, scaffolding involves the instructor providing encouragement and support by asking questions, giving hints, and providing feedback on progress. In essence, instructors are scaffolding the learners’ attempt to apply and demonstrate increasingly complex levels of cognitive skills (Svinicki, 2004).

Bloom’s Taxonomy Applied to Teaching Research and Program Evaluation in Counseling

The following applied example comes from the authors’ department’s CACREP-required course “Research in Counseling and Program Evaluation.” The course is taken by most students in their first semester of the masters in counseling program, meeting weekly for three hours over a 15-week academic semester. The first 11 weeks of the semester covers all the required curricular experiences as outlined in the 2016 CACREP Standards (CACREP, 2016, Section II.F.8.a-j, p. 13). The final four weeks of the course are dedicated to applying the knowledge learned throughout the course in a capstone class group project, under the guidance of the instructor. This capstone project requires students in the course (first-year/first-semester students) to work in a combination of small and large groups in order to develop a

program evaluation survey to be administered to second-year counseling students regarding their impressions of the counseling program after their first year (explained in more detail below). Students are guided on the development of survey items, research questions, research methodology, statistical procedures, and writing up a final program evaluation report with implications for program improvement. The final report is then shared with departmental faculty. While CACREP Standards (2016) only require “foundational knowledge” (p. 9) for research and program evaluation curricular experiences, learning is more meaningful and deeper when knowledge is applied to a real world circumstance that makes sense to students. Incorporating this capstone class group project using the cognitive domain of Bloom’s taxonomy as a guiding principle and set of learning objectives helps counseling students gain a stronger understanding and sense of utility in how research and program evaluation can be applied in the counseling profession.

The following descriptions of the differing levels of Bloom’s taxonomy are an integration from the works of Adams (2015), Anderson and Krathwohl (2001), and Bloom et al. (1956). The work of Anderson and Krathwohl is particularly useful as it contains a comprehensive list of verbs to use in formulating learning objectives, model questions, and instructional strategies for each level of the taxonomy.

Bloom’s Level I: Knowledge

This level in Bloom’s taxonomy is the foundational cognitive skill and refers to the recollection of previously learned material in the form of fundamental facts, terms, and basic concepts; in other words, what factual information and concepts have previously been learned.

Instructional strategy. To begin the process of designing a research and program evaluation survey, the class was asked several questions to elicit the necessary knowledgebase needed. The instructor wrote down all the responses on the whiteboard. The basic goal at this level is for the instructor to guide students in knowing what information and choices are available in the development of a research and program evaluation survey and report. These learning objectives included:

1. Students will list the basic parts of a research and program evaluation report.

2. Students will list all the descriptive and inferential statistical methods that have been learned throughout the course.
3. Students will list all the research designs and methodologies that have been learned throughout the course.
4. Students will list the four program components that comprise the counseling department’s philosophical perspective (i.e., taken from the counseling department’s student handbook).

Product goal. Based on the learning objectives, the product at this level of the taxonomy is simply having students generate lists from recall of what has previously been learned throughout the course. This can serve the purpose of formulating an advanced organizer of information processing to come.

Bloom’s Level II: Comprehension

This next level of the taxonomy includes taking previous knowledge and demonstrating an understanding of facts, concepts, and ideas through a process of comparing/contrasting, organizing, constructing, and/or interpreting the knowledge.

Instructional strategy. The instructor helps guide students to comprehend the strengths and limitations of the choices available to them in the construction of a research and program evaluation survey and report. The class is divided into smaller groups to debate the information while the instructor hovers between groups to offer guidance. The learning objectives include:

1. Students will construct an outline of a research and program evaluation report.
2. Students will compare and contrast descriptive and inferential statistical methods learned throughout the course.
3. Students will compare and contrast the research methodologies learned throughout the course.
4. Students will operationally define each of the four program components that comprise the counseling department’s philosophical perspective.

Product goal. Related to the learning objectives stated above, the product goals include the development of an overall research and program evaluation report outline and what information will be needed (e.g., abstract, purpose and rationale, methodology, results, discussion, implications, and recommendations);

possible research questions and the corresponding research methodology and statistical procedure needed; and finally, developing operational definitions of the four program components that comprise the counseling department's philosophical perspective (e.g., quality of: [a] coursework, [b] supervised clinical experiences, [c] faculty advising, and [d] personal growth experiences).

Bloom's Level III: Application

In this level of the taxonomy, problems and questions in new situations are solved by applying previously learned knowledge through learned facts, concepts, ideas, and rules.

Instructional strategy. The instructor helps guide students in finalizing a research and program evaluation survey. The class is divided into four smaller groups, with each group responsible for developing a list of possible questions to measure each of the four program components that comprise the counseling department's philosophical perspective (as stated previously). The instructor hovers between groups to offer guidance and sequencing so that the individual parts of the research and program evaluation report and survey form a whole. The entire list of questions for each of the four components was then posted for the entire class to debate via the SMART Board. The learning objectives include:

1. Students will develop research questions for the research and program evaluation report.
2. Students will choose with research methodology and design will be used based on the research questions.
3. Students will choose which statistical procedure will be used based on the research questions, research methodology, and design.
4. Students will develop questions from the operational definitions for each of the four program components that comprise the department's philosophy and create a program evaluation survey.

Product goal. This is the most time-intensive part of the overall class capstone project. Related to learning objectives stated above, the instructor guided the students in debating the list of possible survey questions representing each of four components of the department's philosophy until a consensus

was reached for which specific questions were to be included. The class then decided to investigate whether or not there were differences between second-year school counseling and clinical mental health counseling students in terms of their experiences in the program. The research questions were stated as null hypotheses based on questions that represented each of the four program components (i.e., domains) that comprised the department's philosophy (i.e., quality of: [a] coursework, [b] supervised clinical experiences, [c] faculty advising, and [d] personal growth experiences). Based on the research questions, the class determined that an independent samples t-test would be the appropriate statistical procedure to measure mean differences between school counseling and clinical mental health counseling students' experiences over the four program component domains. Since the program evaluation survey was to be specifically administered to second-year counseling students in the two programs, it was determined this was a convenient-sample.

In the end, the final research and program evaluation survey consisted of basic demographic information (i.e., which program is one enrolled in, gender, and full-time or part-time status); four sections of questions/statements representing each of the four program components, with 5 questions/statements for quality of coursework, 5 questions/statements for quality of supervised clinical experiences, 7 questions/statements for quality of faculty advising received, and 7 questions/statements for quality of personal growth. Each question/statement required a response on a 4-point Likert scale ranging from "strongly disagree," "disagree," "agree," and "strongly agree."

In Between Bloom's Level III and IV

Once the final research and program evaluation survey had been completed, the survey instrument was administered by the instructor to second year counseling students (i.e., second year students in the school counseling and clinical mental health counseling programs). Completing the survey was voluntary and no identifying information was included to ensure anonymity. The data from the completed surveys were coded and entered into an SPSS program by the instructor and a graduate assistant. Statistical analyses were computed and a spreadsheet of the results was printed for the class to interpret.

Bloom's Level IV: Analysis

With the research and program evaluation survey results completed and data results tabulated via SPSS, this level of the taxonomy involves the class examining the information, breaking the information down into its component parts, and making inferences based upon the evidence presented. Often, this level is where critical thinking skills go substantially deeper than previous levels of the taxonomy as learners are tasked with distinguishing between fact and opinion.

Instructional strategy. The instructor again breaks the class down into smaller groups and distributes copies of the statistical results to each group. Each group is asked to discuss the results and determine a decision of the null hypotheses on each of the sections of questions/statements representing each of the four program components. The instructor again hovers between each group to help guide the decision-making process. The learning objectives include:

1. Students will analyze the statistical results of the research and program evaluation survey.
2. Students will debate what conclusions can be made based on the statistical results.
3. Students will debate the relationship between the research questions and the findings in the research and program evaluation survey.
4. Students will determine a conclusion between the groups of students who answered the survey questions.

Product goal. Based on the learning objects, the primary product goal at this level of the taxonomy was for the class to make decisions regarding the statistical analyses between the two groups of second-year students completing the research and program evaluation survey.

Bloom's Level V: Synthesis

Compiling all the information into the overall first draft of a research and program evaluation report for class discussion and debate exemplifies this level of the taxonomy. Specifically, the synthesis level involves combining elements of information together in order to create some unique product and discuss the patterns of or alternatives to it.

Instructional strategy. The instructor again breaks the class into smaller groups, with each group

responsible for writing up a particular section of the research and program evaluation report (e.g., abstract, purpose and rationale, methodology, results, discussion, implications, and recommendations). The instructor again hovers between groups to help guide the writing of the report. Once each group has finished writing their assigned section, the instructor compiles it all into one first-draft document and the class debates and discusses any modifications needed. The learning objectives include:

1. Students will discuss and theorize the different components of the research and program evaluation report.
2. Students will discuss what evidence there is to improve or modify future research questions or methodology.
3. Students will discuss if there are any other explanations that could have influenced differences between the group results.
4. Students will discuss what implications and recommendations can be made from the results of the research and program evaluation survey results.

Product goal. Based on the learning objectives, the final product goal is a first-draft of the overall research and program evaluation report.

Bloom's Level VI: Evaluation

This final level of the taxonomy involves presenting and defending opinions based on judgements about information and evidence.

Instructional strategy. The instructor posts the first draft of the research and program evaluation report on the SMART Board for the entire class to see. Scrolling through the report line-by-line and section-by-section, the class is guided by the instructor in making any final debates, comments, modifications, evaluations, recommendations, or limitations within the report. The learning objectives include:

1. Students will make final recommendations for counseling program improvement.
2. Students will state what information is being used to support these recommendations.
3. Students will prioritize these recommendations.
4. Students will state the overall limitations of this research and program evaluation report.

Product goal. Based on the learning objectives, a final capstone research and program evaluation

report was submitted to the department's program faculty and second-year students.

Results

The research and program evaluation survey developed by first-year counseling students examined the current experiences between second-year counseling students enrolled in the school counseling and clinical mental health counseling programs based on questions measuring each of the four program components (i.e., domains) that comprised the department's philosophy (i.e., quality of: [a] coursework, [b] supervised clinical experiences, [c] faculty advising, and [d] personal growth experiences). The research questions for all program component domains were stated as null hypotheses, meaning there would be no differences found between second-year school counseling and clinical mental health counseling students in terms of perceived quality of experiences. The null hypotheses were supported in three of the four domains; second-year school counseling and clinical mental health counseling students reported equal high levels of positive experiences in the domains representing quality of coursework, supervised clinical experiences, and personal growth. The null hypothesis for quality of faculty advising was not supported, with school counseling (SC) students reporting statistically significant higher levels of faculty advising quality than clinical mental health counseling (CMHC) students. Follow-up with the second-year students revealed some reasons for this quality of advising difference, including:

- SC students received all their advising from one faculty member as opposed to CMHC students who received advising from several faculty members. Thus, CMHC students often felt they received conflicting advising messages.
- SC students felt their advisor was more accessible and communicated more quickly than CMHC advisors.
- SC students felt that they received more information and assistance about clinical expectations from their advisor than did CMHC students.
- SC students felt they received more assistance in developing a plan of study and determining electives than did CMHC students.

Discussion and Implications for Counselor Educators

Knowledge in research and program evaluation for counseling students has long been an established CACREP-core curricular requirement for accredited programs. While current CACREP Standards (2016) only require "foundational knowledge" (p. 9) for research and program evaluation curricular experiences, it is the authors' contention that learning is more meaningful and deeper when knowledge is applied to a real world circumstance that makes sense to students. This may be especially true in a research and program evaluation in counseling course as students often may not see the practical utility and application of conducting counseling research (e.g., program or clinical) in a meaningful way (Murray, 2009; Nielson, 2015; O'Brien, 1995; Wester & Borders, 2015; Yager & Wilson, 1986). By incorporating a capstone class group project in the research and program evaluation in counseling course using the cognitive domain of Bloom's taxonomy as a guiding principle and set of learning objectives, we further contend that counseling students gained a stronger understanding and sense of utility in how research and program evaluation can be applied in the counseling profession. This was evidenced in student course evaluation comments specifically related to the project, stronger scores on student research and program evaluation measures, and feedback from other faculty teaching courses where examining research was required.

The integration of teaching research and program evaluation in counseling within an established taxonomy of scaffolded learning objectives originally developed by Bloom et al. (1956), a taxonomy which formulates the foundation of many pedagogical philosophies (Anderson & Krathwohl, 2001; Krathwohl, 2002), the example presented here also addresses some of the concerns offered by Barrio Minton et al. (2014) regarding the lack of instructional research and scholarship documenting pedagogical methods in counselor education. Citing the work of Barrio Minton et al. (2014), Mallot et al. (2014) sum up the concerns in counselor education pedagogical research succinctly "For the majority of research addressing instruction, directives focused on course content and specific techniques and were more often grounded in competency documents or clinical resources rather than in learning theories or higher education research" (p. 295). As a result,

the authors' encourage other counselor education faculty to publish what specific strategies grounded in established teaching and learning theories they are currently using in teaching CACREP-core required courses; especially those courses in assessment, career development, and research and program evaluation, which are sorely lacking in counselor education pedagogical research.

Finally, an additional implication from the example provided here is the information gathered from current students in the program regarding a quality assurance measure and resulting modification adjustments in program improvement. Efforts to document quality assurance in higher education, including counselor education programs, have increased significantly over the last 15 to 20 years (Warden & Benshoff, 2012; Welsh & Dey, 2002). Beginning with the 2009 CACREP standards, and continuing with the 2016 standards, increasing emphasis has been placed on quality assurance measures as it relates to the measurement of student learning outcomes through evidenced-based practices and program evaluation (CACREP, 2009; 2016). Not only is quality assurance concerned with student learning outcomes, but equally important are measurements that assess and evaluate an overall academic program (i.e., counselor education) based on various stakeholder group input. Specifically, CACREP has long required that accredited counselor education programs include current students, alumni, supervisors, employers, and other stakeholder groups in program evaluation initiatives. While feedback from each stakeholder is valued, there is perhaps none more important than that of current students since their learning experiences directly impact their personal and professional development (Warden & Benshoff, 2012; Welsh & Dey, 2002). The findings in this own research and program evaluation in counseling survey demonstrated that current clinical mental health counseling students rated quality of advising less favorably than their school counseling student counterparts, information that may not have been otherwise discovered. As a result, modifications in program improvement through more effective advising for clinical mental health counseling students were made by faculty to accommodate these student concerns.

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The Impact of Brief God Attachment Workshop Attendance on God Attachment

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Abstract

Attachment to God or one's Divine Attachment Figure (DAF; Counted, 2016) may be influenced by a variety of factors, including one's attachment to a parent earlier in life. This research seeks to explore the efficacy of a brief, four-hour workshop on anxiety and avoidance levels of one's attachment to God, as measured by the avoidance and anxiety subscales of the Attachment to God Inventory (AGI; Beck and McDonald, 2004). In addition, general well-being scores were measured by the WHO-5 Well-Being Index (WHO-5; Topp, Østergaard, Søndergaard & Bech, 2015). Various interventions were utilized in this workshop including security priming, mindfulness, and allegorical-bibliotherapy. Results indicate no significant change in anxiety or wellbeing. However, results demonstrate a statistically significant decrease in avoidance scores, as measured by the AGI. Discussion on the implications of these findings is provided.

Anxiety is an increasing mental health issue for students in the higher education classroom (Bonfiglio, 2015) and a common reason clients seek counseling. Research shows that social anxiety can negatively affect student class attendance, use of counseling services, adaptability, and teacher judgment of intellectual ability by causing fear of stigmatization and poor performance (Russell & Topham, 2012). Existing research suggests that seeking proximity to an attachment figure may help regulate anxiety (Cassidy & Shaver, 2002). John Bowlby together with Mary Ainsworth (who was his research partner for nearly half a century) co-founded attachment theory and established both conceptual and empirical research for the theory (Steele & Steele, 2008; Holmes, 2014). Bowlby and Ainsworth conducted research on the relational patterns of children. Beck & McDonald

(2004) explain Bowlby's introduction of attachment theory by suggesting three types of attachment: secure, avoidant, and anxious. Main & Solomon (1990) note a fourth attachment style, known as disorganized. Most notably, the attachment style developed during one's childhood influences the individual's relationships with others into adulthood and has the potential to influence other areas of life (Beck & McDonald, 2004).

Research suggests that when attachment figures become unavailable, a representation of the attachment figure may serve a regulatory function. A Divine Attachment Figure (DAF; Counted, 2016), such as God in the Judeo-Christian worldview, is portrayed as always available. According to the literature, two predominant pathways to God attachment exist: correlational and compensation (Kirkpatrick & Shaver, 1990). The former asserts that children who have formed healthy attachment bonds with caregivers may transfer these positive attributes over into their relationship with God (Kirkpatrick, 1999; Granqvist, 2005). In contrast, the compensation hypothesis allows for the individual's relationship with God to help compensate for painful experiences or unhealthy attachment style with caregivers.

In the workshop, interventions such as excerpts from the weaver prayer, a prayer for abuse survivors that includes symbolic language, were utilized. Foote (1994) states:

...these threads were broken, ripped from the fabric of me, and I was afraid to show anyone the tear. I thought it was my fault, that all would look and say, "What horror!" Now we pick up this broken thread, my weaving God and me. Now we do the work of repair, and as the fabric is made strong I look in surprise and say to myself, 'What beauty I reclaim!' Out of the torn places, I reclaim wholeness. Out of the broken places, I reclaim strength... (p. 17)

Other interventions used included security priming (Mikulincer & Shaver, 2007) and Cognitive Behavioral Analysis System of Psychotherapy situation analysis (CBASP; McCullough, 2003; Sibcy & Knight, 2017). The situation analysis is a highly structured set of questions typically used for clients with chronic depression who have become perceptually disengaged from their interpersonal environments. These clients often have a history of what is described as early psychological insults. According to McCullough,

Lord, Conley, & Martin (2010), psychological insults have been defined as:

a continuous series of experiences the developing child encounters over time which are of a 'low grade' nature and associated with interpersonal punishment/rejection of some kind- usually perpetrated by Significant Others and trauma... (McCullough, 2008; Nemeroff, Heim, Thase et al., 2003; Wiersma, Hovens, van Oppen et al., 2009; p. 319)

or what attachment researchers call attachment injuries (Knight & Sibcy, 2018). The situation analysis used in CBASP has been defined as a "multi-step social problem solving exercise designed to (1) overthrow preoperational functioning, (2) expose the maladaptive behavior of the patient so that it can be modified, (3) demonstrate to the patient that his/her behavior has consequences" (McCullough, 2003, p. 839-840). In practical terms, the activity involves identifying an interpersonal event that was problematic in some way. After the event is identified, it is described as a story that includes a clear beginning, middle, and end. This capacity to recount autobiographical episodes with coherence is used in gold standard assessments such as the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985; Steele & Steele, 2008) and this process may have implications for attachment. Other interventions used in the workshop, such as allegorical-bibliotherapy (Thomas et al, 2009), have shown promising results when used to increase one's attachment to God (Knight et al., 2017). In the existing literature, there is a lack of evidence suggesting a correlation between these interventions and reduced levels of anxiety. This research examines the impact of interventions designed to strengthen one's God attachment on attachment security and anxiety levels.

The purpose of this study is to fill this gap in the God attachment literature by first examining the efficacy of workshops designed to facilitate proximity seeking to a DAF in a Judeo-Christian population of graduate students at a mid-size university in central Virginia. Participants were offered participation in an experiential workshop designed for those who are interested in improving their relationship with God through understanding God as an attachment figure. Additionally, this research seeks to examine the relationship between well-being and God-attachment in the same population and present possible

implications for counselors. To accomplish these goals, God attachment and well-being were assessed in each participant before and after participation in God attachment workshops. These workshops included contemplative prayer and mindfulness-based interventions designed to improve well-being in university students and build healthy attachment-based relationships (Garzon, Hall & Ripley, 2014).

The researchers' first hypothesis (H_1) states there will be a statistically significant difference between the mean Attachment to God Inventory (AGI) scores before and after participating in the God attachment workshops. A paired samples t-test was conducted to analyze within groups differences before and after the workshops on the AGI. The researchers' second hypothesis (H_2) states that there will be a statistically significant difference in the scores on the Attitudes Towards God Scales-9 (ATGS-9) before and after the God attachment workshops. A paired samples t-test was conducted using SPSS in order to compare the mean ATGS-9 scores before and after treatment. The researchers' third hypothesis (H_3) is that there is a statistically significant difference in well-being as measured by the WHO-5 Well-Being Index (Topp, Østergaard, Søndergaard & Bech, 2015) before and after participation in the God attachment workshops. A paired samples t-test was conducted using SPSS in order to compare the mean WHO-5 scores before and after treatment. Results and implications for counselors are discussed.

Literature Review

Bowlby and Ainsworth's attachment theory plays a key role among relationships and how an individual bonds with others (Holmes, 2014). From a young age, a child either comes to understand his or her environment as nurturing and secure, or as chaotic and unsafe. Similarly, human attachment can affect an individual's relationship with a Divine Attachment Figure (DAF). For instance, a study conducted by Sandage, Jankowski, Crabtree, & Schweer (2015) includes information on the compensation hypothesis, which asserts that an individual finds security in God as a result of poor or absent parenting. Additionally, the study explains a second hypothesis of attachment to God, known as the correspondence hypothesis. The results of this study demonstrate a positive correlation between avoidant adult attachment and God-avoidant attachment. For instance, individuals with narcissistic personalities typically experience

avoidant attachment in learning to focus on emotional self-reliance, as seeking support from caregivers was likely rejected (Sandage et al., 2015). Therefore, spiritual vulnerability was found to be a mediator of insecure attachment to God.

Furthermore, research has explored how individuals conceptualize and experience God (Olson et al., 2016; Davis et al., 2013). An individual's God-image is how he or she experiences God emotionally, whereas one's God concept refers to the individual's cognitive understanding of God (Rasar, Garzon, Volk, O'Hare, & Moriarty, 2013). The two differ from each other in the sense that God-image recognizes an individual's feelings towards God, while God concept is what one thinks or knows about God. Both terms are key constructs in how an individual relates and attaches to God. Rasar et al. (2013) conducted a manualized treatment protocol on God-image and God attachment among 30 undergraduate students attending a Christian university. The study indicates positive spiritual outcomes after the implementation of spiritually focused groups. More specifically, results point to a significant increase in loving God, others, and oneself as measured by the Theistic Spiritual Outcomes Survey (TSOS; Richards et al., 2005).

Moreover, Olson et al. (2016) completed a ten-week manualized treatment protocol using narrative-experiential interventions to promote change in God-image. God Image Narrative Therapy (GINT; Davis, 2009; Olson et al., 2016) was implemented to assist individuals in gaining a new perspective of attachment as a critical human need. Therapists had clients recall personal and spiritual narratives to identify characters, themes, and conflicts, among other concepts. The therapist and participant then co-constructed an alternative growth-promoting narrative. The results of this study indicate an increase in religious and spiritual meaning making, positive emotions, and insight (Olson et al., 2016).

Methods

After approval from the Institutional Review Board (IRB), researchers sought adults as participants for this study. Primarily, university students of at least 18 years of age and of any gender or ethnic background were recruited for this study, with the goal being to attain a diverse group of adult participants. Individuals under the age of 18 were excluded from the study. The workshops were conducted on two evenings,

a Tuesday and Thursday night, for two hours each night. Fourteen participants attended the workshops in total. However, 11 individuals participated in both workshops for four hours total, while three individuals participated in just one workshop (two hours total). A small N design was used. Participants ($n = 11$) completed pre and post-test assessments to determine workshop efficacy. Participants' attachment to God and well-being were assessed before and after participation in interventions designed improve one's attachment to God.

Instruments

The Attachment to God Inventory (Beck and McDonald, 2004), the Attitudes Toward God Scale (Wood et al., 2010), and the WHO-5 Well-Being Index (Topp, Østergaard, Søndergaard & Bech, 2015) were utilized in this study. The first three assessments were utilized to measure participants' attachment to God, while the WHO-5 was used to measure well-being.

Attachment to God Inventory (AGI): This assessment is a 28-item measure used to assess participants' feelings toward and experiences with a relationship with God (Beck and McDonald, 2004). This inventory was selected for its accessibility, internal consistency, and construct validity. The AGI uses two subscales—Avoidance of Intimacy and Anxiety about Abandonment (Rasar et al., 2013). Cooper, Bruce, Harman, & Boccaccini (2009) explain research support behind the assessment's high level of internal consistency with both subscales, stating Cronbach's alpha levels of .86 (Avoidance of Intimacy) and .87 (Anxiety about Abandonment). Furthermore, Beck and McDonald (2004) explain the enhancement of construct validity through the inclusion of two subscales. This assessment uses rankings on a 7-point Likert scale, with scores for each subscale ranging from 14 to 98. A sample from the assessment states, "I worry a lot about my relationship with God;" participants rank the level of agreement with this statement on a scale from 1 to 7 (Beck and McDonald, 2004, p. 103).

The God Image Scale: Rasar and colleagues (2013) state the God Image Scale (GIS) "measures a person's God image using six subscales, including Presence (Cronbach's $\alpha = .95$), Challenge (Cronbach's $\alpha = .81$), Acceptance (Cronbach's $\alpha = .83$), Benevolence (Cronbach's $\alpha = .84$), Influence (Cronbach's $\alpha = .89$),

and Providence (Cronbach's $\alpha = .89$)" (p. 271). To promote accessibility and high internal consistency, researchers chose to use the GIS for the current study. The GIS is a 72-item assessment which utilizes a 4-point Likert scale, with scores ranging from 12 to 48 for each of the subscales (Rasar et al., 2013). A sample statement from this assessment is, "I am sometimes anxious about whether God still loves me," and participants rank their level of agreement on a scale of 1 to 4 (Lawrence, 1997, p. 225).

The Attitudes Toward God Scale (ATGS-9): The ATGS-9 is a 9-item assessment developed to expand the study of spiritual comfort and struggle towards God. The measure consists of two subscales, "anger towards God" and "comforted by God." According to Wood et al. (2010), the measure helps to determine the state (disengaged or engaged) of feelings of anger or disappointment, as well as comfort towards God. The instrument consists of items rated with an 11-point Likert-type scale ranging from 0 to 10, with 0 being not at all true, and 10 being extremely true. Examples of items on the scale are "trust God to protect and care for you" and "feel abandoned by God." Individuals measure each item based on how they resonate with the sentence. Factor analysis conducted on the instrument revealed two factors: positive attitudes towards God and disappointment and anger with God (Wood et al., 2010). There is a correlation between positive attitudes towards God and measures of religiosity and conscientiousness (Wood et al., 2010). Negative coping, lower religious participation, greater distress, higher neuroticism, and entitlement were associated with the second factor or disappointment and anger with God. The positive attitudes scale produced an alpha of .95 and above when measured with other instruments, and .80 and above for the disappointment and anger with God scale, indicating good reliability.

The Wellbeing Scale (WHO-5): The WHO-5 is a 5-item instrument which includes rankings on a 6-point Likert scale, with 0 being none of the time and 5 being all of the time. This tool measures the subjective well-being of individuals (Topp et al., 2015). The instrument has adequate validity and has been used as a screening tool for depressive disorders, as well as an outcome measuring tool in clinical trials and beyond (Topp et al., 2015). Examples of WHO-5 items include: "I have felt cheerful and in

good spirits," "I have felt calm and relaxed," "I have felt active and vigorous," "I woke up feeling fresh and rested," and "My daily life has been filled with things that interest me." Each item is rated on how well each of the 5 statements applies to the individual within the last 14 days.

Procedures

The God attachments of university students was assessed before and after participation in contemplative prayer and mindfulness-based interventions designed to improve attachment to God. Attachment to God was assessed pre and post workshops using the Attachment to God Inventory (Beck & McDonald, 2004), the God Image Scale (Lawrence, 1997), and the Attitudes Toward God Scale (Wood et al., 2010). Participant well-being was also measured pre and post workshops using the WHO-5 Wellbeing Scale (Topp, Østergaard, Søndergaard & Bech, 2015).

Interventions used throughout the God attachment workshops include the following: CBASP Situation Analysis (McCullough, 2000; Knight & Sibcy, 2018), Mindfulness Exercises (Garzon & Ford, 2016; Knight & Sibcy, 2018), Security Priming (Mikulincer & Shaver, 2007), Bibliotherapy (Thomas, 2009), and the God Image Automatic Thought Record (Rasar, 2012). Participants were also given a "Seeking Proximity to God Manual: Bibliotherapy Interventions Using Hannah Hurnard's *Hinds' Feet on High Places*" (see A). This manual is a chapter-by-chapter literary companion to the allegorical novel, focusing on all aspects of the Christian walk from suffering to joy. The "Seeking Proximity to God Manual" uses bibliotherapy interventions combined with experiential components, such as prayer and journaling, designed to increase participant awareness of God's presence throughout all stages of maturity in a relationship with God. Participants were also encouraged to take part in a future God attachment group study using the "Seeking Proximity to God Manual."

Results

The first of the previously mentioned hypotheses were tested as follows: The researchers' first hypothesis (H_1) states: There will be a statistically significant difference between the mean Attachment to God Inventory (AGI) scores before and after participating in the God Attachment workshops. In order to analyze the pre- and post-test differences in attachment to

God, a paired samples t-test was conducted using SPSS.

Trends toward strengthened God attachments were found. A statistically significant decrease in AGI-Avoidance scores was determined after participation in the God Attachment Workshops ($M = 39$, $SD = 9.35$, $n = 10$, $t(9) = -2.67$, $p = .026$). For AGI-Anxiety scores, although a slight actual decrease in scores was determined (NS), a statistically significant difference was not ($M = 52.27$, $SD = 16.11$, $n = 11$, $t(10) = -.555$, $p = .591$). These AGI-Anxiety results may be attributable to chance rather than the workshops. However, for avoidance, these results suggest that participation in the brief, four hour long God attachment workshops is associated with statistically significant trends toward more secure God attachment.

Another hypothesis that was tested in the study was, “ H_2 : There will be a statistically significant difference in the Attitudes Towards God Scales-9 before and after the God Attachment Workshops.” A paired samples t-test was conducted using SPSS in order to compare the mean ATGS-9 scores before and after treatment. Results for the ATGS-9 indicate there was not a statistically significant difference between pre-test and post-test scores for positive attitudes towards God ($M = 41$, $SD = 6.16$, $n = 11$, $t(10) = .688$, $p = .507$). For the disappointment and anger towards God dimension of the ATGS-9, there also was not a statistically significant difference between pre- and post-test scores ($M = 5.09$, $SD = 5.22$, $n = 11$, $t(10) = .301$, $p = .770$).

The WHO-5 Well-Being Index was utilized to test the final hypothesis: “ H_3 : There is a statistically significant difference in well-being as measured by the WHO-5 Well-Being Index before and after participation in the God Attachment Workshops”. A paired-samples t-test was conducted using SPSS before and after treatment to compare the mean WHO-5 scores. Results did not support this hypothesis ($M = 13.27$, $SD = 4.56$, $n = 11$, $t(10) = .420$, $p = .684$).

Discussion

The purpose of this study was to determine the efficacy of a brief four-hour God attachment workshop series on improving one’s attachment to God and well-being. The research team discovered a statistically significant decrease in the dimension of AGI-Avoidance, finding no other statistically significant increases or decreases in scores. This

may be attributable to the relative stability of the population, as the participants were primarily college students (only one member of the population was not a student) in a relatively homogeneous Christian population (“U.S. Religion Census,” n.d.). Note, Beck & McDonald (2004) found the mean anxiety score on the AGI for a Christian college population to be 47.03, while the mean AGI-avoidance score was 41.06. So, the mean anxiety and avoidance scores in our sample compare in that our population scored higher in AGI-anxiety ($M = 52.27$) and lower in avoidance ($M = 39$) compared to the population in the Beck & McDonald (2004) study.

Additionally, it is possible that participants may not have recently experienced a disorganizing event, such as a major trauma or loss. Therefore, if one already has a fairly stable attachment to God and general well-being, it may be difficult to improve that attachment after only four hours of experiential workshop participation. Nevertheless, a statistically significant decrease in avoidance was observed. The interventions used in the workshops invited participants to “move towards” God as an attachment figure, thereby implicitly targeting avoidance. On the other hand, Counted (2016) performed a qualitative study consisting of interviews conducted with 15 Christians youths who exhibited an anxious attachment style (these individuals scored high in anxiety on the AGI) to their Divine Attachment Figure (DAF). The behavioral manifestation of the secure base in terms of attachment to God is not yet conclusive.

Consider Marvin, Cooper, Hoffman, and Powell’s (2002) work on the Circle of Security. The top side of the circle represents the attachment system being shut off and the exploration system being turned on so that the child may move from the secure base to explore his or her environment. This secure base manifestation of exploration in terms of attachment to God requires further investigation for clear definition. Proctor, Miner, McLean, Devenish, and Ghobary Bonab (2009) indicate that “conceptualizing how the secure base function might manifest proved challenging. While broadly mentioned in the ATG literature, this function of ATG is generally not well defined” (p. 252). Future mixed methods and qualitative research should investigate how participants with low anxiety and avoidance on the Attachment to God Inventory manifest exploration in their narrative self-reports.

In this study, a half standard deviation of change can be considered noteworthy for AGI-Avoidance and AGI-Anxiety scores. Change may be considered more meaningful in groups with overall lower attachment to God. Twenty percent of participants made over one standard deviation of change. Additionally, participation in the God attachment workshops was associated with a statistically significant decrease in God attachment related avoidance. Therefore, it may be assumed that participants with higher baseline levels may benefit more from participation in such workshops. Limitations of this study include a small N design and a relatively homogeneous population. Future research may consider utilizing a population of individuals struggling with addiction who have high levels of avoidance towards God and in romantic relationships. Giugliano (2003) reports that such individuals may overregulate negative feelings and therefore rely on alcohol or pornography to better feel emotion. Future researchers should consider using interventions over a longer period to evaluate how workshops longer in duration may influence God attachment related anxiety and avoidance. Bibliotherapy interventions can be combined with other experiential interventions in a group format for a 10-week manualized study using the "Seeking Proximity to God Manual." Additionally, future research may seek to include individuals with initially higher levels of avoidance and attachment to God. Participant view of anxiety towards God should also be considered, as some may view a certain level of anxiety as necessary and even beneficial. In summary, the present study, despite limitations of small N design, brief intervention duration, and homogeneous population, revealed findings indicating an association between participation in brief research-based God attachment workshops and a meaningful and statistically significant decrease in God Attachment related avoidance.

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Appendix A

[Excerpt taken from the “Seeking Proximity to God Manual”]

Seeking Proximity to God Manual: Bibliotherapy Interventions Using Hannah Hurnard’s Hinds’ Feet on High Places

By Keaghan Macon, presented at Dr. Anita Knight’s *God Attachment Workshop*
Liberty University, February 6-8, 2018

In God image and God attachment research, bibliotherapy utilizes the power of the written word as a transforming agent to alter one’s image of God (Thomas, 2009). Christian allegories, such as *The Chronicles of Narnia*, allow the unique opportunity for readers to identify with the characters of the stories, and thus be more receptive to learning from the themes and truths the author presents. Research has shown that the effects of bibliotherapy interventions are most significant when combined with other experiential components, such as prayer, Scripture memorization, and group discussion; and these effects can be even more significant than the effects of group therapy without the use of bibliotherapy (Rasar et al., 2013).

The following manual is designed to explore relevant themes and parallels from *Hinds’ Feet on High Places* which apply to the concept of God image and may consequently improve one’s attachment style to God. This manual can be used individually as a study guide or in groups to spark discussion, but more significant results with bibliotherapy interventions have involved experiential aspects through group discussion. Since this manual is a detailed literary companion to the novel, if using the manual with a group, consider discussing two chapters at each group session and selecting one to two questions from each chapter to discuss as time permits...



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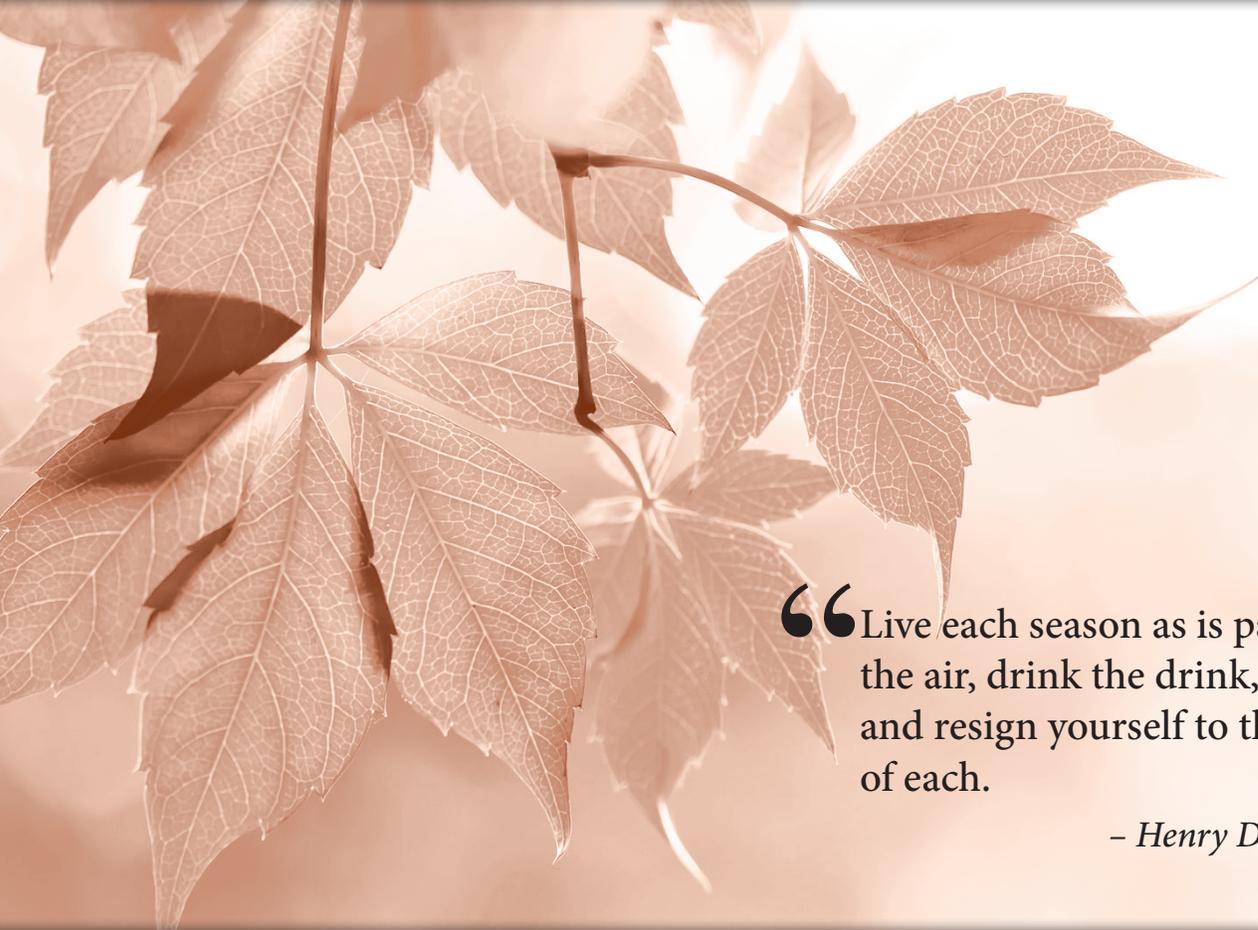
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“Live each season as it passes; breathe the air, drink the drink, taste the fruit, and resign yourself to the influences of each.”
– Henry David Thoreau