TENNESSEE COUNSELING ASSOCIATION JOURNAL

TENNESSEE COUNSELING ASSOCIATION JOURNAL ● VOLUME 10 ● NUMBER 1 ● 2025

Letter from the Editor:

Dear Reader,

On behalf of the Tennessee Counseling Association and the Tennessee Association for Counselor Education and Supervision, I am pleased to offer you the 2025 edition of the Tennessee Counseling Association Journal. We hope the information presented contributes to your knowledge regarding counseling and encourages your exploration of new topics.

The purpose of the *Tennessee Counseling Association Journal* remains constant: to promote professional growth and creativity of TCA members, Tennessee counselors, counselors nation-wide, and other helping professionals. We hope the research and ideas shared in this journal hearten readers to provide best practices to clients, expand notions of counseling, and share innovative counseling strategies with peers.

The target audience for this journal is counselors in all specialty areas, and we invite manuscripts of interest for professionals in all areas of counseling. We welcome manuscripts that: (a) integrate theory and practice, (b) delve into current issues, (c) provide research of interest to counselors in all areas, and (d) describe examples of creative techniques, innovations, and exemplary practices.

As this edition is completed, we would like to express our sincere appreciation to the TACES and TCA leadership for their continued support of the journal.

Sincerely,

Patrick Murphy, PhD, NCC, LPC-MHSP
Associate Professor
Lindsey Wilson University

Lisa Davies, EdD
Assistant Professor
Lipscomb University

Tennessee Association for Counselor Education and Supervision

Tennessee Counseling Association Journal
Editorial Board

Dr. Sarah Fucillo
Lindsey Wilson University

Dr. Derrick Shepard
The University of Tennessee at Martin

Dr. Douglas Devaney
Pellissippi State Community College

Dr. Laura Smith
Lindsey Wilson University

Dr. Tyra A. Watts
Vocational Consultant

Dr. Yvette Carter
Professional School Counselor

Surviving and Thriving: African American or Black College Women's Responses to Racially Charged Events Occurring on Campus

Taneshia Greenidge
University of Memphis

Sondra Smith-Adcock
University of Florida

M. Kristina DePue
University of Nevada-Reno

Mahalia Mays
University of Memphis

This qualitative study used a transcendental phenomenological approach to explore the lived experiences of African American or Black college women's experiences on a college campus where racially charged events occurred. The researchers conducted ten in-depth semi-structured interviews with African American or Black college women to focus on racial socialization, sense of self, and campus climate. Data was analyzed using Moustakas' (1994) phenomenological methods, with bracketing applied throughout to maintain trustworthiness. Findings revealed three core themes: 1) familial, cultural, and spiritual messages that shaped sense of self, 2) coping with discrimination and campus involvement experiences, and 3) campus solutions centered around increased visibility, resources, and mental health. Participants highlighted the vital role of racial socialization messages in fostering their sense of self and resisting discriminatory messages on campus. Implications underline the need for culturally responsive counseling services, increased representation of Black women in higher education spaces, and institutional accountability in addressing campus racism. The study findings add to the growing literature on racial socialization and offers recommendations for enhancing the well-being of Black women students.

Charged Events

The college years are a time when individuals take on roles involving greater responsibilities, gain increased independence from their immediate families, begin intense exploration of their identity, and face new challenges, which may include navigating racism for

African American students (Plunkett et al., 2016). Prior research shows that students of color have experienced marginalization, discrimination, and isolation within higher education (Mwangi et al., 2018). For Black women, going to college serves as a period of discovering authenticity and resisting stereotypes of what it means to be a Black woman (Winkle-Wagner et al., 2018). Navigating higher education spaces that are predominantly White institutions (PWIs) can especially present obstacles related to the oppression and marginalization of the intersecting racial and gender identities of Black women (Winkle-Wagner et al., 2018). Black women's experiences in higher education cannot be fully understood without examining the intersection of race and gender. Kimberlé Crenshaw's (1989) framework of intersectionality highlights how overlapping marginalized identities create distinct forms of oppression. For Black college women, their racial identity cannot be disentangled from gendered experiences that position them within stereotypes such as the "Strong Black Woman" or subject them to gendered racial microaggressions (Lewis et al., 2016). These intersectional burdens create unique stressors that not only shape how Black women perceive campus racial climates but also influence the coping strategies available to them in response to racially charged events.

Increased exposure to racially charged events on college campuses in recent years has affected the experiences of Black or African American women (Mwangi et al., 2018). Exploring Black women's college experiences is critical in understanding how Black women cope with racially charged events on campus. This focus also highlights how women perceive their universities' responses to these events and provides support to those who are directly impacted and harmed. In understanding how Black women cope with racially charged events, studying the potential protective role that racial socialization plays may be beneficial in understanding the resiliency of Black women (Harris-Britt et al., 2007). With racial socialization developing implicitly and explicitly in childhood in the form of racial pride messaging in youth and preparation for biases (Harris-Britt et al., 2007), women's racial socialization may help them before, during, and after they face racially charged events and discrimination on campus. Racial socialization functions as a protective factor for Black women so that potential encounters with racially charged events do not have as severely negative consequences.

Racially Charged Events on College Campuses

Racially charged events or incidents remain prevalent on college campuses and have occurred in various ways across time, with increasing frequency over the last decade; although documentation of these instances' dates to the civil rights era (Davis & Harris, 2016; Patel & Wang, 2025). Racially charged events or incidents on college campuses, unfortunately, often do not get appropriately addressed and typically remain undocumented until negative media coverage and disruptive campus protests occur (Davis & Harris, 2016). Davis and Harris (2016) defin**e** racial incidents or racially charged events as an umbrella term under which institutional microaggressions, hate crimes, and ethno-violence fall. The racial climate in the United States shows heightened doubt regarding race relations, increased public visibility of police brutality toward Black people, and empirical evidence of implicit anti-Black racial bias (Mwangi et al., 2018).

The presence of racially charged events has shaped most campus climates, with one recent example being a video-recorded incident at the University of Kentucky that occurred between a Black woman student and a White woman student, in which the White student physically assaulted the Black student while calling her a racial slur (Edwards, 2022). Jones (2021) articulated commonalities among Black people regarding their experiences of racial microaggressions. However, Black women's experiences are unique due to the intersectionality of their marginalized racial and gender identities, which also shapes their college experience. The impact of these events is further compounded by the ways race and gender interact to produce misogynoir, or the simultaneous racialized and gendered stereotyping of Black women (Bailey, 2010, 2013). For example, Black women are often rendered invisible in conversations about racial justice while simultaneously being hypervisible when they challenge racist or sexist structures (Newton, 2022). This dual identity intensifies the harm caused by racially charged incidents, as Black women must contend not only with anti-Black racism but also with sexist assumptions about their intellect, comportment, and belonging in academic spaces.

Adding to an often-hostile atmosphere, studies have also found that when higher leadership from institutions, such as presidents, respond to racialized incidents, Black students perceive their statements as inadequate, performative, and lacking action (Briscoe, 2024). In examining university presidential responses, one study found a trend that many presidents address the person acting racist but not the underlying belief of racism and broader systemic implications of the incidents (Cole & Harper, 2017). University responses also tend to focus more on fostering an inclusive community rather than addressing how the racialized event has actively worked against that mission (Cole & Harper, 2017). This lack of support only invalidates and worsens the lived experiences of Black students during their time in higher education.

The U.S. Department of Education is currently investigating 52 universities in 41 different states for engaging in "racial preferences and stereotypes in education programs and activities" (Kim, 2025). However, taking more direct action to address racism and systemic oppression on college campuses may appear too risky in the present political atmosphere (Kim, 2025). This climate further complicates making recommendations for change to higher education institutions that would naturally like to avoid legal trouble.

Although college campuses have attempted to improve the representation of minority students, these efforts do not always improve the racial climate on campuses (Mwangi et al., 2018). Racial tensions between Black and White students have increased with the rising diversity of institutions of higher education, especially with the ongoing changing political landscape (Johnson et al., 2024). With overt incidents of racism increasing nationally and on college campuses, it is important to explore the experiences of African American or Black college women and the influence that racial socialization has on how they navigate racially charged events on a college campus. Black women may face gendered racial microaggressions within the college academic sphere, both within classroom settings and more broadly on campuses (Newton, 2022).

Racial Socialization

Racial socialization refers to the implicit, explicit, purposeful, and unintended ways that parents' beliefs and behaviors convey views about race to their children in African American families and communities (Harris-Britt et al., 2007). In an early conceptualization of racial socialization, Triple Quandary Theory described what African American parents face in raising their children: balancing the tasks of promoting cultural pride, preparing children for life in mainstream society, and preparing children to deal with racism and discrimination (Boykin & Toms, 1985; Rodriguez et al., 2008). Because enduring racism can be an invisible adverse childhood experience (ACE), it is crucial to understand the ways in which racism creates social and even biological vulnerabilities for Black children from the beginning (Iruka et al., 2021). According to Triple Quandary Theory, these barriers set the stage for how Black families cope and integrate their children into a society that often uplifts anti-Black rhetoric and systems.

As a protective barrier against prejudice and racial discrimination, racial socialization is a foundation for healthy development in early childhood and is taught by caregivers (Causey et al., 2015). Livingston and McAdoo (2007) linked racial socialization to the development of a strong sense of self, thus preparing children to cope with barriers and inequalities present in American society. Many authors have emphasized the socialization role in the development of African American racial identity (Brown & Krishnakumar, 2007; Causey et al., 2015). Caughy et al. (2003) found that nearly 90% of the 200 parents interviewed reported conveying racial or cultural pride messages. Caughy and colleagues' (2003) research findings indicated that children from homes rich in African American culture had greater factual knowledge and better problem-solving skills due to the family messaging about race that they received. Furthermore, racial pride was associated with fewer behavioral problems (Caughy et al., 2003).

The benefits of racial socialization extend into adulthood. For example, a study of 98 African American college students found parental involvement and social support as significant factors in the development of self-esteem among college students (Causey et al., 2015). Additionally, Black mothers in particular aim to instill racial socialization messaging into their college-aged daughters to protect them from potential threats in institutionalized spaces such as academia (Leath et al., 2020). Thus, positive racial socialization from an early age helps foster wellness, self-esteem, and resiliency among Black children into adulthood. While racial socialization continues into adulthood, the literature is unclear on how this process occurs, especially considering the ongoing threats that college students must navigate.

Decades of findings on racial socialization have focused on childhood development into adulthood. However, specific research is still needed to explore and understand the relationship between racial socialization (family messages about race) and navigating racially charged events on a college campus. Exploring the experiences of Black women is of great importance as they must navigate these incidents while facing dual oppression by both race and gender. With Black women experiencing both invisibility and hypervisibility in social and academic spaces on campuses, it is important to highlight their voices to combat the invalidation and marginalization to which they are susceptible (Newton, 2022).

The purpose of the current study was to explore the lived experiences of African American or Black college women on a college campus where racially charged events occurred. We were also interested in how women's racial socialization shaped these experiences. To meet these goals, the researchers sought to answer the following question: What are African American or Black college women's lived experiences with discrimination and racially charged events on a college campus, and how does racial socialization help them cope?

Method

Using a Transcendental Phenomenological approach (Moustakas, 1994), through in-depth semi-structured interviews, we explored participants' understanding of racial socialization and experiences with racial events.

Participants

The principal investigator received approval from the Institutional Board (IRB). Participants were recruited through purposive sampling methods. The researchers distributed study flyers via university email listservs, student organizations that primarily serve African American or Black students, and campus cultural centers. Interested students contacted the research team directly and were screened to ensure they met inclusion criteria before being scheduled for interviews. The researchers recruited ten participants (N = 10) who met the inclusion criteria.

The inclusion criteria required participants to: (a) self-identify ethnically as African American or Black, (b) self-identify as a woman, (c) be enrolled as an undergraduate college student, (d) attend a U.S. university, and (e) can describe their experience with racially charged events on a college campus.

Participants' ages ranged from 19 to 25: four (40%) of the participants were 19, two (20%) were age 20, three (30%) were age 21, and one (10%) was age 25. All participants identified as African American or Black. Two participants (20%) were sophomores, three (30%) were juniors, and five (50%) were seniors.

The women came from diverse family households. Half of the participants came from a household consisting of a biological mother and father; two (20%) from a single-mother household, and three (30%) participants came from a household consisting of their biological mother and stepfather. All participants selected their pseudonyms.

Data Collection Procedures

Participants provided demographic information in the form of a questionnaire. Participants completed a 60-minute initial interview and a 30-minute follow-up interview. The research team informed participants that their data was confidential regarding their identity. Individual interviews were transcribed using transcription software and then transcribed again by hand to check for accuracy. Transcribed data was de-identified. During the initial and follow-up interviews, participants were asked to discuss their experiences regarding receiving messages about race and racial identity from parental figures and how these messages shaped their experiences on a college campus during racially charged times. The Sample interview questions were: What messages have you received about race from your support

system? And have you experienced anything as a college student that impacted your sense of self or how you view yourself in the larger college community?

Data Analysis

The researchers used Moustakas' (1994) steps for phenomenological data analysis. In the first step of data reduction, the team created a list of codes. First, they organized the data and then read it closely, making margin notes to develop a set of codes (Creswell, 2007). The codes were then sorted into textual themes. A textual description approach was used in which the researcher wrote a description of what the participants experienced (Creswell, 2007). Using a process of imaginative variation, the researchers then wrote descriptions of the context or setting that influenced how the participants experienced the phenomenon, which is referred to as structural description (Creswell, 2007). The use of these data analytic procedures helped clarify the participants' perspectives and meanings, compare similarities and differences from the participants' individual interviews, and capture the essence of the phenomenon of the women's experiences (Moustakas, 1994).

Credibility and Trustworthiness

To enhance the credibility and trustworthiness of the study, several qualitative strategies were employed. First, bracketing was applied throughout data collection and analysis to set aside researcher assumptions and ensure participants' voices were centered (Moustakas, 1994). Member checking was incorporated by conducting follow-up interviews, which allowed participants to review and clarify their responses, thereby strengthening accuracy and credibility. Peer debriefing occurred among the research team to challenge interpretations, reduce individual bias, and confirm emerging themes. The study also maintained an audit trail by documenting analytic decisions, coding processes, and reflexive notes, which enhanced dependability and confirmability. Finally, thick descriptions of participant narratives were provided in the findings to promote transferability, allowing readers to determine the applicability of results to other contexts. These combined strategies supported methodological rigor and strengthened the findings.

Subjectivity Statement

The research team consisted of four researchers, three who serve as counselor educators at public institutions, and one who is a doctoral student in a counseling psychology program. All the researchers are experiencing the political and cultural climate changes on their respective college campuses. Of the researchers, two are Black women who have experienced racial discrimination and racially charged events on a college campus and understand firsthand how these incidents impact African American and Black women. The primary researcher also worked in clinical settings that served Black adolescent girls and college-aged women. From her clinical experiences, she wanted to explore what messages about race the students had received throughout their lifetime and how these messages helped them navigate school. Two of the researchers were counselor educators during the 2016 election and witnessed the impact that the political climate had on students. All of the researchers have witnessed hate speech on college campuses and felt the

impact on the college climate. Protests, hate speech, political changes (i.e., removal of Diversity, Equity, and Inclusivity), and racially charged events continue to impact college campuses, and all researchers have been affected**.**

Exposure to hate speech on a college campus led to the research question for this study: What are the experiences of African American or Black college women with racial socialization and discrimination amid racially charged events on a college campus? The researchers wanted to explore the experiences of African American or Black women while they navigated college and racially charged events on campus. They also wanted to know what was assisting these students with their trajectory through school, knowing that the political climate and racially charged events were occurring on college campuses nationwide.

Findings

Findings are presented as three structural composite themes. The final themes included: 1) familial, cultural, and spiritual messages that shaped sense of self, 2) coping with discrimination and campus involvement experiences, and 3) campus solutions centered around increased visibility, resources, and mental health.

Familial, Cultural, and Spiritual Messages that Shaped Sense of Self

The participants' sense of self as Black women was shaped by affirming messages from culture, family, religion, and mentors, while also being challenged by societal messages of underrepresentation, lack of belonging, and racial bias. All participants spoke about how messages about race, culture, and racial socialization shaped their sense of self. Lucy expressed, "My parents have always been proud to be Black, and then, so is the rest of my family. I've never felt like it wasn't okay to be Black." Shay received similar messages and alluded to race being a social construct, discussed stereotypes that she encountered, and ways she overcame them, as well as loving being Black. Shay stated, in reference to overcoming stereotypes, "I became even less apologetic about me being Black." Messages about race helped shape the participants' perspectives on themselves as Black women. Seeing positive images of Black women and having positive, influential role models and mentors encouraged a sense of self-worth and confidence. Kit Kat viewed Black women as "breaking boundaries, being together and supporting each other, getting acknowledgements, resiliency, and working hard for what we want." Kalessi described that she knew it was amazing to be Black but did not feel that way until movements such as Black hair movements, Black Lives Matter, and Black Girl Magic helped her embrace her appearance and Black identity. In reference to Black women, Kalessi described messages she received from her dad. She shared, "My dad once told me that because I am Black, and I am a woman, that I have to work twice as hard as everybody else because things aren't going to come easy to me." This dual identity was echoed throughout participants' narratives, with many noting that their families prepared them for compounded barriers that would emerge specifically because they were both Black and women. These gendered messages reinforced an awareness of inequities in academic and professional contexts, while also encouraging resilience. Unlike their male peers, participants were reminded that stereotypes about Black femininity, such as being overly aggressive, loud, or less capable, could intersect with racial stereotypes to create additional layers of marginalization. Racial

socialization extended beyond racial pride to encompass the realities of navigating life as Black women within patriarchal and racist structures.

The women received messages from their support systems that contributed to their sense of self as African American or Black college women, including family, mentors, and religious figures. Fenty stated that community belonging, relating to others, self-care, and family all had positive impacts on her development. She explained, "Community belonging. Finding people who are interested in the same things, which makes me feel better about the stuff that I do or finding people who have the same problems. It's like, 'oh it's normal to feel this way.'" Shay shared that her mom, stepdad, grandmother, and social/school activities had positive impacts on her. Kalessi stated that her mom's encouraging words, support, and presence had positively impacted her, along with her brothers helping her develop tough skin. Religious beliefs also helped combat racial messages and events on campus, contributing to participants' sense of self. Valencia shared, "I think it goes back to faith number one because, again, like God validates me, so I don't need like other people." Similarly, Shannon stated, "Sometimes when I'm sad or whatever I just tell myself like if God thought I was, you know, worthy to be on this earth or if I have a purpose or whatever then I'm obviously of value." For Shannon, religion played a huge role in how she viewed herself. She referred to a term called "Godfidence," which represented religion for her.

Experiences on campus and academic influences impacted the participants' sense of self and assisted with navigating campus. The messages participants shared were both uplifting and challenging. Valencia stated, "I feel like they don't expect us to be here [college] sometimes. So being here, and we see each other, I feel like we're breaking their norms of what they think a Black woman should be." Lucy's teacher's perspective of her played a major role in her sense of self. Lucy shared, "When I talk to teachers it was nice and then when I had the realization that my teachers liked me because I was a good student, and I was a nice person, that kind of helped with self-esteem." Women also shared messages from mentors who believed in them. Triple L stated, "I do have like certain mentors that check up on me every now and then… I would say basically them always reassuring me that you're worthy of so much more and you have value." Kit Kat explained, "I'll say just like the positive influences in my life, like my mentors. People from my church… We were, like always together, empowering. Just positive messages like letting me know I can do stuff. That my circumstances didn't define who I was." However, Kit Kat also expressed her frustration with the lack of representation on campus and noted difficulty talking to people who are not racial minorities about her struggles. She explained, "I feel like all the advisors I talked to, they're all White. And so even though I feel comfortable talking to them about other stuff, when it comes to the discrimination against and race stuff, it's like they're White so they can't really understand me anyways."

Coping with Discrimination and Campus Involvement Experiences

To deal with unrest on campus, participants described how their college experiences shaped their sense of self. These experiences influenced how they felt the university and their peers viewed students of color. Shannon described her experiences as not

feeling valued on campus, noting that the campus does not care about Black people and does not see her the way she sees herself. Valencia shared, “A lot of situations we’re put in, it’s like they don't understand what they're saying is hurtful or comes off as prejudice.” Shay explained how her sense of self becomes a concern on campus. She said, “I doubt myself before I even can get there, and I think the college climate, because it is so huge, I don't think it's helped completely.” The participants discussed different forms of discrimination on campus, events they witnessed, and the impact these experiences had on how they felt. Kit Kat described discrimination on campus as feelings of tension and discomfort when racially charged speakers came to campus. She explained that if she didn’t have a strong sense of self, discriminatory acts on campus would have negatively impacted her. Kalinda described events on campus as making her feel like the campus does not care about Black people, as well as feeling that the university included Black people only for the numbers. She said, “I feel like [the university] needs their numbers, but they clearly don’t care enough. It’s still only six percent Black people.”

Safety on campus was another concern mentioned. Some participants received strong messages about personal safety from parents and family members. Lucy stated, “I went back to my apartment, and I stayed there for the rest of that night just because my family was concerned that something might happen.” Kalessi described witnessing racially charged events as scary and felt confused as to why the university would not prioritize her safety. She felt her safety was not important and that the school did not care about her. When it came to the impact of discrimination on campus, most felt it had a temporary effect. Fenty shared, “[My self-esteem] definitely comes into question... but then once I gather confidence from knowing that I'm not supposed to feel this way or that this is not the way that things are supposed to be, it just comes relatively back to where it was.” Kit Kat stated, “I don't feel like my self-esteem personally has been like affected on campus negatively. Just because I still have like those positive influences in my life.”

Participants mentioned various strategies to help cope with discrimination through their relationships with family and friends. Valencia stated, “Family and friends, always [have] my back and [give] me advice about how to deal with stuff.” Some found involvement on campus, joining clubs or organizations, and attending events hosted by campus groups to be helpful. Kalessi said that friends, other student advocates, organizations on campus, and her mentorship work helped her cope with discrimination. Participants found peace in knowing that others had similar experiences to theirs. Triple L shared that she found security in finding other people, not feeling alone, and feeling as if she belonged because she connected with others experiencing similar issues. Valencia reflected on the impact of racially charged statements or gestures on her persistence and resilience. She explained, “I feel like to me it's like a hit to their face that I'm not getting affected by their blows. I feel like I'm a symbol of like strength.”

The women felt a strong pride and honor toward their ancestors and Black figures who paved the way for them to attend the university. Shay reflected on her experience in college:

“When things are trying to tear us down, we pull it out of ourselves to build ourselves up. I have been in several challenging situations, but they say the flower that blooms in adversity is like the most beautiful. And it's when I step out of my class, and I'm walking all over this

orange red brick I almost feel honored because there is such a huge progression made by people before me and because I'm taking the steps now, there will be people here to walk after me and that's why I feel good."

Campus Solutions Centered Around Increased Visibility, Resources, and Mental Health

Participants placed strong emphasis on wanting to be seen and valued by their university. Increased visibility or representation of Black women on campus was a core solution mentioned. Kit Kat suggested that the university create an initiative to increase representation. She stated, "An initiative on campus that recognizes Black women and more representation around campus as far as advertisement and higher positions." Fenty shared, "I feel like having more organizations and more representation would definitely be something that I would be interested in." She also found greater representation in different organizations on campus and more community outreach helpful. Kalessi felt there was a need for increased diversity among staff and more accessible, relatable resources. She explained, "There are resources. I just feel like if we could relate to them more it would be extremely helpful to us."

All participants offered solutions to their university on how to improve the college climate and increase inclusivity. Programming was a major theme. Shannon suggested, "More programming and having open dialogue about maybe discrimination." Lucy felt it was important for the university to communicate support for women of color. She suggested, "Having those messages that people write or nice notes where they put like 'we support you, you were loved' or something like that. Either it's like drawn in chalk or a little Post-it notes around campus." Skyler also shared, "I think one thing that the university can do is listen to like our thoughts and our feelings, which will soon lead to change." She also suggested more interactions with Black women students and creating partnerships.

Participants wanted to see more support for Black women on campus. Valencia recommended, "Having a group that can advocate for ourselves on campus." Triple L suggested the university host conferences to support Black women, such as "one or two motivational, inspirational conferences that kind of give words of encouragement." Kit Kat believed get-togethers and empowerment events would also be important to support Black women students. She added, "I think mentorship would be a good thing. Like just us being paired with somebody on campus who, like, can relate to us or in, like, a higher position." Participants also discussed educating counterparts and including classes at the freshman level to improve how students, faculty, and staff interact. Shay stated, "If everyone could take a class that kind of highlights the different parts of self-esteem, of privilege, of racial injustice and how that leaves impressions with people." Valencia suggested "incorporating more current events and diversity training into a course during freshman year" and added, "I think educating our counterparts about how to treat people with respect."

In addition to campus initiatives, mental health services were also discussed. Kalinda strongly advocated for improvements to the university's approach to mental health services. She stated, "I really think as an institution, mental health could be better, like, incorporated." Kalinda also encouraged the university to offer mental health programming throughout the year, not only during stressful times. Participants were specific about services they felt would help. Valencia suggested, "I think having support groups." Shay echoed

this, stating, “Support groups as a way to help Black women increase or maintain their self-esteem being on a campus where discrimination occurs” would be important. Kalessi added, “There are not a lot of Black counselors here, so I think that could be an issue.” She also discussed how the university counseling center could improve to reduce apprehension among Black women seeking counseling services: “Make the counseling center cater to people of color more.”

The Essence of the Experience Statement

Ten African American college women reported that togetherness and connections to other Black students helped them reduce the personal impact of discrimination on campus. These women shared how family messages shaped them into the people they are and influenced their self-perception. Positive messages from family members and social support protected participants from the harm of discrimination and racially charged events. The women conveyed a strong sense of who they were, the importance of their own view of self, and the value of positive family messages in coping with discrimination. They recommended that university administrators become familiar with the challenges faced by African American or Black college women and provide more resources that promote inclusivity.

Discussion

In the current findings, women shared how messages from parents, extended family, friends, and religious affiliations helped them manage or cope with racially charged events on college campuses; this aligns with previous literature (Hope et al., 2025). This finding also supports those of Harris-Britt et al.’s (2007) and Hughes et al.’s (2006) who found racial socialization serves as a protective factor by fostering resilience and positive self-concept in African American youth. Consistent with Livingston and McAdoo (2007), participants described how racial pride messages and preparation-for-bias strategies from caregivers buffered against discriminatory campus experiences. Livingston and McAdoo emphasized that African American parents, and fathers in particular, play a central role in fostering resilience by instilling cultural pride and preparing children to face societal inequalities. Similarly, the women in this study shared how their families equipped them with both affirmations of worth and practical guidance for navigating racial and gendered barriers in college. These findings suggest that the protective mechanisms identified in childhood extend into emerging adulthood, continuing to shape Black women’s sense of self and ability to cope with discrimination in higher education settings.

Mentors, community programs, and teachers were also discussed as influential. These influences shaped the women’s sense of self and understanding of racial messages. Current findings echo those of Patterson (2004) and DeFrancisco and Chatham-Carpenter (2000), who postulated that social support systems, such as family, friends, church, and community, were primary contributors to self-esteem in African American women. Current findings also align with a similar study by Thelamour et al. (2019), which found that parents’ socialization strongly influenced Black students’ identities. For emerging adults, views of self and racial identity are partially linked to perceptions of interactions with their parents, and African American parents continue to influence their children during adulthood (Plunkett et al., 2016). Some of the young women in this study explained that although they were now young adults, they still sought out

their parents' perspectives and advice. The women also noted that their parents' influence reminded them of their abilities and values, which contributed positively to their sense of self. These findings align with prior research linking perceived parent-child relationships to high self-esteem and resilience in African American women (Causey et al., 2015). For women, emotional support contributed to how they navigated college campuses where Black women encounter racism. Current findings indicated that women received messages about race and culture from their caregivers, which positively affected them despite the negative messages represented in society.

Racially charged incidents such as hate speech, slurs, and attacks negatively affect campus climate and students' sense of belonging (Johnson et al., 2024). For the women in this study, racial socialization shaped how they navigated college amid a tense political climate. While many had a strong sense of self, exposure to discrimination and stereotypes challenged their self-worth (Lewis et al., 2016). Our findings extend prior work by showing how the dual lens of race and gender influenced how participants interpreted campus climates, were perceived by others, and developed coping strategies. This aligns with research on gendered racial microaggressions, which highlights the unique psychological toll of racism and sexism on Black women (Lewis et al., 2016; Newton, 2022; Jones, 2021). Participants also described barriers such as classroom discrimination and being overlooked for opportunities.

To cope, the women relied on racial socialization learned within their families, which prepared them to confront inequality (Causey et al., 2015; Livingston & McAdoo, 2007). They also turned to peer support groups, shared experiences with other minoritized students, and sought guidance from trusted individuals. These strategies helped them preserve their sense of identity and safety while navigating the racial climate on campus.

Findings of the current study suggest messages about race and historical messages were one way that the women coped with discrimination on campus. Specifically, racial socialization messages from parents fostered a sense of pride and self-acceptance. This inner strength helped counteract the political and campus climate, which relayed messages of not belonging and not being cared for. Historical messages served as reminders of the sacrifices that other Black figures made so the women could attend their current predominantly White university. This finding resonates with Hope et al. (2025), who observed that spiritual and historical frameworks provide Black college women with strength and validation in the face of racial adversity. Similarly, Thelamour et al. (2019) emphasize how shared cultural narratives and same-ethnic peer connections sustain belonging and resilience on predominantly White campuses, reflecting the ways participants in this study drew from collective history as a source of empowerment. Women seemed to show a sense of pride and a fighting spirit for equality fostered by the messages received. Positive racial socialization messages were key in helping the women overcome racially charged events and discrimination on campus. This finding is consistent with research on racial socialization strengthening racial identity and psychological resilience and safeguarding against the emotional and academic harms associated with discrimination (Neblett et al., 2009; Hughes et al., 2006; Bynum et al., 2007).

These results extend prior research on racial socialization as a protective factor (Caughy et al., 2003; Neblett et al., 2009), and according to Black women, may be a personal resource in emerging adulthood as they navigate complex racial climates on campuses. By situating participants' narratives within this broader literature, the current study affirms the continued salience of family and community-based messages in counteracting institutional invalidation, while also highlighting the necessity of gender-specific frameworks that account for misogynoir and intersectional marginalization (Bailey, 2010, 2013; Crenshaw, 1989). The women's stories reinforces the importance of culturally responsive supports that address the dual oppressions of race and gender in higher education contexts.

Implications for Counseling

The women in this study believed that support groups would be a beneficial service, as they can provide a sense of community, a safe space for African American college women to express frustrations, create and develop healthy coping skills, and normalize their experiences. Jones and Pritchett-Johnson (2018) agreed that group therapy models may attend to the specific needs and concerns of Black women as they face challenges. In addition to support groups on campus, the women in this study hoped to see Black women hired on campus to increase their sense of belonging, provide opportunities for mentorship, and help students feel more supported. Hiring Black women counselors can encourage more Black college women to use the university's mental health services (Center for Collegiate Mental Health, 2016). Culturally similar counselors may be a strong preference for Black students (Cabral & Smith, 2011), especially for students with high racial consciousness (Duncan & Johnson, 2007).

The women in this study were hesitant to seek counseling services provided by the institution due to the lack of Black female representation within the counseling system and across campus. Consistent with prior studies, Jones and Pritchett-Johnson (2018) reported that both Black women and Black men tend to pursue counseling apprehensively. The low numbers of Black counseling staff can discourage Black students from seeking or continuing care, as they may feel that White counselors cannot fully relate to their experiences (Anderson, 2020; LeViness et al., 2020). Consistent with the women in this study, previous researchers found that African American women may fear that counselors will not meet their expectations (Harris, 2012). Underlying this fear is a history of cultural mistrust between Black clients and White service providers, who have historically subjected Black clients to devaluation and negative imaging, which has contributed to a lack of use of counseling services (Jones & Pritchett-Johnson, 2018). Counselors should use open questioning about the experiences of Black women students, which will allow them the opportunity to communicate their own experiences rather than being treated as representative of all Black women. There is also a need to focus on creating a campus climate of advocacy for the needs of Black women and implementing this concept within college counseling centers.

Limitations and Recommendations for Future Research

This study provided insight into how Black women navigated a predominantly White college campus during racially charged events. These women did not want to represent all Black women; however, they provided meaningful accounts of their lived experiences.

We aimed to honor the women by giving them the platform for their voices to be heard. The trustworthiness of the study findings depends on the women's stories of their personal experiences, which may be subject to memory recall or bias. Future qualitative studies could strengthen findings through multiple data sources (e.g., journaling, photographs) or multi-perspective approaches (e.g., case study design). Increasing the sample size or conducting multi-institutional research could also enhance representation and diversity of experiences on college campuses.

Since context matters, women's experiences with racial socialization as it pertains to racially charged events and/or incidents on a college campus may appear differently at Historically Black Colleges and Universities compared to PWIs. Comparative studies across institutional types (e.g., HBCUs, PWIs, minority-serving institutions) are needed to understand how setting shapes racial socialization. With the ever-evolving political climate, replicating this study would allow for more insight into the lived experiences of Black women on college campuses during racially charged events. Further studies will provide a deeper understanding of how women experience the world and how racial socialization influences their self-understanding and conceptualization of experiences.

Additionally, studies on college counseling services could identify strategies to help mitigate the effects of racialized stressors and inform outreach and programming. Research on counselor training models should explore how personal and cultural influences, along with racial socialization, affect therapeutic engagement with African American college women. Future research may also examine how racial socialization messages are passed down across generations and their long-term impact on Black women's mental health. In addition, examining social media's influence on racial messages among Black college women regarding representation and online activism is needed.

Conclusion

This study highlights the unique ways African American or Black college women navigate racially charged events on predominantly White campuses while carrying the dual burdens of race and gender. Through racial socialization messages from families, mentors, and faith communities, participants developed resilience and a strong sense of self that enabled them to resist harmful stereotypes and cope with discrimination. Their lived experiences underscore that racial socialization not only provides a foundation for self-esteem but also functions as a protective factor in adulthood when Black women face systemic inequities in higher education.

At the same time, the findings reveal persistent gaps in institutional responses, campus climate, and available support systems. Universities must not only acknowledge but also act upon the intersecting realities of racism, sexism, and misogynoir that shape Black women's experiences. Culturally responsive counseling, increased representation, and intentional community-building are critical steps in fostering belonging and affirming students' full identities.

By centering the voices of Black college women and recognizing the interplay of race and gender, this study contributes to a growing body of literature that calls for higher education institutions to move beyond performative inclusion toward structural change and accountability.

References

Anderson, G. (2020, October 22). *The Emotional Toll of Racism*. Inside Higher Ed. https://www.insidehighered.com/news/2020/10/23/racism-fuels-poor-mental-health-outcomes-black-students

Bailey, M. (2010). They aren't talking about me… *Crunk Feminist Collective*. Retrieved from https://www.crunkfeministcollective.com/2010/03/14/they-arent-talking-about-me/

Bailey, M. (2013). New Terms of Resistance: A Response to Zenzele Isoke. *Souls*, *15*(4), 341 343. https://www.researchgate.net/publication/262938845_New_Terms_of_Resistance_A_Response_to_Zenzele_Isoe

Boykin, A. W., & Toms, F. D. (1985). Black child socialization: A conceptual framework. In H. P. McAdoo & J. L. McAdoo (Eds.), *Black children: Social, educational, and parental environments* (pp. 33–51). Sage Publications, Inc.

Briscoe, K. L. (2024). "Failing to respond": Black graduate students' perceptions of a university president's responses to racialized incidents. *Journal of Diversity in Higher Education, 17*(2), 97–109. https://doi.org/10.1037/dhe0000388

Brown, T. L., & Krishnakumar, A. (2007). Development and validation of the adolescent racial and ethnic socialization scale (ARESS) in African American families. *Journal of Youth and Adolescence*, *36*(8), 1072–1085. https://doi.org/10.1007/s10964-007-9197-z

Bynum, M. S., Burton, E. T., & Best, C. (2007). Racism experiences and psychological functioning in African American college freshmen: Is racial socialization a buffer? *Cultural Diversity & Ethnic Minority Psychology, 13*(1), 64 71. https://doi.org/10.1037/1099-9809.13.1.64

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*(4), 537–554. doi: 10.1037/a0025266

Caughy, M. O., O'Campo, P. J., Randolph, S. M., & Nickerson, K. (2003). The influence of racial socialization practices on the cognitive and behavioral competence of African American preschoolers. *Child Development*, *73*(5), 1611 1625. https://doi.org/10.1111/1467-8624.00493

Causey, S. T., Livingston, J., & High, B. (2015). Family structure, racial socialization, perceived parental involvement, and social support as predictors of self-esteem in African American college students. *Journal of Black Studies*, *46*(7), 655–677. https://doi.org/10.1177/0021934715592601

Center for Collegiate Mental Health. (2016). 2016 annual report (Publication No. STA 15-108). State College, PA: Pennsylvania State University.

Cole, E. R., & Harper, S. R. (2017). Race and rhetoric: An analysis of college presidents' statements on campus racial incidents. *Journal of Diversity in Higher Education*, *10*(4), 318–333. https://doi.org/10.1037/dhe0000044

Crenshaw, K. (1989). *Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics.* University of Chicago Legal Forum, 1989(1), 139–167.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five traditions*. SAGE.

Davis, S., & Harris, J. C. (2016). But we didn't mean it like that: A critical race analysis of campus responses to racial incidents. *Journal of Critical Scholarship on Higher Education and Student Affairs*, *2*(1). https://ecommons.luc.edu/cgi/viewcontent.cgi?article=1020&context=jcshesa

DeFrancisco, V. L., & Chatham-Carpenter, A. (2000). Self in community: African-American women's views of self-esteem. *Howard Journal of Communications, 11*, 73-92. https://www.researchgate.net/profile/April-Chatham Carpenter/publication/263262057_Self_in_Community_African_American_Women's_Views_of_Self-Esteem/links/568a8ab708ae 1e63f1fbd37b/Self-in-Community-African-American-Womens-Views-of-Self-Esteem.pdf

Duncan, L. E., & Johnson, D. (2007). Black undergraduate students' attitude toward counseling and counselor preference. *College Student Journal, 41*(3), 696–719. https://psycnet.apa.org/record/2008-00861-018

Edwards, J. (2022, November 11). University of Kentucky bans student who repeatedly used the n-word. *Washington Post*. https://www.washingtonpost.com/nation/2022/11/11/university-kentucky-racial-slur-attack/

Harris, A. L. (2012). Barriers to group psychotherapy for African American college students (Doctoral dissertation). Retrieved from http://corescholar.libraries.wright.edu/etd_all/669/

Harris- Britt, A., Valrie, C. R., Kurtz- Costes, B., & Rowley, S. J. (2007). Perceived racial discrimination and self-esteem in African American youth: Racial socialization as a protective factor. *Journal of Research on Adolescence*, *17*(4), 669 682. https://pmc.ncbi.nlm.nih.gov/articles/PMC2917995/

Hope, M. O., Leath, S., Henschke, L. E., Onuoha, A. C., & Quiles, T. (2025). "My life's light": Black college women's religious and spiritual responses to racial discrimination. Journal of Diversity in Higher Education. Advance online publication. https://dx.doi.org/10.1037/dhe0000646

Hughes, D., Rodriguez, J., Smith, E. P., Johnson, D. J., Stevenson, H. C., & Spicer, P. (2006). Parents' ethnic-racial socialization practices: A review of research and directions for future study. *Developmental Psychology, 42*(5), 747 770. https://doi.org/10.1037/0012-1649.42.5.747

Iruka, I. U., Harper, K., Llyod, C. M., Boddicker-Young, P., De Marco, A., & Blanding, J. (2021). *Anti-Racist policymaking to*

protect, promote, and preserve Black families and babies. Equity Research Action Coalition. https://equity coalition.fpg.unc.edu/wp-content/uploads/LG21036-CT-Anti-Racist-Policymaking-for- -Fams-Final-r2_Web-1.pdf

Johnson, J. M., Scott, S., Phillips, T., & Rush, A. (2024). Ivy issues: An exploration of Black students' racialized interactions on Ivy League campuses. *Journal of Diversity in Higher Education, 17*(2), 165–175. https://doi.org/10.1037/dhe0000406

Jones, A. M. (2021). Conflicted: How Black women negotiate their responses to racial microaggressions at a historically white institution. *Race Ethnicity and Education*, *25*(5), 738–753. https://doi.org/10.1080/13613324.2021.1924136

Jones, M.K., & Pritchett-Johnson, B. (2018). "Invincible Black Women": Group Therapy for Black College Women. *The Journal for Specialists in Group Work,* 43(4), 349-375.https://doi.org/10.1080/01933922.2018.1484536

Kim, J. (2025, March 14). *Over 50 universities are under investigation as part of Trump's anti-DEI crackdown*. Npr.org; NPR. https://www.npr.org/2025/03/14/g-s1-53831/dei-universities-education-department-investigation

Leath, S., Butler-Barnes, S., Ross, R., & Lee-Nelson, Z. (2020). What happens if they come for you? An exploration of mothers' racial socialization on discrimination with Black college women. *Psychology of Women Quarterly*, *45*(2), 194–211. https://doi.org/10.1177/0361684320979679

LeViness, P., Gorman, K., Braun, L., Koenig, L., & Bershad, C. (2020). The association for university and college counseling center directors annual survey: 2019. In *aucccd.org*. The Association for University and College Counseling Center Directors. https://www.aucccd.org/assets/documents/Survey/2019%20AUCCCD%20Survey-2020-05-31-PUBLIC.pdf

Lewis, J. A., Mendenhall, R., Harwood, S. A., & Browne Huntt, M. (2016). "Ain't I a woman?": Perceived gendered racial microaggressions experienced by Black women. *The Counseling Psychologist, 44*(5), 758 780. https://doi.org/10.1177/0011000016641193

Livingston, J. N., & McAdoo, J. L. (2007). The roles of African American fathers in the socialization of their children. *Black families*, *4*, 219-237. https://www.researchgate.net/publication/292777086_The_roles_of_African_American_fathers_in_the_socialization_of_their_children

Moustakas, C. (1994). Phenomenological research methods. Sage Publications.

Mwangi, C.A.G., Thelamour, B., Ezeofor, I., & Carpenter, A. (2018). "Black Elephant in the Room": Black Students Contextualizing Campus Racial Climate Within US Racial Climate. *Journal of College Student Development 59*(4), 456-474. https://muse.jhu.edu/article/699392

Neblett, E. W., Jr, Smalls, C. P., Ford, K. R., Nguyên, H. X., & Sellers, R. M. (2009). Racial socialization and racial identity: African American parents' messages about race as precursors to identity. *Journal of youth and adolescence*, *38*(2), 189–203. https://doi.org/10.1007/s10964-008-9359-7

Newton, V. A. (2022). Hypervisibility and invisibility: Black women's experiences with gendered racial microaggressions on a white campus. *Sociology of Race and Ethnicity*, *9*(2), 164–178. https://doi.org/10.1177/23326492221138222

Patel, A., and Wang, C. (2025). Online Racial Discrimination and College Student Mental Health: Social Support as a Moderator. *J. Racial and Ethnic Health Disparities*. https://doi.org/10.1007/s40615-025-02405-w

Patterson, K. L. (2004). A longitudinal Study of African American women and the maintenance of a healthy self-esteem. *Journal of Black Psychology, 30*(3), 307-328. https://journals.sagepub.com/doi/10.1177/0095798404266065

Plunkett, S. W., White, T. R., Carter, D. W., & Horner, M. E. (2016). Parental Support and Psychological Control in Relation to African American College Students' Self-Esteem. *The Journal of Pan African Studies, 9*(4), 199-218. https://www.jpanafrican.org/docs/vol9no4/JuneJuly-13-Plunkett.pdf

Rodriguez, J., McKay, M. M., & Bannon, W. M. (2008). The role of racial socialization in relation to parenting practices and youth behavior: An exploratory analysis. *Social Work in Mental Health*, *6*(4), 30–54. https://doi.org/10.1080/15332980802032409

Thelamour, B., George Mwangi, C., & Ezeofor, I. (2019). "We need to stick together for survival": Black college students' racial identity, same-ethnic friendships, and campus connectedness. *Journal of Diversity in Higher Education*, *12*(3), 266 279. https://doi.org/10.1037/dhe0000104

Winkle-Wagner, R., Kelly, B. T., Luedke, C. L., & Reavis, T. B. (2018). Authentically me: Examining expectations that are placed upon Black women in college. *American Educational Research Journal*, *56*(2), 407–443. https://doi.org/10.3102/0002831218798326

Social Wellness of Counselor Education and Supervision Doctoral Students before and during COVID-19: Implications and Future Directions

Alexandria H. Barnette
East Tennessee State University

Joel F. Diambra
University of Tennessee Knoxville

Wellness is a foundation of the counseling profession (ACA, 2014; NBCC, 2016), and counselor educators and supervision doctoral students (CESDS) are to embody wellness in their various roles during their programs and afterward (Wester, 2009). These strenuous and sometimes competing roles affect their wellness practices, particularly their social wellness practices and their feelings of connection and support from their various support systems (Pierce & Herlihy, 2013). This presents a challenge considering counseling is a social and relational practice and counseling professionals are to demonstrate wellness competency through establishing and maintaining social relationships with others in their support network (Gibson et al., 2021). Additionally, the COVID-19 pandemic affected CESDS as they were not immune to the resulting social repercussions (Bray, 2020). This article reviews CESDS wellness overall, the importance of social wellness in the form of connection and support, ways in which COVID-19 affected CESDS' social wellness, cultural factors associated with CESDS social wellness, program obligations of CESDS, and support system and distance-related factors associated with CESDS social wellness. We offer implications for future research and counselor educators.

In their seminal work, Myers et al. (2000) defined the term wellness as "a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community" (p. 252). The promotion of wellness practices is foundational to the counseling profession and to the education of future counseling professionals (ACA, 2014; NBCC, 2016). The profession encourages counselors to dedicate time toward the development of wellness competencies across the lifespan (Marshall, 2018) and to incorporate acts of self-care, a demonstration of wellness (Gibson et al., 2021), at various points in their regular schedule to prevent burnout or vicarious trauma (Harrichand et al., 2021). Counselor education and

supervision doctoral students (CESDS) are to monitor their own wellness and self-care practices to be most effective in their multiple roles (e.g., teaching, supervising, leadership, advocacy, research, service) (Wester et al., 2009). Due to the impact CESDS will have through their interpersonal relationships with peers, students, and the profession through these many roles, it is imperative to consider CESDS' wellness and self-care practices (Gleason & Hays, 2019).

One of the ways that counseling professionals are to demonstrate wellness competency is through establishing and maintaining social relationships with others in their support networks (Gibson et al., 2021) These practices aid in their social wellness. Even when considering the importance of their overall wellness and maintenance of social relationships, it is common for CESDS to compromise various areas of wellness while they are in their doctoral programs (Pierce & Herlihy, 2013). This can include social wellness in the form of personal social support and connection to social networks, an area of wellness that the COVID-19 pandemic affected (Pérez-Escoda et al., 2020). The COVID-19 pandemic caused significant loss in social connection and support for many people (Deng et al., 2021) providing a distinct time point to explore how such a large-scale event affected social connection and support. In a profession which values promoting social wellness in others, it is imperative that we understand how future counselor educators and supervisors tasked with this endeavor experience social wellness themselves.

To provide necessary context relaying the importance of this topic, we will provide information on the wellness experiences of CESDS. Then, we explain the importance of social wellness and outline how CESDS experienced social wellness both before and during the COVID-19 pandemic. Next, we provide information on cultural factors associated with CESDS social wellness and program obligations and factors pertaining to social connection and support for CESDS. Last, we provide implications for counselor educators, CESDS, and other counseling professionals to consider in future research and education/program development.

Social Wellness

Counseling is inherently a social and relational endeavor between counselor and client(s). Because counselors aim to promote positive, healthy relationships in the lives of their clients (Rodriguez, 2016), there is an innate connection between social wellness and the counseling profession. In fact, many researchers consider relationships to be the key to counseling (Cochran & Cochran, 2020; Haverkamp, 2012). In kind, "social wellness is building and engaging in trusting, respectful, and authentic relationships" (University of New Hampshire, 2023). Developing and maintaining social wellness, then, is imperative to being an effective counselor, counselor educator, and CESDS. Aside from building and experiencing authentic relationships, social wellness "involves using good communication skills… respecting yourself and others and creating a support system that includes family members and friends." (Chobdee, 2014). From the perspective of the Indivisible Self Model of Wellness, (IS-WEL; Myers & Sweeney, 2004), social wellness is represented by the Social Self, a second-order factor further funneled into both friendship and love (i.e., romantic) relationships. Researchers depict both friendship and

love relationships as important forms of connection with other people (Myers & Sweeney, 2004). More specifically, friendships and intimate/romantic relationships provide individuals with social connection to others and a feeling of support (Myers & Sweeney, 2004).

Because researchers have cited social support as a strong predictor of positive well-being across one's lifespan (Marshall, 2018; Werner-Seidler et al., 2017), social wellness coincides with a longer, more quality lifespan (Adair et al., 2018). The presence of social connection and social networks help facilitate social and emotional support. Linking to a social network entails the feeling of connection to others (Werner-Seidler et al., 2017), while social support entails feeling supported by one's network. Social connection can also lead to greater positive emotions (Adair et al., 2018). The presence of social support systems can promote physical healing and boost one's immune system (Falagas et al., 2007). Maintaining social connections with one's support system can also lead to an increase in overall life satisfaction (Amati et al., 2018). Having a network of support can contribute to either a reduction of stress (Minor et al., 2013; Thompson et al., 2018) or a better response to stress (Werner-Seidler et al., 2017). These benefits are important considerations for CESDS, who can experience immense stress during their doctoral programs.

COVID-19 and Social Wellness

By early 2023, there were approximately 758.4 million cumulative cases of the coronavirus (COVID-19) and over 6.8 million deaths due to this virus (World Health Organization, 2023). Since the beginning of the COVID-19 pandemic, a vast number of individuals have experienced changes related to their social support and connections (Pantell & Shields-Zeeman, 2020), thus further affecting their social wellness. Many of the changes individuals endured during this pandemic related to experiences of isolation due to social distancing, various degrees of lockdowns, fear of contagion, self or other-imposed quarantine requirements, Centers for Disease Control and Prevention (CDC) mandates or recommendations, widespread mask mandates, school and business closings, and imposed work restrictions, to name a few. The public faced incredible difficulties while limiting physical interactions with the people they were accustomed to interacting with on a regular basis (Pantell & Shields-Zeeman, 2020). The separation of individuals from their various support systems has increased social isolation and loneliness, which can be linked to an increased risk of mortality (Pantell & Shields-Zeeman, 2020).

Recent studies pertaining to physical and mental health during the COVID-19 pandemic further support the importance of social connections with other people. This is especially true during times of stress (Forbes et al., 2021). In various studies, researchers concluded that daily phone or video contact and daily face-to-face contact with others decreased depressive symptomology (Sommerlad et al., 2021), with face-to-face contact proving more beneficial than phone/video contact (Subrahmanyam et al., 2020). In another study, Kee (2021) noted that with international students, the use of technology to communicate with both peers and outside support systems was beneficial for their mental health while social distancing due to COVID-19. Sommerlad et al. (2021) also concluded that the connection between social interaction and depressive symptomology was strongest in participants who, before the pandemic, reported having more social interaction with others in their support systems and those who scored highest on an empathy inventory.

Factors Associated with CESDS Social Wellness

Aside from COVID-19, the social wellness of CESDS is affected by cultural factors, program obligations, and the support systems and distance factors associated with this population.

Cultural Factors

Both before and during the COVID-19 pandemic, cultural factors affected CESDS' social wellness or a lack thereof in their programs. Various intersecting factors related to minoritized identities (e.g., LGBTQ+, women, and ethnic and racial minorities) influenced CESDS' experiences during their programs (Thacker & Barrio Minton, 2021). These experiences can include tokenism, underrepresentation, discouragement, and disconnection (Thacker & Barrio Minton, 2021). These factors may manifest for minoritized identities differently than others. For example, because of the already small number of Black male counselor educators, Black men interested in this field experience hardship finding connections to mentors (Brooks & Steen, 2010). In their study on the experiences of Black women CESDS during the COVID-19 pandemic, Williams (2022) argued that Black women also struggled with social isolation during this long withstanding event. Participants in this study credited utilizing their support networks as a positive influence during their doctoral journeys.

Another notable minoritized identity, international CESDS, can struggle with balancing the dual relationships that come with working alongside both master's counseling students as supervisors and counselor educators as supervisees (Woo et al., 2015); this challenge can affect their social wellness. In 2013, Pierce & Herlihy studied women who identified as mothers. Participants reported struggling with role dissonance, strained relationships, and sacrifices to their overall wellness as major stressors while in their programs. Relating specifically to the experiences of CESDS mothers during the pandemic, Pugh (2022) explained that this population experienced challenges with balancing their various roles and that the level of support they received from both personal and professional sources heavily affected them.

Further understanding the social wellness of CESDS with minoritized identities is important for several reasons. For instance, graduate students of ethnic minority groups, such as African American, Asian American, and international students, are less likely to utilize counseling services to combat the unique stressors they experience (Hyun et al., 2006). Bryan (2018) proposed that intersectionality of minority identities (i.e., LGBTQ+ and minority racial identity) affected how CESDS experienced microaggressions while in their programs. Bryan (2018) also found that LGBTQ+ CESDS experienced challenges with connecting to their faculty and fellow peers and experienced microaggressions due to their LGBTQ+ as being part of the LGBTQ+ community.

Program Obligations Factors

The roles and obligations that coincide with being a doctoral student in any program can be quite challenging (Pierce & Herlihy, 2013; Plath, 2020). This was true both before and during the COVID-19 pandemic. While students, serving as clinical supervisors and

educators to master's level students, CESDS experience unique stressors (Plath, 2020). Programmatic obligations, while necessary to the education of CESDS, may function as barriers to their social wellness. Like the roles in which counselor educators engage, program-related roles that CESDS might fulfill at any given time could include clinician, supervisor, researcher, course instructor, and/or leader and advocate (CACREP, 2015). Because CESDS fulfill these multiple and dual relationship roles throughout their program time, they may feel that they cannot pass up opportunities to build or demonstrate their skills in these areas (Plath, 2020), which may impact the time and energy they spend with their support systems.

Even though counselor education doctoral programs aim to promote wellness to all students, CESDS still experience significant stress (Pierce & Herlihy, 2013), and this stress was further exacerbated by the COVID-19 pandemic forcing many doctoral programs to transition to online formats (Pugh, 2022), an additional stressor that affected CESDS both as students and as supervisors and educators of master's and undergraduate students.

During any given time, some CESDS can struggle with balancing the various roles they play as students and other roles they fulfill outside of their programs (Pierce & Herlihy, 2013). The strenuous obligations connected to studying in a doctoral program frequently strain or impair doctoral students' outside relationships with friends, family, other loved ones, and/or significant others (Pierce & Herlihy, 2013; Sverdlik et al., 2018). Impairments to these social relationships can cause additional stress for doctoral students, and a lack of social support can lower wellness and lead to higher prevalence of mental illness (Sverdlik et al., 2018).

Support Systems and Distance Factors

When doctoral students feel supported by social systems outside of themselves, including family members, friends, supervisors, or other program faculty members, they experience higher motivation to succeed in their programs (Sverdlik et al., 2018). Similarly, support for doctoral students both within and outside of their programs is critical to how they experience wellness (Gleason & Hays, 2019; Pierce & Herlihy, 2013). The importance of support for CESDS became especially apparent during the COVID-19 pandemic (Pugh, 2022; Williams, 2022). In one recent phenomenological study, a lack of connection and experiences of loneliness contributed to feelings of imposter syndrome in some CESDS; conversely, CESDS experienced favorable professional identity development when they experienced feelings of togetherness and connection within their programs (Allen, 2021). In another recent study, the loss of routine physical interaction and felt lack of support from their programs during the COVID-19 pandemic caused multiple CESDS participants to experience disappointment or frustration (Plath, 2020). Some participants of this same study noted that they experienced a lack of support from outside their programs, as well (Plath, 2020).

Personal and Peer Support Systems

Even perceived support from various personal sources, including peers and family, can help CESDS succeed in completing their programs (Minor et al., 2013; Protivnak & Foss, 2009). Support from various cohort members can be beneficial because of the shared

experiences and understanding that these peers can provide (Minor et al., 2013). Peer support from cohort members or members of different CESDS cohorts in the same program can also help CESDS better manage the rigor of their programs (Minor et al., 2013). In a study on the experiences of CESDS mothers, multiple participants noted that they experienced positive support from other mothers who were also in their programs (Pierce & Herlihy, 2013). This positive support from cohort members was important because it affected how participants felt about the overall support they received while in their programs. This same theme was visible during Pugh's (2022) study that looked at the experiences of CESDS mothers during the COVID-19 pandemic, showing that personal support is a lasting factor to their wellness experiences. In a different study, Black women CESDS shared a similar theme when expressing how they leaned on their personal support systems (i.e., friends and family) during the pandemic (Williams, 2022).

Professional Support Systems

Like counselor educators (Myers et al., 2016), professional support people (e.g., department heads, dissertation chairs, program faculty, and mentors and advisors) are important to the overall wellness of CESDS (Gleason & Hays, 2019; Minor et al., 2013). Prior to the COVID-19 pandemic, researchers noted that an increase in the support of CESDS' wellness practices from faculty and other collegial/professional sources could benefit this population of doctoral students (Gleason & Hays, 2019). Support from individuals CESDS view as academic mentors and advisors is especially important for CESDS' success in their programs because this support can aid in reducing stress that they might experience when conducting the various roles within their programs (Minor et al., 2013). For CESDS who also identified as mothers, the importance of faculty support, alongside personal support, was a broad theme (Pierce and Herlihy, 2013).

Distance from Support Systems

Many prospective CESDS move away from their current support systems to attend their programs (Minor et al., 2013). This can cause issues because CESDS run the risk of losing physical contact with support systems when they move to other states or regions to attend their programs. The feeling of disconnect may decrease by establishing strong social support at the start of their doctoral programs (Minor et al., 2013), however, this does not always happen.

While CESDS may maintain social connection with their support networks from afar, many can still experience feelings of loneliness and isolation due to the physical distance from these support systems. Plath (2020) completed a quantitative, empirical study on the wellness and self-care habits of CESDS and uncovered that the inability to gather in physical spaces to the same pre-pandemic degree with friends and family adversely affected CESDS' social wellness. Plath (2020) also found that a major theme related to the overall wellness of CESDS was the impact that social distancing requirements had on their daily experience. Strategies to combat the impact of physical isolation for CESDS can come in the form of connection by way of digital formats. Using social media and other digital technologies can contest CESDS feelings of isolation and disconnect from support systems (Clark et al., 2018). The use of digital platforms for both learning and connection with CESDS is an important addition to the current understanding of social wellness. Research shows that

the amount of interactive time with others might be even more impactful, even if that interaction occurs via a digital platform (Snow & Coker, 2020).

Implications

The literature review on CESDS, social wellness, and the pandemic provides implications for CESDS and counselor educators. Here we offer suggestions for future research and curriculum/program design.

Research

Social wellness and sources of social connection and support for CESDS need further exploration (Perepiczka & Balkin, 2010; Pierce & Herlihy, 2013). This exploration could increase CESDS self-understanding and awareness of the importance and practice of personal social wellness and its professional connections and implications (Plath, 2020). Future research on CESDS social wellness could aid counselor educators to explore ways to better serve their students and aid in the development of the student's helping skills needed to be successful counselors (Plath, 2020). Future research studies focused on this topic are timely as there is still limited research related to the self-care habits of CESDS (Gleason & Hays, 2019; Plath, 2020).

For many people, the start and continuation of the COVID-19 pandemic created barriers to preferred self-care and wellness methods (Plath, 2020). This unprecedented global event illuminated an important gap in the existing/current research. While research exists on the overall wellness experiences of CESDS, there are currently no studies pertaining specifically to the experience of social wellness of CESDS during the COVID-19 pandemic. Recent studies determined that various CESDS subpopulations, including working mothers (Pugh, 2022), Black women (Williams, 2022), and CESDS in CACREP-accredited programs (Plath, 2020), benefited from the connection and support they received from systems both within and outside of their programs during the COVID-19 pandemic. Future research could continue to fill in gaps related to the overall social wellness experience of CESDS during this time. More specifically, future studies could focus on CESDS from CACREP-accredited programs as the participants. Other options might be to only study CESDS from in-person programs or CESDS before/after achieving candidacy status. To accurately capture the experiences of social wellness for more CESDS, researchers could conduct studies exploring specified groups.

Future research on CESDS social wellness would also benefit from more stratified sampling procedures to represent the diversity of CESDS. Although studies on the overall experience of specific subpopulations of CESDS during COVID-19 exist, most previous studies on CESDS wellness included large, broad samples of CESDS. Even before the COVID-19 pandemic, previous researchers (Protivnak & Foss, 2009) noted that it was necessary to utilize smaller, more purposeful sampling of CESDS in future studies. Examples of more purposeful sampling relating to CESDS identities might include only studying the social wellness of CESDS who come from a particular racial or ethnic background, those who identify as first-generation college students, or international CESDS.

Another option for future research would be to utilize more qualitative methods to better understand the experience behind CESDS social wellness during the COVID-19 pandemic. Qualitative research provides an ideal method for exploring social wellness and helps understand behavior within the scaffold of the social structures in which actions and conduct occur (Creswell, 2017). Because qualitative methodologies provide personal insights and rich, thick descriptions of the doctoral student experience (Sverdlik et al., 2018), we encourage diverse qualitative approaches to studying social wellness (Thompson et al., 2018). Through qualitative methodologies, we could also learn in more vivid detail about the social wellness experiences of CESDS from varying backgrounds and identities during the unique political and social climate of the world today.

Curriculum and Program Design

Researchers have suggested strategies to integrate elements of self-care and wellness into CACEP curriculum considering the COVID-19 pandemic (Harrichand et al., 2021) and strategies to address the overall wellness and self-care strategies of CESDS while still experiencing the pandemic (Plath, 2020). To address social wellness specifically, curricular changes could focus on allowing students to work in pairs or groups when practicing their supervision, teaching, research, and other skills associated with their professional identity development. Providing time during class for students to reflect upon and express their social wellness could highlight its importance and help CESDS consider it in regular intervals. To assess these efforts, counselor educators could use pre and post course measures and/or formative assessments throughout. Adding a social wellness component, prompt, or question to existing summative evaluation practices would be easy.

Aside from course curriculum, counselor educators could design programs to better facilitate social wellness. One way could be incorporating more opportunities for peer and professional mentorship. Because mentorship relationships typically involve one person guiding or supporting another in their career or other life pursuits, there is a direct tie to the support aspect of social wellness. This support can come from peers who are further in matriculation or professionals who are already counselor educators and would align with CACREP (2015) standards that already instruct counselor educators to promote mentoring relationships of CESDS.

Mentorship relationships within programs benefit CESDS by providing guidance and support, a practice that some CESDS reported was lacking in their programs both before and during the COVID-19 pandemic (Williams, 2022). These mentorship relationships might be more critical to CESDS of minoritized identities who experienced more intensified challenges with isolation in their programs due to the COVID-19 pandemic (Williams, 2022). Examples of mentorship relationships might include ones between CESDS and their dissertation chairs, research groups with trusted faculty members or advisors, and peers who are further progressed in their doctoral journeys. For CESDS of various minoritized identities, these relationships can be especially meaningful when established between individuals with the same or similar identities.

CES programs, or the program's Chi Sigma Iota chapter, could schedule and host regular social outings such as a book club, board game night, mic night, bowling team, pet picnics, pub trivia teams, and other events. Social group gatherings sans an academic agenda provide a unique atmosphere that can elicit healthy therapeutic factors (e.g., development of socializing techniques, cohesion, interpersonal learning, universality, etc.) that promote group camaraderie and social wellness (Yalom & Leszcz, 2005).

Outside of individual programs, CESDS can also gain support and mentorship from professional organizations and associations (Minor et al., 2013). As a part of their program design, counselor educators might consider requiring that CESDS join one or more professional associations with the expressed intent of eliciting avenues in which CESDS establish a broader professional and social network in the present and for their future. Some of the noted benefits of joining and being active in professional or student organizations in the counseling field include gaining access to peers and mentors outside of the CESDS' immediate circles who can offer further support, opportunities to network with individuals who can link CESDS to potential future jobs, and connections with others who might be interested in similar research or practice specialties. Membership in professional organizations can take place at the state, regional, and national levels.

Conclusion

Wellness is a foundation of the counseling profession (ACA, 2014; NBCC, 2016), a foundation that guides how all counseling professionals, including CESDS, function in their respective areas. For many, the COVID-19 pandemic heavily affected their wellness, especially social wellness (Pantell & Shields-Zeeman, 2020). Even before the COVID-19 pandemic, doctoral students, like CESDS, with staunch support networks, inside and outside their academic program, experienced higher motivation to succeed than peers who lacked strong social support and networks (Sverdlik et al., 2018). These findings illuminate the importance of social support for CESDS and substantiate the need to gain a better understanding of the social wellness of this subpopulation of counseling professionals. Through future research and potential changes to curriculum and program design, not only can CESDS excel in their current academic endeavors due to attention to their social wellness, but this effort may impact their future careers as counselor educators and supervisors.

References

Adair, K. C., Fredrickson, B., Castro-Schilo, L., Kim, S. L., & Sidberry, S. (2018). Present with you: Does cultivated mindfulness predict greater social connection through gains in decentering and reductions in negative emotions? *Mindfulness, 9*(issue #), 737–749. https://doi.org/10.1007/s12671-017-0811-1

Allen, W. (2021). *The development of teacher identity in counselor education doctoral students*. (Doctoral dissertation, University of Tennessee, Knoxville). https://trace.tennessee.edu/utk_graddiss/6542

Amati, V., Meggiolaro, S., Rivellini, G., & Zaccarin, S. (2018). Social relations and life satisfaction: The role of friends. *Genus, 74*(1). https://doi.org/10.1186/s41118-018-0032-z

American Counseling Association (2014). *2014 ACA code of ethics*. https://www.counseling.org/knowledge-center/ethics#2014code

Bray, B. (2020). Starting post-college life in a pandemic. *Counseling Today, 63*(2), 28–33. https://ct.counseling.org/2020/08/starting-post-college-life-in-a-pandemic/

Bryan, S. E. (2018). Types of LGBT microaggressions in counselor education programs. *Journal of LGBT Issues in Counseling, 12*(2), 119–135. https://doi.org/10.1080/15538605.2018.1455556

Brooks, M., & Steen, S. (2010), "Brother Where Art Thou?" African American male instructors' perceptions of the counselor education profession. *Journal of Multicultural Counseling and Development, 38*, 142-153. https://doi.org/10.1002/j.2161-1912.2010.tb00122.x

Chobdee, J. (2014, June 4). Social wellness. https://wellness.ucr.edu/social_wellness.html

Clark, J. L., Algoe, S. B., & Green, M. C. (2018). Social network sites and well-being: The role of social connection. *Current Directions in Psychological Science*, *27*(1), 32–37. https://doi.org/10.1177/0963721417730833

Cochran, J. L., & Cochran, N. H. (2020). *The heart of counseling: Practical counseling skills through therapeutic relationships (3rd ed.)*. Routledge.

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

Creswell, J. W. (2017). *Qualitative inquiry & research design: Choosing among five approaches (4th ed.)*. Los Angeles: SAGE Publications.

Deng, J., Zhou, F., Hou, W., Silver, Z., Wong, C. Y., Chang, O., Drakos, A., Zuo, Q. K., & Huang, E. (2021). The prevalence of depressive symptoms, anxiety symptoms and sleep disturbance in higher education students during the COVID-19 pandemic: A systematic review and meta-analysis. *Psychiatry Research, 301*, 113863. https://doi.org/10.1016/j.psychres.2021.113863

Falagas, M. E., Zarkadoulia, E. A., Ioannidou, E. N., Peppas, G., Christodoulou, C., & Rafailidis, P. I. (2007). The effect of psychosocial factors on breast cancer outcome: A systematic review. *Breast Cancer Research, 9*(4), pp – pp. https://doi.org/10.1186/bcr1744

Field, T. A., Snow, W. H., & Hinkle, J. S. (2020). The pipeline problem in doctoral counselor education and supervision. *The Professional Counselor, 10*(4), 434–452. https://doi.org/10.15241/taf.10.4.434

Forbes, P., Pronizius, E., Feneberg, A. C., Nater, U., Piperno, G., Silani, G., Stijovic, A., & Lamm, C. (2021). The benefits and limits of social interactions during COVID-19 lockdown. *PsyArXiv Preprints*, 1-24. https://doi.org/10.31234/osf.io/ae6t9

Gibson, D. M., Wolf, C. P., Kennedy, S. D., Gerlach, J., Degges-White, S., & Watson, J. (2021). Development of the counselor wellness competencies. *Journal of Counselor Leadership and Advocacy*, *8*(2), 1-16. https://doi.org/10.1080/2326716X.2021.1925997

Gleason, B. K., & Hays, D. G. (2019). A phenomenological investigation of wellness within counselor education programs. *Counselor Education and Supervision, 58*(3), 177-194. https://doi.org/10.1002/ceas.12149

Harrichand, J. J. S., Litam, S. D. A., & Ausloos, C. D. (2021). Infusing self-care and wellness into CACREP curricula: Pedagogical recommendations for counselor educators and counselors during COVID-19. *International Journal of Advanced Counselling, 43*(issue), 372–385. https://doi.org/10.1007/s10447-021-09423-3

Haverkamp, B. E. (2012). The counseling relationship. In E. M. Altmaier & J.-I. C. Hansen (Eds.), *The Oxford handbook of counseling psychology* (pp. 32-70). Oxford University Press.

Hyun, J. K., Quinn, B. C., Madon, T., &Lustig, S. (2006) Graduate student mental health: Needs assessment and utilization of counseling services. *Journal of College Student Development, 47*, 247-266. http://dx.doi.org/10.1353/csd.2006.0030

Kee, C. E. (2021) The impact of COVID-19: Graduate students' emotional and psychological experiences. *Journal of Human Behavior in the Social Environment, 31*(1-4), 476-488. https://doi.org/10.1080/10911359.2020.1855285

Marshall, R. C. (2018). *Counselor educators' wellness levels' impact on how they promote wellness.* [Doctoral dissertation, University of Tennessee]. https://trace.tennessee.edu/utk_graddiss/5058

Minor, A. J., Pimpleton, A., & Stinchfield, T. (2013). Peer support in negotiating multiple relationships within supervision among counselor education doctoral students. *International Journal of Advanced Counselling, 35*(issue), 33–45. https://doi.org/10.1007/s10447-012-9161-9

Myers, J. E., Mobley, K., & Booth, C. S. (2003). Wellness of counseling students: Practicing what we preach. *Counselor Education and Supervision, 52*(issue), 264-274. https://doi.org/10.1002/j.1556-6978.2003.tb01818.x

Myers, J. E., & Sweeney, T. J. (2004). The indivisible self: An evidence-based model of wellness. *Journal of Individual Psychology, 60*(issue), 234-244.

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The Wheel of Wellness counseling wellness: A holistic model for treatment planning. *Journal of Counseling & Development, 78*(issue), 251–266. https://doi:10.1002/j.1556-6676.2000.tb01906.x

National Board for Certified Counselors. (2016). *NBCC code of ethics*. https://www.nbcc.org/Assets/Ethics/ NBCCCodeofEthics.pdf

Pantell, M. S., & Shields-Zeeman, L. (2020). Maintaining social connections in the setting of COVID-19 social distancing: A call to action. *American Journal of Public Health, 110*(9), 1367-1368. http://dx.doi.org/10.2105/AJPH.2020.305844

Perepiczka, M., & Balkin, R. S. (2010). Relationship between wellness and age, matriculation, and relationship status of counselor education doctoral students. *The Journal of Humanistic Counseling, 49*(2), 203-216. https://doi.org/10.1002/j.2161-1939.2010.tb00098.x

Pérez-Escoda, A., Jiménez-Narros, C., Perlado-Lamo-de-Espinosa, M., Pedrero-Esteban, L. M. (2020). Social networks' engagement during the COVID-19 pandemic in Spain: Health media vs. healthcare professionals, *International Journal of Environmental res Public Health, 17*(14), 5261. https://doi.org/10.3390/ijerph17145261

Pierce, L. A., & Herlihy, B. (2013). The experience of wellness for counselor education doctoral students who are mothers in the southeastern region of the United States. *Journal of International Women's Studies, 14*(issue), 108–120. http://vc.bridgew.edu/jiws/vol14/iss3/8

Plath, A. M. (2020). *Wellness and self-care of counselor education and supervision doctoral students* (Doctoral dissertation, Northern Illinois University). https://www.proquest.com/docview/2451867149/fulltextPDF/D6056AC7ACE847F7PQ/1?accountid=14766

Protivnak, J. J., & Foss, L. L. (2009). An exploration of themes that influence the counselor education doctoral student experience. *Counselor Education and Supervision*, *48*(4), 239-256. https://doi.org/10.1002/j.1556-6978.2009.tb00078.x

Pugh, S. M. (2022). *Exploring the lived experiences of working mothers persisting in CACREP-Accredited CES doctoral programs transitioning through the Covid-19 pandemic: A phenomenological study*. [Doctoral dissertation, Liberty University]. https://digitalcommons.liberty.edu/cgi/viewcontent.cgi?article=4850&context=doctoral

Rodriguez, H. (2016, May 31). Evidence for social wellness - Part 1. American Counseling Association. https://www.counseling.org/news/aca-blogs/aca-counseling-corner/aca-member-blogs/2016/05/31/evidence-for-social-wellness---part-1#

Snow, W. H., & Coker, J. K. (2020). Distance counselor education: Past, present, future. *Professional Counselor*, *10*(1), 40-56. https://doi.org/10.15241/whs.8.2.131

Sommerlad, A., Marston, L., Huntley, J., Livingston, G., Lewis, G., Steptoe, A., & Fancourt, D. (2021). Social relationships and depression during the COVID-19 lockdown: Longitudinal analysis of the COVID-19 Social Study. *Psychological Medicine,* volume(issue), 1–10. https://doi.org/10.1017/S0033291721000039

Subrahmanyam, K., Frison, E., & Michikyan, M. (2020). The relation between face-to-face and digital interactions and self-esteem: A daily diary study. *Human Behavior and Emerging Technologies, 2*(2), 116–127. https://doi.org/10.1002/hbe2.187

Sverdlik, A., Hall, N. C., McAlpine, L., & Hubbard, K. (2018). The PhD experience: A review of the factors influencing doctoral students' completion, achievement, and well-being. *International Journal of Doctoral Studies*, *13*(1), 361-388. https://doi.org/10.28945/4113

Thacker, N. E., & Barrio Minton, C. A. (2021). Minoritized professionals' experiences in counselor education: A review of research. *Counselor Education and Supervision, 60*(1), 35–50. https://doi.org/10.1002/ceas.12195

Thompson, I. A., Wolf, C. P., Mott, E., Baggs, A. S., Thompson, E. S., Callueng, C., & Puig, A. (2018). Luna yoga: A wellness program for female counselors and counselors-in-training to foster self-awareness and connection. *Journal of Creativity in Mental Health*, *13*(2), 169-184. https://doi.org/10.1080/15401383.2017.1348918

University of New Hampshire (2023) *Social wellness*. https://www.unh.edu/health/social-wellness

Werner-Seidler, A., Afzali, M.H., Chapman, C. Sunderland, M., & Slade, T. (2017). The relationship between social support networks and depression in the 2007 National Survey of Mental Health and Well-being. *Social Psychiatry and Psychiatric Epidemiology, 52*(1), 1463–1473. https://doi.org/10.1007/s00127-017-1440-7

Wester, K. L., Trepal, H. C., & Myers, J. E. (2009). Wellness of counselor educators: An initial look. *The Journal of Humanistic Counseling, Education and Development*, *48*(1), 91-109. http://dx.doi.org/10.1002/j.2161-1939.2009.tb00070.x

Williams, C. D. (2022). *The lived experiences of Black women in CES doctoral programs during the COVID-19 pandemic*. [Doctoral dissertation, Walden University]. https://utk.idm.oclc.org/login?url=https://www.proquest.com/dissertations-theses/lived-experiences-black-women-ces-doctoral/docview/2623033892/se-2

Woo, H., Jang, Y. J., & Henfield, M. S. (2015). International doctoral students in counselor education: Coping strategies in supervision training. *Journal of Multicultural Counseling and Development, 43*(4), 288–304. https://doi.org/10.1002/jmcd.12022.

World Health Organization. (2023, March 2) *WHO Coronavirus (COVID-19) Dashboard.* https://covid19.who.int/

Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). Basic Books.

Relational-Cultural Supervision in a Digital World: Centering Multicultural Competence and Connection

Tiffany Hairston

Tiffanie Sutherlin
Michael S. Jones
Damon D. Chambers
University of the Cumberlands

This article explores the application of Relational-Cultural Theory (RCT) in online supervision, particularly in fostering multicultural competence in counselor education. As virtual modalities increasingly shape clinical training, supervisors must address the relational and cultural nuances unique to digital spaces. RCT offers an intentional, relationship-centered framework to enhance supervision effectiveness across cultural lines. Drawing from current literature, ethical standards, and illustrative practice, this paper highlights strategies to build mutual empathy, cultural reflexivity, and empowerment in virtual supervision. Strengths, limitations, and ethical considerations, such as confidentiality and technological competence, are examined, positioning RCT as a responsive and ethically sound model for contemporary supervision.

The shift to online supervision, accelerated by the COVID-19 pandemic, has presented unique challenges and opportunities for counselor educators and clinical supervisors. While virtual platforms expand access, they also introduce complexities in communication, relationship-building, and multicultural sensitivity (Xing et al., 2023). Traditional supervision models may struggle to capture the relational and cultural nuances necessary in diverse digital spaces. Fickling et al. (2019) highlight this concern, noting that supervisees from underrepresented backgrounds often feel disconnected or misunderstood when cultural identities are not actively addressed.

As authors, we believe that multicultural competence is a vital part of our work; therefore, this article is not simply a theoretical discussion but a purposeful offering for clinicians seeking guidance on integrating cultural awareness, relational depth, and intentionality into their supervision practices. We posit that Relational-Cultural Theory (RCT) offers a timely and powerful lens to enhance multicultural supervision in online environments, supporting clinicians and supervisees in navigating cultural complexity, fostering authentic connections, and empowering growth-fostering supervision relationships.

Grounding the Framework: What Is Relational-Cultural Theory?

Jean Baker Miller first articulated relational-Cultural Theory (RCT) in her seminal text, *Toward a New Psychology of Women* (1976), where she challenged traditional psychology's individualistic, autonomy-driven assumptions. Miller proposed that growth occurs

through connection, not separation. RCT builds on this foundation by emphasizing the importance of mutual empathy, relational authenticity, empowerment, and attention to human development's social and cultural contexts (Miller & Stiver, 1997; Jordan, 2018).

Our understanding of RCT aligns with its evolution in clinical supervision; Comstock et al. (2008) and Lenz (2014) articulate how RCT can foster relational depth, support supervisee development, and attend to power and marginalization in supervisory relationships. As counselor educators and clinicians, we see the integration of RCT not as a set of isolated techniques but as a guiding philosophy that centers on mutual respect, cultural responsiveness, and shared growth. This perspective is particularly critical in online supervision, where physical distance can hinder the natural emergence of relational connection. The task, then, is to be intentional: to use technology to promote, not diminish, relational and cultural presence.

Multicultural Competence in the Digital Era

Multicultural competence, as defined by the Multicultural Counseling Competencies (Sue et al., 1992) and expanded by the Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2016), is central to ethical supervision. These competencies encourage supervisors to cultivate self-awareness of their cultural identities, develop knowledge of diverse worldviews, and practice culturally attuned skills. In virtual supervision, these competencies take on heightened importance.

Online supervision alters the landscape of relational and cultural exchange. Supervisors may miss nonverbal cues, supervisees may experience disconnection, and cultural miscommunications may go unrecognized. Springer et al. (2021) and Gong et al. (2023) observe that supervisees in digital contexts may feel unseen or misunderstood, particularly when their racial, ethnic, or cultural experiences are minimized. Additionally, Jordan (2018) emphasizes that disconnection, especially unaddressed disconnection, can lead to relational rupture, which is more challenging to repair without physical presence.

Given these challenges, RCT provides a necessary scaffolding for maintaining cultural presence and relational authenticity in online supervision. The intentional practice of mutual empathy, cultural reflexivity, and empowerment can transform the online supervision space into one that mirrors the warmth, responsiveness, and depth of face-to-face interactions. Rather than being a barrier, the digital format can become a conduit for creativity and cultural attunement when guided by relational principles.

Applying RCT in Online Supervision: Intentional Strategies

The digital environment presents a new supervisory landscape that requires adaptation without compromising depth, authenticity, or cultural responsiveness. Through our experiences as supervisors and counselor educators, we have identified several practical applications of RCT that strengthen the supervisory relationship and align with multicultural competence in online settings.

Creating space for mutual empathy is foundational. We recommend establishing consistent, synchronous video meetings to share facial expressions, tone, and body language. This visual presence supports emotional attunement and will enable supervisors to

model active listening and validation. Galante et al. (2016) and Purgason et al. (2022) demonstrate that empathy conveyed through digital platforms remains impactful when intentional and consistent.

Encouraging cultural reflexivity is equally vital. Supervisors can invite supervisees to engage in structured reflection activities such as journaling or cultural identity mapping and then discuss these reflections during supervision. Stargell et al. (2020) and Abernethy and Cook (2011) highlight how these practices help deepen cultural awareness and allow for critical dialogue around identity, worldview, and bias.

Relational authenticity can be fostered through supervisor transparency and the normalization of vulnerability. Sharing appropriate personal experiences, especially those related to growth or cultural learning, reinforces that the supervisory space is one of mutual learning rather than a rigid hierarchy. Comstock et al. (2008) and Cormier et al. (2023) suggest that such transparency invites supervisees to bring their whole selves to the relationship, enhancing trust and safety.

Additionally, empowering supervisees through collaborative agenda-setting and goal-tracking allows them to shape their supervision experience. Supervisors might use shared digital documents or secure learning platforms to co-create session topics and reflect on progress. Williams and Raney (2020) and Springer et al. (2021) illustrate how this empowerment contributes to supervisee engagement and confidence.

Finally, using multimedia to engage in cultural dialogue, such as assigning videos, articles, or podcasts that explore cultural themes, can expand the range of voices and experiences represented in supervision. This practice allows supervisors and supervisees to jointly examine how culture intersects with clinical work, as Dietz et al. (2011) and Powell et al. (2024) recommended. These dialogues become opportunities to affirm diverse experiences and build deeper cultural attunement when grounded in RCT principles.

Benefits and Ethical Considerations

Integrating Relational-Cultural Theory into online supervision offers both professional and developmental benefits. Supervisors who utilize RCT principles report deeper relational bonds with their supervisees and increased supervisee satisfaction, particularly in trust, cultural responsiveness, and empowerment (Logan et al., 2021; Perlman et al., 2020). In our work, we have observed that growth-fostering relationships marked by mutual empathy, authenticity, and cultural validation are more than achievable in online environments; they are necessary for effective and ethical supervision.

Moreover, RCT aligns with the competencies needed for effective telehealth and remote education, especially as outlined in counselor training standards (Springer et al., 2021; Stargell et al., 2020). It supports the formation of supervisory alliances that are resilient to the disconnection and flattening that sometimes occur in digital settings.

The 2014 ACA Code of Ethics emphasizes the importance of ensuring client confidentiality, obtaining informed consent specific to distance counseling, and maintaining appropriate technological boundaries (Kaplan et al., 2017). Supervisors are ethically required to

use secure communication platforms, monitor for competence in tele-supervision delivery, and adapt their approaches based on the supervisee's setting. The NBCC Code of Ethics similarly mandates that supervisors deliver distance-based services only within their areas of training and competence, use encrypted and confidential platforms, and document all digital communications thoroughly. These standards align well with the core tenets of RCT, particularly its emphasis on transparency, cultural safety, and contextual responsiveness.

Despite these strengths, challenges remain. Supervisors must be vigilant about ethical concerns unique to virtual supervision, such as managing time zone differences, verifying supervisee locations, and addressing varying access to private digital spaces (Lenz, 2014). Disrupted nonverbal cues, digital fatigue, or unforeseen power dynamics technology introduces may affect supervisory relationships. These considerations require supervisors to adopt flexible, intentional practices that honor relational depth and ethical rigor.

Illustrative Vignette: Dr. Reyes, a Latina clinical supervisor, conducts virtual supervision sessions with Priya, an Indian-American supervisee working in a rural school setting. Priya expresses uncertainty about addressing race-based bullying with clients. Dr. Reyes shares a personal story of navigating cultural dissonance early in her career, modeling self-disclosure, and invites Priya to reflect on how her cultural values shape clinical choices. Together, they co-create a reflection journal where Priya explores intersectional identity themes weekly. Applying RCT principles of mutual empathy, cultural reflexivity, and empowerment builds a supervision alliance that supports competence and confidence in cross-cultural work.

While RCT offers a compelling relational lens, some critiques include concerns about its empirical limitations and scalability. Lenz (2016) notes that although RCT provides a valuable framework for understanding client experiences, support for RCT-based interventions is still emerging, and more robust validation of outcomes is needed. Furthermore, RCT's emphasis on deep emotional attunement may pose challenges in high-volume or time-constrained supervision environments, where affective depth and mutuality may be harder to sustain. These critiques highlight the importance of blending RCT with practical structures and measurable outcomes in supervisory models.

Integrating Relational-Cultural Theory into online supervision offers both professional and developmental benefits. Supervisors who utilize RCT principles report deeper relational bonds with their supervisees and increased supervisee satisfaction, particularly in trust, cultural responsiveness, and empowerment (Logan et al., 2021; Perlman et al., 2020). In our work, we have observed that growth-fostering relationships marked by mutual empathy, authenticity, and cultural validation are more than achievable in online environments; they are necessary for effective and ethical supervision.

Moreover, RCT aligns with the competencies needed for effective telehealth and remote education, especially as outlined in counselor training standards (Springer et al., 2021; Stargell et al., 2020). It supports the formation of supervisory alliances that are resilient to the disconnection and flattening that sometimes occur in digital settings.

Despite these strengths, challenges remain. Supervisors must be vigilant about ethical concerns unique to virtual supervision, such as maintaining confidentiality on digital platforms, managing time zone differences, and addressing supervisee discomfort with technology (Lenz, 2014). Disrupted nonverbal cues, digital fatigue, or differing levels of access to reliable internet and private spaces may affect supervisory relationships. These considerations require supervisors to adopt flexible, intentional practices that honor relational depth and ethical rigor.

Integrating RCT into digital supervision supports supervisees' professional growth and cultivates culturally responsive counselors prepared to serve diverse populations across multiple modalities. As we shift toward hybrid and remote training models, RCT offers a valuable and necessary framework for navigating the evolving terrain of clinical supervision.

Conclusion

As clinical supervision continues to evolve within digital and hybrid spaces, the need for models that uphold relational integrity and cultural responsiveness has never been greater. Relational-Cultural Theory (RCT), emphasizing mutual empathy, empowerment, and social context, provides a timely and compelling framework for counselor educators and supervisors navigating online environments. Through intentional practices such as fostering authentic connection, encouraging cultural reflexivity, and co-creating supervision processes, supervisors can preserve the depth and integrity of the supervisory relationship, even at a distance.

RCT meets the standards set forth by multicultural counseling competencies and enriches supervision by elevating supervisees' voices, identities, and lived experiences. As we adopt new technologies and formats in counselor education, RCT reminds us that relationships remain at the heart of ethical, effective, and transformative supervision. By embracing this model, we move closer to a supervisory practice that is digitally adept and deeply human.

References

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

National Board for Certified Counselors. (2016). Policy regarding the provision of distance professional services. https://www.nbcc.org/Assets/Ethics/NBCCPolicyRegardingPracticeofDistanceCounselingBoard.pdf

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. Journal of Multicultural Counseling and Development, 44(1), 28–48. https://doi.org/10.1002/jmcd.12035

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. Journal of Counseling & Development, 70, 477–486. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x

Abernethy, C., & Cook, K. (2011). Resistance or Disconnection? A Relational-Cultural Model of Supervision. Journal of Creativity in Mental Health, 6(1), 2–14. https://doi.org/10.1080/15401383.2011.560067

Comstock, D. L., Hammer, T. R., Strentzsch, J., Cannon, K., Parsons, J., & Salazar, G. (2008). Relational-Cultural Theory: A Framework for Bridging Relational, Multicultural, and Social Justice Competencies. Journal of Counseling & Development, 86, 279–287. https://doi.org/10.1002/j.1556-6678.2008.tb00510.x

Cormier, S. R., Manson, J. L., & Haynes, S. D. (2023). Relational–cultural play therapy supervision: Theory and application. Practice Innovations, 32(3), 135–145. https://doi.org/10.1037/pla0000194

Dietz, S. S., Dotson-Blake, K. P., Enselman, D., Jones, L., Sexton, E., Waller, M., & Richardson, M. (2011). An International Learning Experience: Looking at Multicultural Competence Development through the Lens of Relational-Cultural Theory. Journal of Computers, 6(1), 147–154. https://doi.org/10.22229/THG802643

Fickling, M. J., Borders, L. D., & Hays, D. G. (2019). Disrupting the dominant discourse: White privilege in counselor education. Journal of Counselor Leadership and Advocacy, 6(2), 124–136. https://doi.org/10.1080/2326716X.2019.1624419

Galante, J., Galante, I., Bekkers, M. J., & Gallacher, J. (2016). Effect of kindness-based meditation on health and well-being: A systematic review and meta-analysis. Journal of Consulting and Clinical Psychology, 84(6), 537–549. https://doi.org/10.1037/ccp0000096

Gong, X. G., Wang, L., Rong, G., Liu, D. N., & Tian, L. (2023). Effects of online mindfulness-based interventions on mental health. Frontiers in Psychology, 14. https://doi.org/10.3389/fpsyg.2023.1073647

Jordan, J. V. (2018). Relational–cultural therapy. American Psychological Association. https://doi.org/10.1037/0000092-000

Lenz, A. S. (2014). Integrating Relational-Cultural Theory Concepts Into Supervision. Journal of Creativity in Mental Health, 9(2), 234–247. https://doi.org/10.1080/15401383.2013.864960

Logan, N. L., Goodwin, A., & Stelter, R. L. (2021). Online supervision practices in counselor education. The Professional Counselor, 11(3), 219–232. https://doi.org/10.15241/nl.11.3.219

From Isolation to Integration: Cross-Cultural Collaboration in Counseling Research

ZeVida A. Jones
Derrick Shepard

The University of Tennessee at Martin

Jennifer M. Cook
University of Texas at San Antonio

Michael Jones
University of the Cumberlands

Advocacy, culture, research, and leadership are indispensable components of professional counselor identity and practice, yet often are initiated individually and not purposefully combined. This article explains the processes and aims of forming a cross-cultural research team that merges intersectional research, advocacy, and leadership development. We share team members' reflections, draw on professional values, and offer recommendations to empower professionals to take an integrated leadership, research, and advocacy approach.

James Baldwin (1961) speaks to the racial desegregation of the 1960s and how the United States needs to come to terms with its past and make changes to create a more positive future. In a similar vein, professional counseling organizations (e.g., the American Counseling Association [ACA], the Council for Accreditation of Counseling and Related Educational Programs [CACREP], Chi Sigma Iota [CSI]) have put their proverbial *stake in the ground* that research and advocacy are essential components of professional identity, clinical practice, and counselor training. Simultaneously, multiculturalism, inclusionary practices, and social justice have become indispensable to these pursuits. CSI has been steadfast in its efforts to develop and promote counseling leadership through the aforementioned lenses. While the counseling profession has seen growth in its commitment to advocacy, research, leadership, and cultural inclusion over the past 30 years with the intent to promote counselor identity and high-quality, culturally appropriate client care, more can be done. Particularly as US society shifts demographically, political polarization intensifies, and injustice, discrimination, and oppression reach unprecedented levels, the counseling profession must continually initiate new ways to demonstrate our holistic, integrated commitment to those we serve through our intentional professional identity and leadership.

In this article, we suggest that while the counseling profession has demonstrated singular and siloed commitments to advocacy, research, leadership, and cultural inclusion quite well, our next professional step is to increase integration across these areas. Integrating advocacy, research, leadership, and cultural inclusion is vital for counseling professionals and those we serve. These elements ensure that counseling practices are equitable, evidence-based, and tailored to each client's needs. Furthermore, counselor educators who work from an integrated approach provide a more holistic and complete educational experience by which they can model the importance of an integrated professional identity for the next generation of counselors. Through sharing our experiences as part of an intentionally designed,

cross-cultural research team, we offer strategies for integrating the key pillars of advocacy, research, culture, and leadership into professional counseling.

Literature Review

The evidence for professional counseling's commitment to culture and advocacy has been substantial and has continued to expand since the inception of the first multicultural counseling standards in 1992 (Cade, 2023; Six advocacy themes, n.d.; Sue et al., 1992a; Sue et al., 1992b). The revised Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2016), the ACA Advocacy Competencies (Lewis et al., 2003; Toporek & Daniels, 2018), and the Association for Assessment and Research in Counseling (AARC) Standards for Multicultural Research (O'Hara et al., 2016) evidence professional progression and commitment. Additionally, counseling journals, special issues, conference themes, specific ethical codes from various counseling organizations (e.g., ACA, NBCC, ASCA, AMHCA), and distinct core CACREP standards (i.e., social and cultural diversity in the 2016 standards, and social and cultural identities and experiences in the 2024 standards), as well as requirements to infuse multiculturalism throughout programs (e.g., program objectives, program mission), and attention to faculty and student diversity, begin to catalog the profession's commitment and actions taken to strengthen the profession and those we serve.

Across the profession, specific efforts were made as a result of intentional discernment and planning that identified increased attention related to culture and advocacy, leadership, research, and professional identity. Kaplan et al. (2014), speaking on behalf of ACA and the eight-year process dedicated to articulating the 20/20 vision for the future of counseling, named seven focus areas grounded in the consensus definition of counseling, including strengthening counselor identity, expanding and promoting the research base of professional counseling, improving public perception and recognition, and advocating for professional issues. Similarly, the Counselor Advocacy Leadership Conference, which was sponsored by CSI in 1998, created six advocacy themes, including increased counselor identity and professional pride, unified and collaborative advocacy, and research substantiating the services counselors provide. The above themes serve as touchstones for the profession. Most notable is that CSI and ACA prioritize professional identity, research, and professional advancement.

CACREP, the largest accreditor of professional counseling programs, has supported CSI and ACA's efforts by consistently promoting advocacy, culture, and research. In the 2016 and 2024 CACREP standards, several specific advocacy standards are listed as core for master's level education, with an entire competency area for doctoral students. Similarly, *social and cultural diversity* (CACREP, 2016) and *social and cultural identities and experiences* (CACREP, 2024) are foundational curriculum areas at the master's level, with specific culture-related standards for specialty areas, including doctoral training.

In terms of research, one of the CACREP's eight core curricular areas for master's students is dedicated to *research and program evaluation*, and one doctoral curricular area is devoted to *research and scholarship*. In the 2016 standards, programs were

required to integrate current counseling research into all core master's and doctoral-level courses; however, in 2024, this directive was confined to doctoral programs. This is a curious change given that the need for masters level counseling students to continue to increase their exposure and use of professional counseling research has not waned, nor does professional counseling research to be conducted (Cook & Ong, under review; Limberg et al., 2020), and is antithetical to calls from counselor educators to strength the profession's research at all levels (Hays et al., 2019). Furthermore, scholars have argued that counselors can drive legislative change by engaging in research production and publication (Farrell & Barrio-Minton, 2019; Hunter et al., 2018). Also, scholars have highlighted that counselor research engagement can strengthen their professional identity, programmatic leadership, and stronghold in the marketplace (Farrell & Barrio-Minton, 2019; Hunter et al., 2018). These efforts align with the priorities of the ACA and CSI, which emphasize research, advocacy, cultural development, and leadership.

We assert that counselors must become leaders for counseling professionals to actualize research and advocacy. Leadership within the counseling profession is essential for the profession's survival, continued success, and maintenance and growth of the quality of services delivered to clients (Meany-Walen et al., 2013). Recognizing this, the ACA, the Association for Counselor Education and Supervision (ACES) and its regions, and CSI established emerging leaders and leadership fellows programs to increase leadership, specifically leaders with diverse identities (Meany-Walen et al., 2013). However, leadership appears not to be a consistent priority across the profession. While leadership remains a core competency area for doctoral students, modifications in the language of the 2024 CACREP standards may indicate a downshift in emphasizing culture and leadership. For example, the 2016 CACREP standards under Standard B.5.l highlighted "ethical and culturally relevant leadership and advocacy practices" (p. 37). Contrasting the 2024 CACREP standards under Standard B.5.m, which refer to "ethical leadership and advocacy practices" (p. 36), omitting the cultural relevance aspect.

Furthermore, and more alarming, there are no core master's level standards related to leadership in the 2016 or 2024 CACREP standards; the only specialty areas at the master's level to retain language related to leadership in the 2024 standards are those for school counselors. School counselors are expected to demonstrate strong leadership skills, including advocating for resources, building strong relationships, and designing and implementing comprehensive school counseling programs (Ratts & Greenleaf, 2016; Young & Bryan, 2015-2016), all of which are affirmed by the American School Counseling Association (ASCA) *Code of Ethics* (2022) and the ASCA national model (2019). However, nothing similar is present in the ACA (2014), AMHCA (2020), or CRCC (2023) ethical codes. Given the leadership emphasis for school counselors, it is natural to assume that such leadership skills are important for all counselors. However, the CACREP standards and ethical codes do not reflect this importance.

Finally, while the counseling profession has made great strides with its efforts regarding culture and research, it appears that much of the culturally focused counseling research has been siloed (Chan et al., 2018) in terms of researchers investigating singular research identity while being the holder of said identity themselves (i.e., so-called *me-search*); simultaneously establishing research teams

who are like-minded through these identities. Often, the result is research about a specific cultural identity conducted by researchers with that identity. Although there are strengths to this approach, we suggest that cultural research practices must expand beyond this siloed approach to include increased intersectionality research and intentional, cross-cultural research teams (Chan et al., 2018) in order for research to be ethical, reflexive, synergistic, and transformative (Arden et al., 2010).

We have outlined a host of strengths within the counseling profession regarding research, culture, leadership, and advocacy, and we have identified a significant limitation: The dearth of intentional cross-cultural research and researchers leaves our profession open to threats by other helping professional researchers to define our core beliefs and values. Part of the solution is for these pursuits to be relationship-driven. The relationship, the foundational core of the counseling profession, mediates the intentional, data-driven course counselors, counselor educators, and supervisors take. The relationship is fueled by the core conditions (Rogers, 1957).

To address the identified gaps, we share our process of developing and working on a cross-cultural research team that prioritized culturally relevant research, advocacy, and leadership. Drawing on our diverse cultural backgrounds and experiences, we intentionally brought together a research team to investigate the experiences of Black counselors from low social class. While this research study was where we started, it was only the beginning; it blossomed into so much more because of our intentional processes.

The team was comprised of ZeVida A. Jones (The Researcher-in-Training), Jennifer Cook (The Captain), Derrick Shepard (The Co-Captain), and Michael Jones (The Resident Comedian). In this article, we share how our journeys as counselor educators intersected and led to forming a multi-identity, candid, agenda-driven, collaborative, and integrated research team. We present team member reflections in each researcher's voice, offering a glimpse into who they are, their goals, motivations, and professional and personal perspectives. After we share each researcher's reflection, we discuss specific components that made our team work and offer suggestions for others who seek to *unsilo* their research teams and research and use their research teams to develop leadership, embody advocacy, and strengthen their professional identities.

Team Member Narratives

In this section, each researcher shares their reflections about the research team. Each member highlights the most significant parts of their individual and shared experiences with other team members. Through these sincere and engaging narratives, we aim to demonstrate how our cross-cultural intersected paths have encouraged leadership development, embodied advocacy and strengthened and built working relationships between counselor educators from diverse backgrounds to inform candid, agenda-driven, collaborative, and integrated research.

The Researcher-in-Training: ZeVida A. Jones (she/her)

Who would have thought a shy, quiet, and almost mute tomboy would meet and join an esteemed research team of three highly regarded counselor educators and researchers? I certainly did not. Why not? Because I grew up in North Memphis, an urban, low-socioeconomic community in Memphis, Tennessee. We received government assistance and feasted on the game my dad hunted. My family was considered *poor* and labeled *underprivileged* by society's standards.

To increase my chances of a better education and achieving a higher socioeconomic status, my mother enrolled me in private violin lessons. The neighborhood school did not offer orchestra as a fine arts class. However, taking private lessons, I received an orchestra transfer, which guaranteed acceptance into an optional junior high and high school. Optional schools provided creative and rigorous coursework and extracurricular programs, and admittance was contingent on the student's academic performance, standardized test scores, behavior, and attendance records. Sadly, without my "reluctant and unenthusiastic" participation in the orchestra, I would not have been able to attend my beloved schools.

I grew up in an environment that greatly influenced my collegiate education and career goals. Despite my parents not attending college and not having the means to pay for tuition, they expected me to be the first in the family to graduate from college. And I did. I am a first-generation college graduate. I have earned two associate degrees, a bachelor's degree, a master's degree, an education specialist degree, and a doctorate. I am a Licensed School and Professional Counselor and a National Certified Counselor. I worked as a high school counselor for two years with the local school district and a charter school. Then, I moved abroad to work as a secondary school counselor for three and a half years before obtaining my current position as an assistant professor at the University of Tennessee at Martin (UTM).

I provided a mini resume to show that despite my educational accomplishments and career achievements, I struggled with imposter syndrome like Derrick. I did not believe I was as "smart, talented, and successful" as others thought. I avoided discussions, presentations, and speaking engagements, preferring to work in the background. Through self-help books, positive affirmations, and thought-stopping techniques, I have made progress in overcoming imposter syndrome. However, when Derrick invited me to join the research team, I relapsed, making it clear that I hadn't completely overcome imposter syndrome and may still experience setbacks. Derrick and I met at UTM. We both work in the counseling department; he teaches clinical mental health courses, and I focus on school counseling. We connected immediately due to our shared race and cultural background. Both of us identify as Black or African American, grew up in low socioeconomic environments, and were first-generation college students. Derrick is direct, focused, strategic, and task-oriented. Whenever we talked about tenure, he always asked, "What's on your research agenda?" Once, when he asked me this, I hesitated, and he said, "Don't worry. I got you." Soon after, he encouraged me to establish a research agenda and invited me to join his research team with Jenn and Michael. Without warning, "Ms. Imposter" emerged and confidently joined the conversation.

I wondered why they chose me, as I had not conducted research since my dissertation. Despite being an international secondary counselor with expertise in middle and high school drama, conflict resolution, college prep, and behavior plans, I lacked experience in race, social class, and cross-cultural research. I hesitated, overanalyzing and convincing myself that I could not accept because Jenn and Michael were highly accomplished in their fields, and Derrick, I felt, had more research experience than I. There was no way I would embarrass myself. However, once again, Derrick's reassurance and persuasion led me to join the intentional cross-cultural research team as its fourth member.

I had the pleasure of meeting Jenn and Michael at our first research meeting, and it immediately felt like a long-awaited family reunion or a joyous reunion with old friends. There was an instant connection! Micheal and I identify as Black or African American and are first-generation college students. Interestingly, we also share the same last name, Jones, and affectionately refer to each other as cousins. Michael is a natural leader and a trailblazer. Due to his sense of humor, I call him the team's resident comedian. Michael's spontaneous wit contrasts my analytical mindset, making our meetings more enjoyable.

Jenn is a White cisgender woman. She is a remarkable leader and expert researcher who generously shares her knowledge to help others. Despite our differences, we share a similar commitment to excellence. Jenn and I possess a laid-back nature and go with the flow, but when it is time to work, we focus on producing quality work. Jenn's extensive research experience on race and social class and her innate ability to successfully coach the team to victory led us to deem her the *Captain*.

I appreciate the mutual respect, support, and encouragement within our team. We all strive to contribute our best to every project, and we are there for each other when anyone needs help. I have learned a great deal from my team members. Jenn and Michael have been wonderful mentors, and their encouragement has led me to take on leadership positions. Jenn persuaded me to co-present with her at a conference in Amsterdam, which was a fantastic experience. Being part of such a culturally diverse research team has been incredibly beneficial. I am grateful to Derrick, Michael, and Jenn for welcoming me and nurturing me as I navigate this new territory of becoming a researcher. Joining their team was the best decision I have made as a counselor educator and researcher-in-training.

The Captain: Jennifer M. Cook (she/her)

Over the last 15 years of conducting research, I have learned that creating a strong research team is a key, proactive step researchers must take when they begin a new project if they want to be successful. Like many, I learned this lesson through hard-fought errors: partnering with individuals whose skills did not complement mine, those who had low investment, and even people who took a competitive approach to collaboration. Now, I create research teams thoughtfully and purposefully.

Intentionally, Derrick and I partnered together because we have similar research interests, complementary skills, matched investment, and an equitable, collaborative spirit. Additionally, this was an opportunity for me to mentor Derrick with his skill development because I have more research and publication experience than he does, and I am committed to mentoring early career faculty and students as others did for me. As we worked to design our study, Derrick suggested we add ZeVida to the team. He discussed her strengths, her desire to learn, and believed she would be a strong addition to the team. I agreed, and we added ZeVida to the team. Concurrently, Michael, a long-time professional friend, expressed to me that he wanted to learn more about qualitative research. I spoke with Derrick, articulating Michael's strengths and desires. He agreed to invite Michael to join us.

It is important to note that while ZeVida's and Michael's strengths and research aspirations played a significant role in our discernment process about whether to invite them onto the team, these were not the only variables we considered. Derrick and I value and understand the important role individuals' sociocultural identities play in their experiences, worldviews, beliefs, and contributions. Furthermore, we planned to research specific cultural variables (i.e., race and social class), so we wanted team members who were not only interested in empirically examining these variables, but also brought diverse perspectives based on their identities and were willing to use their sociocultural knowledge and perspectives to enhance the research process. ZeVida and Michael were a match for our team.

The result was a diverse research team. We share several identities. We all hold doctorates in counselor education, reside in the southern region of the US, share a generational cohort (Generation X), and were reared in low social class and now identify with middle social class in some way. There are differences, too. Racially, I'm White, and my colleagues are Black. ZeVida and I identify as cisgender women, while Derrick and Michael are cisgender men. Two of us have children, two of us do not; only one of us is married, though two have been married in the past. We have diverse religious, spiritual, and political beliefs. This is only a snapshot of who we are, yet we are unified in our drive to understand human behaviors better, to validate the experiences of all persons, and our desire to develop counselors with a strong counselor identity who serve clients from all backgrounds equitably and justly.

The benefits of a diverse research team are numerous and span from study design to publication. Benefits for the counseling profession include identifying gaps in the literature that are missed when research questions and professional *problems* are viewed from a dominant culture perspective only, developing innovative research questions, using non-dominant sociocultural perspectives to inform data analysis and reporting, and adding to representation among the published literature from sociocultural non-dominant voices that are underrepresented. There are benefits for individual research team members, too. We were afforded opportunities to understand ourselves and our professional cross-cultural relationships better, examine our beliefs and preferences, engage in critical thinking and deep dialogue, and to share with others the impact of our experiences as a team. I do not see any drawbacks to working on a cross-cultural research team; however, I acknowledge this may be due to where I am in my personal and professional identity development. I am open to the

process and welcomed the opportunity; I was willing to make mistakes and to be corrected by my colleagues. Undoubtedly, these three components, likely among others, primed me to experience success and to see the strengths of our team.

While every research team has bumps in the road, our team has had an unprecedentedly smooth ride. There are several things that likely contribute to our success, though three stand out to me. First, we built the relationship. While we had individual relationships outside the study (e.g., me with Derrick, ZeVida with Derrick, me with Michael), we built the relationship *as a team*, which was a new relational configuration. As part of this process, we developed trust and understanding through authentic engagement, broaching, collaborative decision-making, fidelity, and honestly, through having some fun with each other each time we met! We allowed time to check in and to *cut up* some in every meeting.

Second, we were willing to dialogue honestly with one another. For example, when it came time to identify roles for conducting the focus group, a group that would be comprised of Black counselors, I posed to the group that my presence as a White person may hinder group discussion given the race-based identity questions we planned to ask. Openly discussing race and the impact of our racial identities is not something most people do; however, it was essential—not only to the data we hoped to collect but also for the respect and care we wanted to demonstrate to our participants. Not only did we discuss and decide as a group for me to sit out of the interview process, ZeVida and Derrick, who co-facilitated the focus group, shared our decision with participants because they knew I was part of the study (I communicated with them via email about the interviews and completing their demographic questionnaire). Our aim was to be transparent about our process, to show respect for their identities, and to model so-called *challenging conversations* about race. To me, these are only *challenging conversations* if one does not understand them as *critical conversations*. I understand these types of conversations as critical because I understand how race has been weaponized in the US, both historically and currently. My race represents the oppressor, the skin color of those who perpetrate racism, discrimination, and microaggressions; the skin color that limits and denies access to valued resources and inflicts emotional, psychological, and physical pain. If I am truly an ally and a co-conspirator with my Black and Brown colleagues, this is a *critical* conversation and one that I was compelled to initiate because the burden of broaching racial differences must not fall unilaterally on people of color: White folks must take responsibility and be proactive.

Finally, we committed to collaboration—true collaboration grounded in collectivism, not *pseudo-collaboration* supported by rugged individualism, in which it becomes evident over time that each person is out for their own personal gains rather than working to benefit the group. For each project endeavor, we discussed and identified leadership, each taking a turn. For example, ZeVida was lead on one conference presentation, while I was lead on another; however, everyone contributes to the process no matter who is leading. Consistently, we empower and support each other and understand that one member's success is *everyone's success*. In turn, when the team is successful, the profession can benefit, which means *clients* can benefit. Our work together is not simply about us, it is about everyone our work reaches and the clients they serve.

The Co-Captain: Derrick Shepard (he/him)

A mentor once told me, "Everyone here has an agenda. If you don't have an agenda, you need one." These words still resonated with me as a Black male who identifies and navigates the world through a working-class lens.

In 2013, I was accepted into a counselor education and supervision PhD program. Being the first to forge new territory in my family is not new. I was the first on my maternal side to graduate from college. Then, I had the audacity to earn a graduate degree. When I started the PhD program, I had no clue what I was doing. I knew I wanted the degree but questioned if the degree wanted me.

To say I floundered at the start of my program would be an understatement. This was until a program faculty member, another mentor, and I were chatting one day. He encouraged me to find a way to integrate my business background with counseling, and pointed me to the book, *Class, Status, and Power*. The referral and book took me on a journey. I knew of socioeconomic status and its meaning within the cultural context of growing up Black and working class in the South, but the hills, valleys, and rabbit holes of social class were a different story. Understanding the intricacies of social class blossomed before me through an economic lens of social injustice that impacts every aspect of this world. There was, and still is, so much to learn about social class. I knew my purpose, but I still did not have an agenda.

The turning point from a purpose to an agenda occurred for me in 2018. I submitted my first solo proposal for a national presentation when I was accepted to present at the 2018 American Counseling Association Conference. My presentation was entitled, *Cultivating Social Class Awareness in the Counseling Profession*, but it could have been titled *A Coming Out Party for Derrick and Social Class in Counseling.* I was alone with no nets or support other than my passion and knowledge of the topic. A roundtable presentation on the last day at the last time slot at the conference, what could go wrong? I just knew that the session would not be well-attended. Well, I was wrong. The seats filled up, and I met a colleague who, to this day, has helped me navigate this Ph.D. world. Part one of my agenda, making a bit of noise in the profession surrounding social class, was accomplished. Part two took a bit more bravery.

Jenn was presenting on social class at the conference. I knew of Jenn because I had read her dissertation and several articles she had published on social class. Jenn's research agenda aligned with mine, in that we both had a passion for integrating social class into counseling. With that like-minded agenda in consideration, I approached Jenn outside of the conference and introduced myself. To my surprise, she knew of my presentation and planned to attend if it were not for the time slot because she was presenting at the same time. She gave me her card and opened the door for us to collaborate in the future after I received my doctoral degree.

After my doctoral degree was conferred, Jenn and I connected and started to discuss possible opportunities to collaborate with a focus on social class in the counseling profession. Jenn inquired about adding Michael to our research team. I have known Michael for years, and we had interacted with each other at various conferences. Michael was approachable, appeared grounded, and, at least from my impression, had a collaborative spirit about him. I readily agreed. As I put in the email response, "The more the merrier." But, in my

opinion, the team was not set yet. I felt the team needed another perspective. We were all on the clinical mental health side of counseling, and I felt a school counselor's perspective would add value to the team. I approached the team about adding ZeVida. They agreed. After discussing the opportunity with ZeVida, she agreed to join the team. Team set.

My experience with this research team has been nothing short of amazing. I do not write those words lightly. Each member of the team brings their own unique experience, talents, and abilities to the team. Jenn, or as I call her, our "captain," has the research *chops* and experience that I feel gives our research team credibility and, more importantly, guidance and direction. Michael has a drive and purpose that keeps the ship moving, while ZeVida has untapped counselor educator researcher potential she is working to uncover. I say these things about our research team and note their strengths because we are a team of unreserved, agenda-focused, collaborative counselor educators.

"Check yourself at the door" could be a slogan of our research team. Our captain runs a tight ship. Jenn schedules a meeting for an hour; we start on time and end on time. However, we may spend 20 minutes catching up, *ripping on each other*, and, more importantly, supporting each other in our struggles. We are open and vulnerable with each other and feel free to remove the masks that are necessary to navigate higher education as racial, gender, and social class of origin minorities. In short, we can breathe and get the work done.

Collaboration is also important for me and my working-class social class identity. Researchers tend to agree that working-class individuals tend to work together for a collaborative purpose to navigate the social class hierarchical society. The collaborative spirit of the team provides me with the fuel to continue when things get tough, as I do not want to let the team down. Besides, they are part of my agenda now, which is to grow and develop the knowledge, awareness, and skills surrounding social class in the counseling profession.

The benefit of being part of a diverse research team is the perspectives each member brings to the table. I know I have *blind spots*, blind spots that were cultivated over time as a Black man from a working-class family living in the South and working toward a doctoral degree, an environment rich in classism and racism. The team has challenged me to dig deeper into identity intricacies, those that the person may or may not present in a salient manner, which is part of my ethical responsibility.

Likewise, a benefit of the team is having a sense of family, while maintaining professional boundaries. Collaborating, for me, is not the standard *quid pro quo* mentality that I have witnessed in the middle and upper social class world of academia. A true collaborative mentality is rare. Thus, I appreciate the team's familial feel and fictive kinship.

The hesitation to participate in the team lies in the all too real imposter syndrome that runs deep within my core. Jenn is a scholar in her own right and league that I strive to achieve, Michael is a national player in the counseling profession, and ZeVida has international experience as a counselor. While I am driven and have a *never say die attitude*, I feel and believe it is not enough to pull my weight. Yet, as a supportive fictive kinship family tends to do, the team reassures me that I am a valuable contributor, which gives me permission to try, to grow, and, more importantly, to fail as a new researcher in the profession.

A mentor once told me, “Everyone here has an agenda. If you don’t have an agenda, you need one.” I have an agenda. An agenda that may take me places or one in which I fall flat on my face and fail. It will be both and much in between. Most importantly for me, I have a research team that pushes me, believes in me, and drives me crazy in the process; I would not have it any other way.

The Resident Comedian: Michael Jones (he/him)

Embarking on my doctoral journey, I found myself at a crossroads between my passion for qualitative research and the pragmatic needs of my academic path. The retirement of a professor who had nurtured my love for qualitative research, left me needing a dissertation chair to guide me through the complexities of qualitative studies. Reluctantly, I shifted my focus to quantitative research. However, my desire for qualitative understanding remained the same, leading me to seek mentorship from Jenn, a respected figure in my academic and personal circle since 2013. Our paths had first crossed as fellows in the NBCC Doctoral Minority Fellowship Program, laying the groundwork for a friendship that was both professional and personal. Jenn, known for her prolific contributions to the field of counselor education through teaching, research, and leadership, embodies the blend of empathy and realism that I have come to admire deeply.

My relationship with Jenn has been a cornerstone of my academic and personal growth. Her down-to-earth attitude and unwavering commitment to the field have been a source of inspiration and guidance. Our shared experiences of navigating the academic landscape as individuals from lower socioeconomic backgrounds have fostered a unique understanding and mutual respect between us. Jenn’s invitation to join a research team exploring the authenticity of Black counselors from low social class in their counseling sessions opened a new chapter in my scholarly pursuits.

Meeting Derrick at the 2014 SACES Conference was pivotal, beginning a friendship grounded in shared aspirations and experiences. His journey from a doctoral student to assistant professor has been a testament to his resilience and dedication to counselor education. Our differences in hobbies and lifestyle, despite our similar outward appearances, underscore the diversity within the African American community, enriching our interactions and broadening my understanding of individuality. He also knew ZeVida and Jenn before the research team came together. He inadvertently became the source connection for everyone on the research team.

ZeVida joining the research team has been exceedingly helpful. She brought innovative ideas and excellent skills, especially using Excel to code our research data. She played a vital role in helping us understand tricky ideas better and strengthened our group's knowledge. Her work shows us how having different viewpoints can lead to a deeper understanding and new research methods.

The focus of our research on the authenticity of Black counselors from lower socioeconomic backgrounds not only aligned with my academic interests but also provided a platform for exploring the nuanced intersections of race, social class, and professional practice. The intentional cross-cultural composition of our team offered a rich tapestry of perspectives, enabling a deeper dive into the lived experiences of our study participants and the broader implications of our findings.

Jenn's decision to step back during the data collection phase and to serve as the auditor underscored the ethical considerations and sensitivity required for qualitative research. Her recognition of the potential impact of her presence on the authenticity of participants' responses demonstrated a nuanced understanding of power dynamics and the importance of creating a safe space for candid discourse.

Our data coding sessions, thoughtfully structured by Derrick, included time for personal reflection and fostered a sense of community and mutual support within the team. This deliberate incorporation of personal engagement enhanced our work efficiency and deepened our connections, highlighting the importance of emotional intelligence in academic collaborations. ZeVida's proficiency with Excel and ability to infuse practical insights into our discussions further exemplified the diverse skill sets that each member brought to the team, enriching our research process and outcomes.

Reflecting on my experiences with this cross-culture research team, I am struck by the profound humility, growth, and excitement permeating this journey. Collaborating with individuals of such caliber and diversity has been a privilege, offering invaluable lessons in resilience, empathy, and the transformative power of shared knowledge. As we look forward to the impact of our collective work, I am reminded of the strength of diversity and the endless possibilities that arise from embracing our unique paths and perspectives. This journey has enhanced my appreciation for qualitative research and deepened my commitment to contributing to the field of counselor education with an open heart and a curious mind. This reflective exploration of my participation in an intentional cross-culture research team embodies the journey of academic and personal growth, enriched by the diversity of experiences, backgrounds, and perspectives within our collaborative endeavor.

Discussion and Recommendations

Our cross-cultural research team's journey exemplifies the transformative potential of a diverse, intentional, and collaborative team of counselor educators who prioritize research, culture, leadership, and advocacy. Across the individual narratives, several shared key factors are evident: valuing authentic collaboration, growth orientation, investment in relationships, personal leadership development, and dispositions such as honesty, fidelity, humor, and a giving spirit. While we each expressed these factors differently, the unified essence is clear. The team came together with the expressed purpose of conducting intersectional identity research (i.e., race and social class) as a team with shared and different sociocultural identities. These messages are powerful and instructive for counselors wishing to *unsilo* research through intentional, cross-cultural research teams investigating intersectional identities (Chan et al., 2018). However, more important is what lies underneath the narratives that contribute to a holistic, integrated approach to professional identity and leadership development through research.

Integrating the key pillars of professional counseling—research, culture, advocacy, and leadership, along with professional identity—has been a central focus within the counseling profession and is evident in our narratives (Hays et al., 2019; Kaplan et al., 2014; Six advocacy themes, n.d.; Toporek & Daniels, 2018). For instance, the team personified an integration of ACA and CSI's commitment to

advocacy, research, and cultural inclusion (Kaplan et al., 2014; Six advocacy themes, n.d.) and that counselor research engagement can enhance professional identity (Hunter et al., 2018). Meany-Walen et al. (2013) argued that leadership within the counseling profession is essential for its survival, continued success, and for maintaining the quality of services delivered to clients, while Arden et al. (2010) cited that collaborative research is at its best when it is transformative, reflexive, ethical, and synergistic. As such, we developed a collaborative, relationship-driven approach that goes beyond professional survival to professional *thriving* by prioritizing integrating research, leadership, and culture, focusing on exploring our clients' intersecting identities (O'Hara et al., 2016). The relationship (Rogers, 1957) was foundational, just as it is in professional counseling practice. Our team's process is one in which professional identity, research, advocacy, and leadership coalesce as unified objectives rather than separate entities because they are uniquely grounded in relationship. Our strategies align with the goals of the ACA (Kaplan et al., 2014) and CSI (Six advocacy themes, n.d.), both of which prioritize a strong counselor identity (CACREP 2016; CACREP, 2024), research, and advocacy (Cade, 2023), while we integrated leadership, diversity, equity, and inclusion at individual and group levels. We listen to each other, ask for help, and provide resources without judgment or undue critique. This does not mean we avoid admitting mistakes, offering corrective feedback, or holding each other accountable (ACA, 2014); it is quite the opposite! Collaboration is paramount and we engage continually fostering genuine relationships.

Intentionally rotating leadership responsibilities within the group ensures that each member can develop their leadership skills. For instance, while the group affectionately refers to Author 2 as "Captain," she is not always the leader in charge. We all have leadership skills and are committed to increasing one another's leadership skills. Cases in point, ZeVida is the first author of this article, while she was second author for two presentations last fall, one in which the Derrick was the lead presenter. During qualitative coding, Derrick and Michael were the primary coders and ZeVida organized the data and processes, while Jenn was the auditor. These are only a few strategies that target leadership development in the team. Benefits of a diverse research team are numerous and span from study design to publication. In terms of benefits for the counseling profession, our work identifies gaps in the literature, some of which might be missed if research questions and professional problems are viewed solely from a dominant culture perspective or from a siloed non-dominant cultural perspective (Arden et al., 2010; Chan et al., 2018). Also, the diverse composition of our team helped foster innovative research questions through a non-dominant sociocultural perspective and consequently informed data analysis and reporting. For individual team members, the collaborative experience affords opportunities to understand ourselves and our professional cross-cultural relationships better, examine our beliefs and preferences, engage in critical thinking and deep dialogue, and share the impact of our experiences as a team.

We recommend cultivating diverse research teams by prioritizing the formation of groups that value diverse sociocultural identities and enriching research questions and methodologies for more comprehensive outcomes. Engaging in critical conversations about race, social class, and other sociocultural variables is crucial for understanding their impact on research and practice (Ratts et al.,

2016) and, as we have articulated in our narratives, must be part of the process. Promoting mentorship and support within research teams helps members navigate imposter syndrome, develop their research agendas, and spurs professional growth, so team members must commit themselves to a *mentoring spirit* and be an unwavering source of encouragement and strength for the team and its members.

Emphasizing true collaboration grounded in collectivism ensures shared leadership roles, collective decision-making, and mutual respect. Values embedded in individualism cannot go unchecked because they are the antithesis of what we propose. Addressing power dynamics with the team and with interactions with participants is essential for creating safe and respectful environments where all voices are heard, disrupting dominant culture expectations and ways of being that have long been deemed *the right way* to interact in professional settings.

In the literature review we offered critique regarding the CACREP standards, counseling ethical codes, and singular-focused agendas, in addition to the array of positive steps our profession has made. The goal of our appraisal is to build on the strengths of our profession, while recognizing and calling for action in areas of growth, such as placing more of an emphasis on leadership development on the master's level and increasing innovative research. By implementing the recommendations we have suggested and using them to stimulate additional ideas and methods, research teams can create more inclusive, equitable, and effective research environments to advance counselor education, professional counseling, counselor identity, advocacy (Hunter et al., 2018). To draw on the quote at the beginning of this article, we acknowledge that we are suggesting a *breakup of the world as one has always known it* in terms of how we enact our professional pillars. We are calling the profession into proactive change with the intent that our holistic, integrated approach to professional identity, research, culture, advocacy, and leadership can serve as a model that promotes a more just and equitable counseling profession. We aim to be a profession with practitioners who better understand their clients' needs and provide more comprehensive support by demonstrating the importance of considering all aspects of their identity and experiences. While there may be the perception that an identity is being lost, a much greater one is being gained.

Conclusion

Based on our ongoing collaboration efforts documented in this article, our collective voices offer insights and suggestions to help strengthen a culturally focused research agenda by integrating advocacy, research, culture, leadership, and professional identity while also providing guidance to help practitioners to equitably serve their clients. Our intentional cross-cultural research team empowers and supports each other, recognizing that individual success contributes to collective success. This collective success benefits the entire profession and, ultimately, the clients we serve. Our work extends beyond ourselves to positively impact everyone our work reaches and the clients they serve.

References

American Counseling Association. (2014). *2014 ACA code of ethics*. https://www.counseling.org/docs/default-source/default-document-library/ethics/2014-aca-code-of-ethics.pdf

American School Counselor Association. (2019). *The ASCA National Model: A framework for school counseling programs* (4th ed.). Author.

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

Arden, C. H., Danaher, P. A., George-Walker, D., Henderson, R., Midgley, W., Noble, K., & Tyler, M. A. (2010). *Sustaining and transforming collaborative research: Principles and practices.*https://research.usq.edu.au/download/cbd52cdc99d61364d2c2aae0ac198b58059bbf3c103e28291ae509e30215fa7f/113431/Arden_Danaher_De_George-Walker_Henderson_Midgley_Noble_Tyler_Ch1_AV.pdf

Baldwin, J. (1961). *Nobody knows my name: More notes of a native son.* Penguin Random House.

Cade, R. (2023). Editorial perspective: Publishing as a form of advocacy in Counseling. *Journal of Professional Counseling: Practice, Theory, & Research, 50*(1), 1-2. http://dx.doi.org/10.1080/15566382.2023.2194201

Chan, C. D., Cor, D. N., & Band, M. P. (2018). Privilege and oppression in counselor education: An intersectional framework. *Journal of Multicultural Counseling and Development, 46*(1), 58-73. http://dx.doi.org/10.1002/jmcd.12092

Commission on Rehabilitation Counselor Certification. (2023). *Code of professional ethics for certified rehabilitation counselors*. Schaumburg, IL: Author. https://crccertification.com/wp-content/uploads/2023/04/2023-Code-of-Ethics.pdf

Cook, J. M., & Ong, L. (Under Review). Masters level counselors' and counseling students' perceptions about their abilities and desire to consume and conduct research. *Journal of Counseling and Development.*

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

Council for Accreditation of Counseling and Related Educational Programs. (2024). *2024 CACREP standards*. https://www.cacrep.org/wp-content/uploads/2024/04/2024-Standards-Combined-Version-4.11.2024.pdf

Chi Sigma Iota. (n.d.). *Six advocacy themes.* https://www.csi-net.org/page/advocacythemes

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

Hays, D.G., Bolin, T., & Chen, C.C. (2019). Closing the gap: Fostering successful research-practice partnerships in counselor education. *Counselor Education & Supervision, 58*(4), 278-292. http://dx.doi.org/10.1002/ceas.12157

Hunter, Q., Balkin, R. S., & Reiner, S. M. (2018). Addressing impact of counseling research: A comparative study of counseling and psychology journals. *Counseling Outcome Research and Evaluation, 9*(2), 80-89. http://dx.doi.org/10.1080/21501378.2017.1403848

Kaplan, D. M., Tarvydas, V. M., & Gladding, S. T. (2014). 20/20: A vision for the future of counseling: The new consensus definition of counseling. *Journal of Counseling & Development*, *92*(3), 366-372. http://dx.doi.org/10.1002/j.1556-6676.2014.00164.x

Limberg, D., Newton, T., Nelson, K., Barrio Minton, C.A., Super, J.T., & Ohrt, J. (2020). Research identity development of counselor education doctoral students: A grounded theory. *The Professional Counselor, 10*(4). 488-500. http://dx.doi.org/10.15241/dl.10.4.488

Meany-Walen, K. K., Carnes-Holt, K., Barrio Minton, C. A., Purswell, K., & Pronchenko-Jain, Y. (2013). An exploration of counselors' professional leadership development. *Journal of Counseling & Development, 91*(2), 206-215. https://doi.org/10.1002/j.1556-6676.2013.00087.x

O'Hara, C., Clark, M., Hays, D.G., McDonald, C.P., Chang, C.Y., Crockett, S.A., Filmore, J., Portman, T., Spurgeon, S., & Wester, K.L. (2016). AARC Standards for Multicultural Research. *Counseling Outcomes Research and Evaluation. 7*(2). 67-72. https://doi.org/10.1177/2150137816657389

Ratts, M. J., & Greenleaf, A. T. (2016). Multicultural and social justice counseling competencies: A leadership framework for professional school counselors. *Professional School Counseling*, *21*(1b), 1–9. http://dx.doi.org/10.1177/2156759X18773582

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95-103. http://dx.doi.org/10.1037/h0045357

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992a). Multicultural counseling competencies: A call to the profession. *Journal of Counseling & Development*, *70*(4), 477-486. http://dx.doi.org/10.1002/j.1556-6676.1992.tb01642.x

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992b). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development*, *20*(2), 64-88. http://dx.doi.org/10.1002/j.2161-1912.1992.tb00563.x

Toporek, R. L., & Daniels, J. (2018). *American Counseling Association advocacy competencies: Updated.* American Counseling Association. https://www.counseling.org/docs/default-source/competencies/aca-advocacy-competencies-updated-may-2020.pdf?sfvrsn=f410212c_4

Young, A., & Bryan, J. (2015-2016). The school counselor leadership survey: Instrument development and exploratory factor analysis. *Professional School Counseling, 19*(1), 1-15. https://www.jstor.org/stable/10.2307/90014784

Self-diagnosis and Help-seeking Behaviors in Transgender Adolescents

Wendy Story
Derrick Shepard
The University of Tennessee at Martin

Adolescence is a critical time for one's social development, and with the rise of social media, more adolescents, including those who identify as transgender, are using it as a place for social support. Although social media has both positive and negative aspects, one concern is that adolescents use social media to self-diagnose mental health issues; misinformation regarding mental health issues on social media can provide complications. Therefore, it is essential for the adolescent to seek information, and help, from reliable and knowledgeable sources. The authors will discuss help-seeking behaviors, implications and suggest best practices for helping the transgender adolescent population.

According to the Williams Institute (2022), approximately 300,000 youth identify as transgender, and the United States lies at a dangerous crossroads in how it will help or hinder the development of this vulnerable population. In fact, the American Civil Liberties Union is tracking over 500 anti-LGBTQ bills at the state level (ACLU, n.d.). These attacks are even more important to consider when it comes to adolescents who identify as transgender because adolescence is a time of self-exploration, discovery, and crisis (Erikson, 1968; Upreti & Chawla, 2023). Transgender youth are even more susceptible to mental health crises during this stage of development (Martin-Storey, 2016; Russell & Fish, 2016). The counseling profession acknowledges that working with marginalized sexual and gender adolescents poses unique challenges (Harper et al, 2012). To help counselors navigate this unique space, the American Counseling Association developed competencies for counseling Transgender clients (Burnes et al., 2010). The competencies address how counselors should work with transgender clients, including understanding how the process of diagnosis can include stigma and oppression for the client (Burnes et al., 2010).

The internet, and by extension, social media, poses additional challenges for adolescents and their development. While social media can provide support and connection (Harness et al., 2023; Selkie et al., 2020), there has been an increase in feelings of loneliness in the adolescent population (Twenge et al., 2021). This loneliness can lead to mental health issues, including depression, anxiety, and self-esteem problems (Elhai et al., 2017; Robertson et al., 2022; Shensa et al., 2017). Another negative effect of social media that has been explored recently is that of self-diagnosis after receiving mental health information via social media (Gomez, 2023; Weigle, 2023). A

recent study by PlushCare (2022) notes that mental health advice videos on TikTok were found to be 83.7% inaccurate and that 14.4% of videos can be damaging to viewers. Researchers have called for additional research on the use of social media by transgender adolescents (Primack et al., 2017; Roberston et al., 2022; Shensa et al., 2017; SurgeonGeneral.gov).

With an understanding that clients are not one-dimensional, counselors are well-served to use an intersectional lens that incorporates the various identities of clients, including their gender expression identity (Ratts et al., 2016). Understanding the developmental needs and processes of transgender adolescents provides a unique and, at times, challenging environment for counselors to do the ethical, evidence-based work needed. The purpose of the article is to raise awareness of how social media influences the development of transgender adolescents, understand possible help-seeking behaviors, and offer recommendations to empower this population through a culturally competent lens.

Adolescents Use of Social Media

Adolescence is an important stage of development for an individual. It is during this stage that young people develop their social skills through interactions with their peers and adults (Upreti & Chawla, 2023). Positive social interactions during adolescence are crucial for an adolescent's mental well-being and development (Selkie et al., 2000) Therefore, the types of social interactions that young people have with those around them, whether they be positive or negative, can impact the way that they communicate others and their relationships later in life.

Social media helps adolescents find and interact with like-minded individuals with similar interests (Amichai-Hamburger et al., 2012) and provides them with the ability to interact immediately with friends and family. In fact, during the COVID-19 pandemic, adolescents spent more time on their digital devices seeking connections with their peers due to social distancing rules (Drew et al., 2021). Researchers have found that transgendered youth have used social media for emotional and social support in online transgendered communities, which positively affected their well-being (Chan. 2023; Selkie et al., 2020).

However, while there are positive aspects to adolescents using social media, there are also negative aspects that should be considered. Negative aspects can include depression, sleep issues, anxiety, behavioral problems, body image issues, and harassment, to name a few (Bozzola et al., 2022; Das & Chauhan, 2022; Selkie et al., 2019). Simultaneously, dangerous trends and challenges on social media have been known to cause physical harm. Therefore, it is important to be knowledgeable about the influence that social media can have on adolescents.

Social Development in Adolescents through social media

Social development during adolescence is the process by which the norms and rules of society are imparted to the next generation (Erikson, 1968; Primack et al, 2017; Upreti & Chawla, 2023). During this time, adolescents start to evaluate their interactions and relationships with others while developing a sense of self (Erikson, 1968). The age of social media (e.g., TikTok) has added a layer to

adolescents' development that previous generations did not tend to in their day (Keles et al., 2020; Palmeroni et al., 2021; Primack & Escobar-Viera, 2017). Researchers have found correlations between the time spent on social media and an increase in anxiety, depression, sleep issues, harassment, and body image issues (Bozzola et al., 2022; Das & Chauhan, 2022; Dittmar, 2007; Keles et al., 2020; Palmeroni et al., 2021 Selkie et al., 2019). Consequently, the developmental landscape has changed and continues to evolve step-in-step with technology.

Transgender social development through social media

Much like the general adolescent population, the transgender adolescent population is a time for self-discovery and crisis. Transgender adolescents experience a sense of incongruence between their assigned sex and the way they self-identify (Kon, 2014). Likewise, transgender adolescents experience bullying, exclusion, and discriminatory practices at school and maybe even at home (Alqahtani, 2024; Selkie, 2019). For the transgender adolescent, social media can be a way out and a place to find support. Selkie et al. (2019) report that transgender adolescents use social media as a community hub, thereby contributing to their social development and allowing them to create bonds with other individuals who have similar qualities and interests to their own.

Coyne et al. (2023), additionally, found that the use of social media by transgender and nonbinary youth is associated with lower rates of mental health problems, in that actively using social media allows them to create online safe places in which they can have positive interactions with others. Further, the study found that taking intentional social media breaks was associated with increases in depression for transgendered and nonbinary adolescents, whereas cisgender youths found that intentional breaks were beneficial for their mental health (Coyne et al., 2023). This highlights the importance and the benefits of transgendered youth having an online community and safe space to be their authentic selves and find connections to others.

Help-Seeking Behaviors in Adolescents

Help-seeking behaviors, which can be a complex phenomenon (Kuhl et al., 1997), refers to how an individual communicates to others that they need help in terms of understanding, advice, information, and treatment in response to a problem or a distressing experience (Rickwood et al., 2005). For adolescents, Rickwood and Thomas (2022) argue that help-seeking behaviors are divided into two different areas: formal and informal. The authors state that formal help-seeking is from a recognized professional help (e.g., a counselor), while informal help-seeking can be from one's social network of family and friends. Help-seeking can be further divided into online help-seeking, such as using the internet and social media platforms, or offline help-seeking, such as in-person help with family, friends, or professionals (Pretorius, 2019).

Several contextual factors contribute to the help-seeking behaviors of adolescents, which include, but are not limited to, race, gender, ethnicity, cultural, and socioeconomic background - all of which can also influence how, when, or even if an individual seeks help

(Planey et al., 2019; Saunders et al., 1994;). Clients from more marginalized identities may view counseling as a stigmatizing process and only seek help from family members or spiritual healers; therefore, they may avoid seeking professional counseling (Hays & Erford, 2023).

Researchers have found that help-seeking behaviors by adolescents have a number of barriers, which include the stigma of mental health and preference for self-reliance, with online barriers being the lack of mental health literacy, treatment avoidance, reluctance to seek help, and risky content (Planey et al., 2019; Pretorius et al., 2019). Ishikawa et al. (2023) found that due to the adolescent's increased autonomy and self-reliance at this stage, adolescents who had higher self-reliance were less likely to seek informal support, especially if they had lower perceived social support. In contrast, if they had higher perceived social support, they were more inclined to seek help. The researchers additionally found that adolescents who were more self-reliant were inclined to use self-help via the Internet as it can provide immediate and autonomous support (Ishikawa et al., 2023). Finally, Valesco et al. (2020) found other barriers to help-seeking, which included stigma associated with mental health problems, family beliefs toward mental health and treatment, mental health literacy, self-sufficiency and autonomy, service personnel availability, and structural factors.

The research supports that there are positive benefits for seeking help for mental health issues, as opposed to individuals attempting to work through issues alone. Petorius et al. (2019) note that the benefits of online help-seeking include anonymity and privacy, immediacy, ease of access, inclusivity, and the ability to connect with others and share experiences. Valesco et al. (2020) found help-seeking facilitators to be mental health literacy, positive prior mental health care, and "higher engagement with the community and having a trusting and committed relationship with relevant adults such as parents, schoolteachers, and counselors" (p. 14).

Help-seeking behaviors by adolescents using social media

Pretorius and Coyle (2021) found that 51.4% of respondents used social media during the COVID-19 pandemic restrictions to support their mental health. The researchers found that adolescents used Instagram the most at 38.7%, to follow body positivity influencers, influencers who focused on mental health issues, and influencers who focused on health and fitness. Additionally, participants followed YouTube influencers for mental health and at home workouts, Facebook provided support groups that focused on specific issues, and while participants did not look for specific content on TikTok, they followed it for distractions and to improve their moods. Finally, the researchers found that 32.6% of the participants used a mental health app to support their mental health, and 13.2% used online professional counseling.

Help-seeking behaviors for transgender adolescents

Social media use by transgendered youth allows them to find social and emotional support and garner a sense of belonging (Chan, 2023; Selkie et al., 2019; Eickers, 2024). A study regarding social media use by transgender and gender-diverse youth by Herrmann et al. (2024) found that transgendered youth felt more understood and accepted online rather than in offline domains and used online groups or platforms for social support. However, they found that about half of the study participants had negative experiences with

social media, which includes cyberbullying and other adverse interactions, and it can be linked to more internalizing problems (Herrmann et al., 2024). Thus, for transgender adolescents, it is important to consider the possible negative impact of social media use.

Unfortunately, transgendered youth may not seek help for various reasons, which can include the fear of disclosure regarding their affectional orientation and gender identity. In a study of the help-seeking behaviors of LGBTQ youth who were experiencing suicidal feelings or self-harm, McDermott et al. (2018) found that transgender youth may be reluctant to seek help due to three factors, including negotiating sexuality, gender, mental health, and age norms; being unable to talk about their emotions; and coping and self-reliance. They found that young people were fearful of negative reactions to their sexuality and gender and feared that adults may not take them seriously. Additionally, these individuals had difficulty expressing their emotions in relation to their sexuality, gender, self-harm, and suicidal feelings and felt that being in control with an emphasis on the importance of being self-reliant were reasons they did not seek help. Finally, their study also found that LGBTQ youth may only seek help in times of crisis, when they are no longer able to cope, thus highlighting this population's need for strengthened help-seeking behaviors.

Adolescent Mental Health and Self-Diagnosis

Researchers have started to explore how social media can influence adolescents' mental health, including self-diagnosing (Gomez, 2023; Primack & Escobar-Viera, 2017; Weigle, 2023). Researchers argue that adolescents are self-diagnosing mental health issues such as dissociative identity disorder, bipolar, autism, and attention-deficit/hyperactivity disorder (Primack & Escobar-Viera, 2017; Weigle, 2023). To this point, PlushCare (2020) extracted 500 videos, transcribed them, and labeled them as misleading if certain criteria were met, such as having inaccurate information, having an unqualified host, and whether it encourages a self-diagnosis. With TikTok, for example, 83.7% of videos on their platform were inaccurate. Even more disturbing, PlushCare (2020) notes that 14.2% of videos could potentially be damaging to viewers.

Adolescents are increasingly using social media to interact with peers and other people of like mind and are additionally using it for their well-being while seeking help and support for mental health concerns. Social media, in short, is helping break down the stigmas associated with mental health. However, as Weigle (2023) argues, misinformation is being spread on social media and causing a social contagion. While biological contagions spread to people in close proximity, a social contagion spreads throughout social media spanning great distances, thereby affecting an individual's thoughts, behaviors, and attitudes (Weigle, 2023). A study by Rizkaka et al. (2023) on participants aged 18 to 25 years-old found that 77.3% have self-diagnosed with a mental health issue after gathering information online. While this study's age range is higher than adolescents, those who are between the ages of 10 and 18, the rate of self-diagnosis in the study is disquieting and further research should explore the rate of diagnosis in adolescents.

The spread of misinformation is causing adolescents to self-diagnose mental health issues that they may or may not have. How adolescents seek help to confirm whether their self-diagnosis is accurate or to get a proper diagnosis needs to be explored. Therefore,

while the literature suggests (Pretorius et al.,2019; Valesco et al., 2020) that there are barriers and facilitators for adolescents in their help-seeking behaviors and that adolescents are indeed turning to social media for information about mental health, the question then becomes: how do adolescents seek help after self-diagnosis? Do they use informal support systems like parents, teachers, and peers, or formal support systems like counselors? More importantly, how do marginalized transgender adolescents seek help once they have self-diagnosed?

Discussion

Social media plays an important role in the lives of adolescents. Through social media, adolescents can stay connected to family and friends; nevertheless, social media can cause issues when adolescents seek out mental health information that may be misinformative and even damaging. This misinformation can lead to self-diagnosing a condition that they may or may not have. How an adolescent seeks help dealing with their self-diagnosis is imperative for a counselor to understand, to provide the best care. If an adolescent's support system is unaware of this social contagion, as Weigle (2023) puts it, they may lack the ability to provide more meaningful and accurate mental health information. Equally important, if the support system is dismissive of the adolescent's concern, it may further exacerbate their mental health state. Therefore, informing, further developing, and supporting an adolescent's support system is imperative to counter the deluge of misinformation on social media.

Social media self-diagnosis is an important matter for counselors to examine because adolescents tend to search out mental health information through social media channels (Gomez, 2023; Primack & Escobar-Viera, 2017; Weigle, 2023). With the amount of mental health misinformation readily available to adolescents, it is important that counselors be aware of this phenomenon and find ways to provide better mental health literacy to their clients. If counselors better understand how social media and self-diagnosis are intertwined for adolescents, they can better address the issue in counseling relationships for better client outcomes.

Practical Implications

How a counselor responds to an individual's self-diagnosis is imperative. While it may be easy to be dismissive and doubt the client, the counselor must regard the client's concerns as serious and build a positive counseling relationship with them. The counselor should take extra steps to ensure that they are expressing empathic understanding and get to know why the client seeks this diagnosis. In this, the adolescent may have a reason they strongly identify with a diagnosis. Thus, what purpose is the diagnosis serving for the client? Weigle (2023) notes that a diagnosis can justify the teen's stress or failures and can provide an excuse for unwanted responsibilities. However, he additionally adds that receiving a diagnosis can be validating for the client. Therefore, counselors should begin by building a positive counseling relationship thereby allowing the client to fully explore why they are seeking a diagnosis and avoid judging the client regarding their concerns.

A second implication for counselors falls squarely within the advocacy realm of the profession. As counselors and advocates, it is imperative to step outside of the counseling room to help our clients, and counselors should educate clients and communities on the spread of misinformation on social media and provide them with more factual information regarding mental health issues. Gomez (2023) notes that mental health professionals should promote mental health support by linking services and groups on their professional social media accounts, thereby canceling out misinformation and providing more factual mental health guidance to adolescents in a way that is meaningful for them. Chan (2023) also notes it is imperative to empower transgender clients to effectively integrate social media into their lives. Counselors can also provide workshops to community members to educate them about the rise of self-diagnosis and provide them with evidence-based mental health information.

A third implication for counselors is that they should educate clients on the potential harm of a diagnosis (Corrigan, 2007). Providing a diagnostic label has inherent risks, which include pathologizing clients, thereby reducing the individual to the diagnosis (Gladding & Newsome, 2018). Corrigan (2007) argues that a clinical diagnosis can exacerbate the stigma associated with mental illness, noting that a diagnostic label can interfere with an individual's work, housing, and other life opportunities. Corrigan (2007) suggests that rather than assigning someone a diagnosis, the counselor should describe the person's mental health as on a continuum, noting that they may have symptoms of the diagnosis, but they are not the diagnosis. Adolescents may, however, have strong feelings and connections with their diagnosis and refuse to accept otherwise, because doing so may cause dissonance within them (Weigle, 2023). In these situations, it is imperative for the counselor to remain patient, focus on the therapeutic relationship, and explain why attaching a diagnostic label may not be appropriate.

The final implication for counselors falls squarely within the essence of the therapeutic relationship. A strong therapeutic relationship is an important factor all counselors need to have in working with clients (Kress et al., 2021). Having a genuine therapeutic relationship with the client provides the counselor with a greater understanding of the presenting issue and goals for their sessions and increases the chances for a positive outcome (Kress et al., 2021). This gives the benefit of determining whether the diagnosis stands as it is or whether there is another issue that needs to be addressed. To build a strong therapeutic relationship with a client who identifies as transgender, the authors recommend that counselors refer to the ALGBTIC competencies (Harper et al., 2013); and engage in continued education with a focus on counseling transgender adolescents through professional counseling associations (e.g., ACA, AMHCA, ASCA).

The counseling profession has a long history of fighting with and for marginalized populations (Lawson, 2016). In today's hyper-charged political landscape targeting adolescents who are minorities when it comes to their sexual orientation and gender identity, it is imperative for counselors to know and understand how these populations may seek help. Social media adds to the complexity of the situation and should be integrated into the counselor's worldview and understanding.

References

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

Alqahtani, N. H. (2024). Children's socialization to gender identity: A study of Laurie Frankel's This Is How It Always Is. *Theory and Practice in Language Studies*, *14*(1), 257-264.

Amichai-Hamburger, Y., Kingsbury, M., & Schneider, B. H. (2013). Friendship: An old concept with a new meaning? *Computers in Human Behavior,* 29(1), 33–39. https://doi.org/https://doi.org/10.1016/j.chb.2012.05.025

Broderick, P. C., & Blewitt, P. (2020). *The Life Span: Human Development for Helping Professionals* (5th ed.). Pearson Education, Inc.

Bozzola, E., Spina, G., Agostiniani, R., Barni, S., Russo, R., Scarpato, E., Mauro, A. D., Antonella Vita, D. S., Caruso, C., Corsello, G., & Staiano, A. (2022). The use of social media in children and adolescents: Scoping review on the potential risks. *International Journal of Environmental Research and Public Health, 19*(16), 9960. https://doi.org/10.3390/ijerph19169960

Burnes, T. R., Singh, A. A., Harper, A. J., Harper, B., Maxon-Kann, W., Pickering, D. L., & Hosea, J. (2010). American Counseling Association: Competencies for counseling with transgender clients. *Journal of LGBT Issues in Counseling, 4*(3-4), 135-159.

Cingel, D.P., Lauricella, A.R.,Taylor, L.B., Stevens, H.R.,Coyne, S.M., & Wartella, E. (2022). *U.S. adolescents' attitudes toward school, social connection, media use, and mental health during the COVID-19 pandemic: Differences as a function of gender identity and school context*. PLOS ONE, 17(10), e0276737. https://doi.org/10.1371/journal.pone.0276737

Chan, R. C. (2023). Benefits and risks of LGBT social media use for sexual and gender minority individuals: An investigation of psychosocial mechanisms of LGBT social media use and well-being. *Computers in Human Behavior*, *139*, 1-11.

Corrigan, P. W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work, 52*(1), 31-9. https://go.openathens.net/redirector/utm.edu?url=https://www.proquest.com/scholarly-journals/how-clinical-diagnosis-might-exacerbate-stigma/docview/215269747/se-2

Coyne S.M., Weinstein E., Sheppard J.A. (2023). Analysis of Social Media Use, Mental Health, and Gender Identity Among US Youths. *JAMA Network Open. 6*(7), e2324389.

Das, S., Gaur, M., & Chauhan, P. (2022). Zooming into social media: A link between social media usage, FOMO & mindfulness among adolescents. *AAYAM: AKGIM Journal of Management, 12*(2), 164-169.

Dittmar, H. (2007). The costs of consumer culture and the "cage within": the impact of the material "good life" and "body perfect" ideals on individuals" identity and well-being. *Psychological Inquiry*, *18*(1), 23-31.

Eickers, G. (2024). Social media experiences of LGBTQ+ people: Enabling feelings of belonging. *Topoi,* 1–14. https://doi.org/10.1007/s11245-023-09994-3

Elhai, J. D., Dvorak, R. D., Levine, J. C., & Hall, B. J. (2017). Problematic smartphone use: A conceptual overview and systematic review of relations with anxiety and depression psychopathology. *Journal of Affective Disorders*, *207*, 251-259

Fung, B. (2023, April 26). Senators unveil bipartisan legislation to ban kids under 13 from joining social media platforms | CNN business. Retrieved from https://www.cnn.com/2023/04/26/tech/senators-social-media-kids-wellness/index.html

Gladding, S. T., & Newsome, D. W. (2018). *Clinical Mental Health Counseling in community and agency settings* (5th ed.). Pearson. Education, Inc.

Gomez, L. A. (2023). *Social Media's Impact on Teens Self-Diagnosing Mental Health Concerns: Systematic Literature* (Doctoral dissertation, California State University, Northridge). Retrieved September 27, 2023, from https://scholarworks.calstate.edu/downloads/qz20t064j.

Harness, J., Domoff, S. E., & Rollings, H. (2023). Social media use and youth mental health: Intervention-focused future directions. *Current Psychiatry Reports*, *25*(12), 865-871.

Harper, A., Finnerty, P., Martinez, M., Brace, A., Hugh, C.C., Loos, B., Harper, B., Graham, S., Singh, A., Kocet, M., Travis, L., Lambert, S., Burnes, T., Dickey, L.M., & Hammer, T.R. (2013). Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex and Ally Individuals. *Journal of LGBT Issues in Counseling,* 7(1). 2-43.

Hays, D. G., & Erford, B. T. (2023). *Developing multicultural counseling competence: A systems approach* (4th ed.). Pearson Education Inc.

Herrmann, L., Barkmann, C., Bindt, C., Hohmann, S. Fahrenkrug, S., & Becker-Hebly, I. (2024). How *social* is social media for transgender and gender-diverse youth? Association of online social experiences with internalizing mental health problems. *European Child & Adolescent Psychiatry*, 1-14.

Ishikawa, A., Rickwood, D., Bariola, E., & Bhullar, N. (2023). Autonomy versus support: Self-reliance and help-seeking for mental health problems in young people. *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, *58*(3), 489–499. https://doi.org/10.1007/s00127-022-02361-4

Keles, B., McCrae, N., & Grealish, A. (2020). A systematic review: the influence of social media on depression, anxiety and psychological distress in adolescents. *International Journal of Adolescence and Youth*, *25*(1), 79-93.

Kon, A. A. (2014). Transgender children and adolescents. *American Journal of Bioethics, 14*(1), 48-50. https://doi.org/10.1080/15265161.2014.862410

Kress, V. E., Seligman, L., & Reichenberg, L. W. (2021). *Theories of counseling and psychotherapy: Systems, strategies, and skills* (5th ed.). Pearson.

Kuhl, J., Jarkon-Horlick, L., & Morrissey, R. F. (1997). Measuring barriers to help-seeking behavior in adolescents. *Journal of Youth and Adolescence*, *26*, 637-650.

Lawson, G. (2016). On being a profession: A historical perspective on counselor licensure and accreditation. *Journal of Counselor Leadership and Advocacy, 3*(2), 71-84.

Martin-Storey, A. (2016). Gender, sexuality, and gender nonconformity: Understanding variation in functioning. *Child Development Perspectives*, *10*(4), 257-262.

McDermott, E., Hughes, E., & Rawlings, V. (2018). Norms and normalisation: Understanding lesbian, gay, bisexual, transgender and queer youth, suicidality and help-seeking. *Culture, Health & Sexuality*, *20*(2), 156–172.

Palmeroni, N., Claes, L., Verschueren, M., Raemen, L., & Luyckx, K. (2021). Internalization of appearance ideals and appearance comparison among adolescent boys and girls: The role of identity formation. *Identity*, *21*(3), 219-237.

Planey, A. M., Smith, S. M., Moore, S., & Walker, T. D. (2019). Barriers and facilitators to mental health help-seeking among African American youth and their families: A systematic review study. *Children and Youth Services Review*, *101*, 190-200.

PlushCare. (2022, November 18). *How accurate is mental health advice on TikTok?*. Quality Online Doctor & Telehealth Medical Provider. https://plushcare.com/blog/tiktok-mental-health/

Pretorius, C., Chambers, D., & Coyle, D. (2019). Young people's online help-seeking and mental health difficulties: Systematic narrative review. *Journal of Medical Internet Research, 21*(11). https://doi.org/10.2196/13873

Pretorius, C., & Coyle, D. (2021). Young people's use of digital tools to support their mental health during COVID-19 restrictions. *Frontiers in Digital Health*, *3*, https://doi.org/10.3389/fdgth.2021.763876.

Primack, B. A., & Escobar-Viera, C. G. (2017). Social media as it interfaces with psychosocial development and mental illness in transitional age youth. *Child and Adolescent Psychiatric Clinics*, *26*(2), 217-233.

Primack, B. A., Shensa, A., Sidani, J. E., Whaite, E. O., Lin, L., Rosen, D., Colditz, J.B., Radovic, A., Miller, E. (2017). Social media use and perceived social isolation among young adults in the U.S. *American Journal of Preventive Medicine*, *53*(1), 1-8.

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28-48.

Rickwood, D., & Thomas, K. (2022). Conceptual measurement framework for help-seeking for mental health problems. *Psychology Research and Behavior Management*, *5*, 173–183. https://doi.org/10.2147/prbm

Rickwood, D., Deane, F., Wilson, C. & Ciarrochi, J.V. (2005) Young people's help-seeking for mental health problems. *Australian E-Journal for the Advancement of Mental Health,* 4(3), 218-251, DOI: 10.5172/jamh.4.3.218

Roberston, L., Twenge, J. M., Joiner, T. E., & Cummins, K. (2022). Associations between screen time and internalizing disorder diagnoses among 9-to 10-year-olds. *Journal of Affective Disorders*, *311*, 530-537.

Russell, S. T., & Fish, J. N. (2016). Mental health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth. *Annual Review of Clinical Psychology*, *12*, 465–487. https://doi.org/10.1146/annurev-clinpsy-021815-093153

Saunders, S. M., Resnick, M. D., Hoberman, H. M., & Blum, R. W. (1994). Formal help-seeking behavior of adolescents identifying themselves as having mental health problems. *Journal of the American Academy of Child & Adolescent Psychiatry*, *33*(5), 718-728.

Selkie, E., Adkins, V., Masters E., Bajpai, A., & Shumer, D. (2020, March). Transgender adolescents' uses of social media for social support*. The Journal of Adolescent Health: Official publication of the Society for Adolescent Medicine.* https://pubmed.ncbi.nlm.nih.gov/31690534/

Shensa, A., Escobar-Viera, C. G., Sidani, J. E., Bowman, N. D., Marshal, M. P., & Primack, B. A. (2017). Problematic social media use and depressive symptoms among US young adults: A nationally-representative study. *Social Science & Medicine*, *182*, 150-157.

Twenge, J. M., Haidt, J., Blake, A. B., McAllister, C., Lemon, H., & Le Roy, A. (2021). Worldwide increases in adolescent loneliness. *Journal of Adolescence*, *93*, 257-269.

Upreti, R., & Chawla, A. (2023). Social Development: An iimportant aspect for adolescence. *Indian Journal of Positive Psychology*, 14(2), 249-251.

Weigle, P. (2023). Psychoeducation or psychiatric contagion? Social media and self-diagnosis. *Psychiatric Times*, 40(05), 14–15.

Complex Trauma and Attachment Patterns Associated with Maladaptive Development in Adulthood: A Review of Literature

Tony Michael
Corrin Brown
Tennessee Tech University

Complex trauma is a fundamental concept in understanding the perspectives responsible for advocating for increased specificity in the diagnosis and treatment of individuals with extensive developmental trauma. Chronic, prolonged trauma is often associated with interpersonal victimization to the extent that individuals are subjected to various forms of child maltreatment perpetrated by primary caregivers over a long period of time. Within this review, representations of complex trauma and research regarding adverse childhood experiences (ACEs) will be addressed to explain further variances in complex traumatic exposure and its impact on attachment. Furthermore, complex trauma histories and insecure attachment patterns will be evaluated as they relate to various domains of maladaptive development in adulthood (i.e., interpersonal functioning, mental health, personality, and suicidality). Implications for mental health professionals will be discussed regarding diagnostic considerations, effective treatment, and clinical application to general populations, with special acknowledgment given to trauma-informed care and attachment-based interventions.

Complex trauma is defined as “the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature" (van der Kolk, 2005, p. 401). Complex trauma is most often affiliated with recurrent interpersonal victimization occurring in childhood. It is further conceptualized by the proposed diagnoses of complex posttraumatic stress disorder (C-PTSD) and developmental trauma disorder (DTD), neither of which are formally recognized by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013). Herman (1992) proposed that C-PTSD is a variant of PTSD with notable differences in depth of traumatic exposure and interpersonal victimization. According to the DSM-5, PTSD is considered a viable diagnosis if the individual has been exposed to actual or threatened death, serious injury, or sexual violence with little changes made to the criterion applicable to children being evaluated for posttraumatic stress (American Psychiatric Association, 2013). However, the proposal of C-PTSD illustrates the long-lasting effects of prolonged interpersonal victimization and maltreatment extending beyond a single trauma incident. By acknowledging the gap in adequate diagnosis of complex trauma in childhood, developmental trauma disorder (DTD)

was proposed as an addition to the DSM-5 targeting the unique effects of complex trauma occurring in early childhood during a critical point in development (van der Kolk, 2005; van der Kolk & Pynoos, 2009). The following criterion characterizes DTD: presentation of chronic, prolonged trauma associated with exposure to developmentally adverse interpersonal trauma, repeated dysregulation in response to trauma cues (i.e., affective, somatic, behavioral, cognitive, relational, and self-attribution), persistent alteration of attributions (self and others), and functional impairment overall.

Herman (1992) proposed that the uniqueness of C-PTSD is related to the element of an individual being subjected to coercive control where they cannot flee the unrelenting trauma. The perspective of this paper falls between the continued justification and inclusion of C-PTSD and DTD as formally recognizable diagnoses which target the unique implications of trauma on attachment security. In addition, acknowledging occurrences of complex trauma in the general population could aid in understanding various presentations and consequences on development and interpersonal functioning (i.e., desire or capacity to maintain healthy relationships) given histories of childhood adversity. This review aims to explore representations of complex trauma and their overall influence on attachment security throughout development. Overall trauma exposure and insecure attachment patterns will be evaluated as they relate to various domains of maladaptive development in adulthood, including sustained interpersonal functioning, mental health, personality characteristics, and suicidality. Research regarding adverse childhood experiences (ACEs) will be discussed to further identify variants of complex traumatic exposure, specifically extending the definition of complex trauma beyond maltreatment to other experiences of household dysfunction and impaired caregiving.

Representations of Complex Trauma: Lens of Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) are defined as potentially traumatic events that occur in childhood and include early exposure to violence, abuse, and neglect which can often be accompanied by experiences of household dysfunction (i.e., witnessing domestic violence, family mental illness, and substance abuse) (Felitti et al., 1998). For this review, complex trauma will be discussed through the lens of adverse childhood experiences (ACEs) as research has communicated their value in evaluating negative outcomes (i.e., health, behavioral, etc.) later in life (Felitti et al., 1998; Hughes et al., 2017; Merrick et al., 2019). Researchers have paid special attention to the risk associated with those who report experiencing four or more ACEs contributing to ACE risks for future generations (i.e., violence, mental illness, and substance use) (Hughes et al., 2017). Merrick et al. (2019) found that 60% of a nationally representative U.S. sample reported exposure to at least one ACE, with over 24% reporting exposure to three or more before adulthood. Within this sample, emotional abuse was most prevalent at 34.42%, followed by parental separation (27.63%) and household substance use (27.56%). In a systematic review conducted from 1980-2010 analyzing the prevalence of interpersonal trauma and trauma-related disorders in a population characterized as having a severe mental illness (i.e., schizophrenia, borderline personality disorder), results indicated a higher prevalence of physical abuse (47%), sexual abuse (37%), and posttraumatic stress (30%) compared to general population samples

characterized by lower rates of trauma exposure with bipolar and depressive symptomatology (Mauritz et al., 2013). Overall, patterns of child maltreatment are common, with further acknowledgment given to populations with complex trauma histories and the impact on psychological functioning accompanied by clinical significance and impairment.

Regarding instances of household dysfunction, research has further discussed the implications of disengaged parenting as contributing not only to more instances of child maltreatment by nature but also due to its specific impact on attachment insecurity overall (Briere et al., 2017). Exposure to impaired caregiving, in combination with instances of physical and psychological maltreatment, could have a strong impact on attachment development. Specifically, Tedgård (2019) found that children exposed to pervasive parental substance use (i.e., impaired caregiving) often presented with the parentified style of attachment characterized by the children adopting a parenting role themselves, especially in cases of taking care of their siblings—further evaluation and research is needed regarding the parentified attachment style and its impact on psychosocial functioning. For this review, parentified attachment will not be thoroughly discussed; however, its developmental relevance does not go unnoticed. The link between interpersonal victimization and attachment adversity continues to be explored to capture best the long-term effects of pervasive exposure to violence and impaired caregiving (Spinazzola et al., 2018). Individuals exposed to high rates of interpersonal victimization and attachment adversity were shown to present with multiple symptoms associated with developmental trauma disorder (DTD).

In considering exposure to adverse events regardless of nature and traumatic impact, the age of onset is important. Research has shown that early exposure to trauma is linked with various negative outcomes, including psychological and psychosocial functioning as well as subsequent psychopathology (i.e., increased risk for depression and PTSD-related symptomatology) compared to individuals exposed to trauma later in life (McCutcheon et al., 2010; Ogle et al., 2013; Dunn et al., 2017). A study comparing samples of individuals with reported histories of sexual abuse concluded that those who experienced sexual trauma earlier in life presented with a variety of concerns associated with cognitive and emotional dysregulation, identity, self-destructive behavior, and interpersonal functioning (i.e., social avoidance) compared to groups with later victimization (Wonderlich et al., 2001). The main focus of this review is to highlight the detrimental impact of interpersonal trauma occurring during critical developmental periods associated with healthy attachment development and later optimal functioning.

Impact on Attachment Security

Secure vs. Insecure Attachment Styles

Attachment theory is based upon the understanding of an individual "seeking and maintaining proximity to another individual," most often an individual's mother, by which a “lasting psychological connectedness” is formed (Bowlby, 1969; Ainsworth & Bell, 1970). One's attachment to their mother is often fully represented in a child's behavior. Research has continually aimed to connect threats to such attachment, which could result in lasting problematic behavior throughout one's development. Secure attachment is characterized by

children having their needs met by caregivers with confidence in their ability to explore and accept comfort when in distress (Ainsworth et al., 1971; Ainsworth et al., 1978). Ainsworth found that securely attached children were most often represented in her samples assessing the interactions of caregivers with their children via The Strange Situation. Patterns of attachment insecurity are characterized by atypical interactions with caregivers by either showing limited attention during exploration (i.e., avoidant attachment) or too much attention to their caregiver, which negatively impacts their ability to explore their environment (i.e., ambivalent/resistant attachment).

In reviewing similar patterns in foundational research, a large nationally representative sample of American adults was found to exhibit a higher prevalence of secure attachment, with 35% reporting characteristics associated with anxious/ambivalent and avoidant attachment styles (Mickelson, 1997). Children with ambivalent attachment styles display an unquenchable desire for dependency but find it difficult to accept comfort from their caregiver due to their overall acclimation to responsiveness inconsistency (Ainsworth & Bell, 1970). Furthermore, avoidant attachment shows increased independence due to their acclimation to a caregiver that is either unresponsive or actively rejects their needs. It was concluded that the prevalence of insecure attachment was often exacerbated by childhood adversity and interpersonal trauma.

In evaluating the lasting effects of insecure attachment extending from childhood relationships, research has further categorized patterns of attachment based on one's view of self and expectations regarding relationships with others (Bartholomew, 1990; Bartholomew & Horowitz, 1991). Bartholomew (1990) identified a four-group attachment model compromised of secure, preoccupied, dismissive, and fearful forms of attachment. Secure attachment is characterized by increased comfort in relationships while maintaining an increased sense of autonomy and a positive self-view. In addition, an individual's positive self-perception is accompanied by a positive view of others and a desire to maintain healthy relationships. Preoccupied attachment is distinguished by a fixation on relationships with others, evidenced by a negative view of self while prioritizing the assumed desires of others. An individual with a preoccupied attachment will present with an increased desire to gain approval from others, likely associated with the same desire often exacerbated by one's parents maintaining inconsistency and insensitivity in parenting style. Dismissive attachment is characterized by decreased need or desire to maintain relationships due to a positive view or priority of the self. Individuals with dismissive attachment styles can be described as denying the need for social contact due to likely active rejection by caregivers experienced in childhood. Lastly, fearful attachment is characterized as one fearing intimacy and relationships while maintaining a sense of avoidance from others despite an internal desire for social connectedness.

Implications of Insecure Attachment: Internal Working Model

Initially proposed by Bowlby (1969), the concept of the “internal working model” is best described as the phenomenon of early attachment experiences becoming the framework for an individual’s knowledge of self and others in the context of relationships and the belief that attachment figures are available, responsive, and helpful (Bowlby, 1980). Internal working models of attachment can be further

defined as a system of cognitive, emotional, and behavioral responses associated with how individuals perceive and respond to social stimuli and seek out experiences with others to meet their needs (Collins & Allard, 2001). Individuals can then collect their relational experiences and construct a sense of meaning and framework for how they proceed with future interpersonal experiences. Each individual has a unique history or set of circumstances that contribute to developing their internal working model of attachment. It would be difficult to explain the complexity of internal working models without understanding the depth of experiences that relate to attachment and interpersonal relationships across one's development (Collins & Allard, 2001). Mirroring the foundational understanding that an individual's attachment is highly contingent upon their relationship with their mother, Guarnieri (2015) found that one's sense of life satisfaction and secure attachment to others (specifically romantic partners) was based on having a secure attachment to their mother. In other words, attachment to maternal figures in early development creates a strong foundation for a sense of autonomy and the ability to achieve close bonds with others throughout life. Within this review, threats to this internal working model are present in cases of individuals with histories of maltreatment and complex trauma (Roazzi et al., 2016). Specifically, cumulative trauma negatively impacts the sense of self-efficacy and general ability to develop social skills to maintain relationships effectively. As Bartholomew (1990) discussed, individuals, can develop negative perceptions of self and others, which translates into a sense of relational hopelessness and external locus of control.

Complex Trauma as Threat to Secure Attachment

Research has shown that individuals who are subjected to adverse childhood experiences are more likely to present with characteristics of insecure attachment in adulthood and struggle with competencies associated with social connection and maintaining healthy relationships (Frederick & Goddard, 2008; Doyle & Cicchetti, 2017). Adults with histories of childhood neglect and physical abuse often present with higher levels of attachment anxiety (Widom et al., 2018). Interestingly, having a history of neglect is associated with anxious and avoidant attachment in adulthood. Both anxious and avoidant attachment styles predicted mental health outcomes associated with higher anxiety and depression and low self-esteem. Furthermore, instances of abuse (i.e., physical, emotional, sexual) and neglect (i.e., physical and emotional) have been linked to preoccupied, fearful, and dismissing attachment styles, with such histories showing a negative association to secure attachment (Erozkan, 2016).

In a study evaluating the role of poor parenting, child abuse, and attachment in dating violence perpetration in college students, Tussey et al. (2018) discovered correlates associated with attachment anxiety (i.e., child physical abuse and witnessing domestic violence) and attachment-avoidant behavior (i.e., increased child physical abuse). Individuals who reported poor maternal relationship quality displayed patterns consistent with both anxious and avoidant styles of attachment, with gender differences noted in females reporting lower attachment avoidance than males in addition to females being more likely to perpetrate dating violence (i.e., higher attachment anxiety associated with actions that are consistent with the fear of losing significant other or feelings of rejection) (Tussey et al., 2018). Murphy et al. (2014) further identified that as ACE scores increased in the absence of emotional support, female adults were more likely to be

classified as having an unresolved attachment, or their attachment could not be classified overall. Regarding ACEs consistent with occurrences of household dysfunction, researchers have found that young children with incarcerated fathers displayed patterns of extreme distress, especially for those who witnessed their father's crime (27%) or witnessed their arrest (22%) (Poehlmann-Tynan et al., 2017). Children who witnessed these events were more likely to have insecure attachments to their caregivers, especially when sensitivity and responsiveness to such distress were absent.

In evaluating the stability of attachment styles over time, Waters et al. (2000) contacted 50 participants two decades after participation in the Ainsworth Strange Situation Study (1978) and evaluated changes in attachment classification based on the presence of negative life events (i.e., loss of parents, parental divorce, life-threatening illness, parental psychiatric disorder, physical and sexual abuse by family members). Participants who reported a history of one or more stressful life events were 66.6% more likely to move from the secure infant attachment classification to insecure attachment in early adulthood, with no changes displayed in participants who were already classified as insecurely attached in infancy. Overall, this relationship between attachment and stressful life events can be complicated as participants could change attachment classification regardless of previous classification during infancy or the presence of stressful life events. However, this relationship can still be influenced throughout development, given the level of adversity experienced. Exposure to complex trauma and interpersonal victimization would likely challenge one's attachment model and negatively impact their ability and confidence to pursue future relationships when past experiences have resulted in direct harm or lack of responsiveness to the needs presented.

Maladaptive Development in Adulthood

Interpersonal Functioning

Research has shown significant associations between ACE scores and later interpersonal difficulty mediated by emotional dysregulation, with cumulative ACEs predicting stronger deficits in interpersonal functioning (Poole et al., 2018). Childhood adversity has been previously linked to individuals having smaller social networks and feeling more emotionally isolated from others. Past experiences of emotional neglect and parental intimidation lead to the highest rates of later neuroticism (Wilson et al., 2006). Furthermore, Allen and Lauterbach (2007) found that interpersonal dependency is most often in individuals with prolonged, complex trauma compared to individuals with single-incident trauma histories or those with no trauma history. In relating these findings to attachment style, Bistricky et al. (2017) found that higher interpersonal trauma is linked with avoidant attachment, lower self-compassion, and lower interpersonal competence overall. This constellation of psychosocial findings was also significantly associated with greater posttraumatic stress symptomatology. The assumption for treatment consists of targeting attachment with acknowledgment of compassion to counteract the presence of posttraumatic symptoms.

Mental Health

Emotional abuse is a prominent correlate with negative mental health outcomes (Edwards et al., 2003; Chapman et al., 2004; Mandelli et al., 2015). In addition, experiencing multiple forms of abuse or household dysfunction can negatively impact adult mental health. Furthermore, patterns regarding types of victimization have surfaced associated with the later presence of mood or anxiety disorders (i.e., emotional abuse) and characteristics of disordered personality (i.e., physical neglect) (Carr et al., 2013). Higher incidents of past child maltreatment, especially in combination with emotional abuse, were significantly associated with a higher prevalence of depression and anxiety in adulthood (Edwards et al., 2003; Mandelli et al., 2015). Similarly, experiences of child maltreatment (i.e., emotional abuse) predicted insecure adult attachment in a sample of college students, evidenced by potential issues associated with emotional regulation, self-perception, and overall capacity for adult attachments (Riggs, 2010; Riggs & Kaminski, 2010).

In a sample of 349 clinically depressed adults, 75.6% reported a history of trauma, with 37% experiencing more than one form of trauma, which led to more severe depressive presentations (Negele et al., 2015). Within this sample, emotional abuse was reported most frequently, with many participants sharing histories of sexual abuse. In a nationally representative English sample of adults (n = 3885), 46.4% of individuals suffered at least one ACE, with 8.3% experiencing four or more (Hughes et al., 2016). Further evaluation of life satisfaction and overall mental well-being showed that as ACEs increased, there were presentations of low life satisfaction and low mental well-being. In addition, those with lower mental well-being communicated feeling frequently disconnected from others. Lastly, mental well-being was most strongly associated with individual histories of household dysfunction and sexual abuse. Patterns of child maltreatment arise regarding types of victimization and experiences related to emotional dysregulation or abuse share the strongest link to severity of later psychopathology (i.e., depression and posttraumatic stress) in adulthood mediated by insecure attachment (Greeson et al., 2011; Schierholz et al., 2016).

Personality

Research has shown positive associations between a history of trauma exposure and maladaptive personality development (Granieri et al., 2018; Gander, 2020). Childhood traumatic exposure of an emotional nature appears to maintain the strongest association with maladaptive personality characteristics consistent with harm avoidance and other-directedness (i.e., external locus of control) (de Carvalho et al., 2014). Maladaptive personality development, described by Daud et al. (2008), appears strongly connected to early trauma exposure as individuals become overwhelmed with childhood trauma's cognitive, affective, and behavioral vulnerabilities. The consequences of complex trauma often consist of internalizing and externalizing symptoms. Individuals with certain forms of child maltreatment (i.e., physical abuse) often present with externalizing symptoms most frequently evidenced by antisocial behavior (Dargis et al., 2016).

Furthermore, childhood adversity (i.e., child maltreatment and household dysfunction) has been shown to predict socially prescribed displays of perfectionism and a tendency to hide imperfection in the company of others (Chen et al., 2019). In a sample of

adults diagnosed with varying personality disorders, higher levels of childhood trauma were positively associated with severe deficits in attachment functioning, with patterns of fearful and dismissive attachment styles represented most frequently (Voestermans et al., 2020). In addition, accounts of diminished parental bonding were associated with a higher prevalence of traumatic childhood exposure.

Suicidality

Trauma often leaves individuals with negative cognitions about the world and themselves and a sense of self-blame (Whiteman et al., 2019). Instances of child maltreatment (i.e., sexual abuse, physical abuse, and emotional abuse) have been previously associated with increased risk of suicide attempts and occurrences of suicidal ideation in adulthood, with complex exposure to childhood abuse being closely related to particularly high risk for suicide attempts in adults (LeBouthillier et al., 2015; Angelakis et al., 2019). Davis et al. (2014) found that undergraduate students reporting the presence of PTSD-related symptomatology, particularly the presence of the "detachment/estrangement from others" criterion, were identified as being at higher risk for suicidality. Younger populations that show similar patterns of childhood adversity (i.e., maltreatment, violence, loss, intra-familial, and interpersonal issues) are also associated with higher reports of suicidal ideation and attempts (Serafini et al., 2015). However, Serafini noted further the need to evaluate the specific impact of different types of maltreatment on suicidality, as sexual abuse appeared to display the most consistent connection with suicidal behavior in younger populations. Research has shown that young adults whose immediate family abused them were at the highest risk for suicide (i.e., childhood physical abuse, contact sexual abuse, or both) (Brezo et al., 2008). Increased suicide risk has been previously associated with insecure attachment (i.e., anxious attachment) and unresolved trauma (Miniati et al., 2017). Overall, it appears that trauma exposure could be related to increased suicidality. However, special consideration must be given to populations with complex trauma histories or those who have suffered from direct interpersonal victimization (i.e., sexual abuse).

Implications for Mental Health Professionals

Diagnostic Considerations

Diagnostic considerations for populations with increased occurrences of interpersonal trauma must be addressed as research gaps exist regarding the empirical justification for developmentally appropriate diagnoses. Thorough screening methods for individuals with complex trauma histories would promote continued awareness of the influence of early interpersonal traumatic exposure on psychosocial development, including attachment style and later interpersonal capability. Compared to individuals with non-family-based trauma, individuals with family-based traumatic events continue to represent populations at the highest risk for poor social-emotional health (Campbell et al., 2016). Considerations of complex trauma and its representation in the diagnosis of developmental trauma disorder (DTD) continue to view these prolonged traumatic experiences through a lens of attachment which importance given to the integration of trauma and attachment-based perspective regarding treatment (Rahim, 2014). In addition, Rahim notes that awareness of complex trauma and attachment implications can still be reflected in the treatment of individuals with extensive trauma histories, and it is up to the professional's

discretion as to how they will implement this perspective with clients without a clear ability to diagnosis complex trauma seamlessly as C-PTSD or DTD.

Effective Treatment

In comparing individuals who present with trauma-related disorders versus those with disordered personalities, researchers have found that maybe they are not so different (Wildschut et al., 2018). This review aimed to evaluate the patterns of complex trauma and insecure attachment on adult maladaptive development, and this impact does not stop at general mental well-being. As discussed throughout this paper, the impact of complex trauma, especially acknowledging the interpersonal nature of victimization and associated consequences on attachment functioning, is associated with personality maldevelopment. Therefore, treatment approaches for individuals with complex trauma must include trauma-informed care and interventions specifically created to promote secure, healthy attachment. In addition, more than ever before, therapeutic alliance, rapport, and continued boundary maintenance are most important in counseling (Pearlman & Courtois, 2005). Essentially, through counseling, the therapeutic relationship can become a new representation of secure attachment and safety from which the client can make changes regarding interpersonal skills and confidence in seeking future relationships.

Furthermore, targets in treating individuals with complex trauma histories often include cognitive-behavioral interventions and promoting emotional regulation skills (Karatzias et al., 2018). Often these individuals would present with negative trauma-related cognitions relating to self-perception and attachment anxiety relating to fear of interpersonal rejection or abandonment by those around them. Lastly, Marshall et al. (2020) addressed the importance of urgency in treating children and youth with interpersonal trauma.

Conclusion

Overall, this review aimed to evaluate representations of complex trauma and research regarding adverse childhood experiences (ACEs) as variances in complex traumatic exposure and their impact on attachment. It is believed that complex trauma histories and insecure attachment patterns are associated with various domains of maladaptive development in adulthood (i.e., interpersonal functioning, mental health, personality, and suicidality). Again, special acknowledgment is given to the influence of interpersonal trauma on psychosocial functioning compared to experiences of single-event, non-familial forms of trauma exposure. Implications for mental health practitioners will continue to consist of tailored treatment objectives and treatment models that best accommodate clients with complex trauma histories. Furthermore, future research regarding the impact of various ACEs on attachment security as it relates to adult maladaptive development would be worthwhile.

References

Ainsworth, M. D. S., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development, 41*, 49–67.

Ainsworth, M. D. S., Bell, S. M., & Stayton, D. J. (1971). Individual differences in strange-situation behavior of one-year-olds. In H. R. Schaffer (Ed.) *The origins of human social relations*. London and New York: Academic Press. pp. 17–58.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Allen, B., & Lauterbach, D. (2007). Personality characteristics of adult survivors of childhood trauma. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, *20*(4), 587-595. https://doi.org/10.1002/jts.20195.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

Angelakis, I., Gillespie, E. L., & Panagioti, M. (2019). Childhood maltreatment and adult suicidality: a comprehensive systematic review with meta-analysis. *Psychological medicine*, *49*(7), 1057-1078. https://doi.org/10.1017/S0033291718003823.

Bartholomew, K. (1990). Avoidance of intimacy: An attachment perspective. *Journal of Social and Personal Relationships*, *7*(2), 147–178. https://doi.org/10.1177/0265407590072001.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: a test of a four-category model. *Journal of personality and social psychology*, *61*(2), 226.

Bistricky, S. L., Gallagher, M. W., Roberts, C. M., Ferris, L., Gonzalez, A. J., & Wetterneck, C. T. (2017). Frequency of interpersonal trauma types, avoidant attachment, self-compassion, and interpersonal competence: A model of persisting posttraumatic symptoms. *Journal of Aggression, Maltreatment & Trauma*, *26*(6), 608–625. http://dx.doi.org/10.1080/10926771.2017.1322657.

Brezo, J., Paris, J., Vitaro, F., Hebert, M., Tremblay, R. E., & Turecki, G. (2008). Predicting suicide attempts in young adults with histories of childhood abuse. *The British Journal of Psychiatry*, *193*(2), 134-139. https://doi.org/10.1192/bjp.bp.107.037994.

Briere, J., Runtz, M., Eadie, E., Bigras, N., & Godbout, N. (2017). Disengaged parenting: Structural equation modeling with child abuse, insecure attachment, and adult symptomatology. *Child abuse & neglect*, *67*, 260-270. http://dx.doi.org/10.1016/j.chiabu.2017.02.036.

Bowlby, J. (1969). *Attachment. Attachment and loss: Vol. 1. Loss*. New York: Basic Books.

Bowlby, J. (1980). *Loss: Sadness & depression. Attachment and loss (vol. 3); (International psycho-analytical library no.109)*. London: Hogarth Press.

Campbell, C., Roberts, Y., Synder, F., Papp, J., Strambler, M., & Crusto, C. (2016). The assessment of early trauma exposure on social-emotional health of young children. *Children and Youth Services Review*, *71*, 308–314. http://dx.doi.org/10.1016/j.childyouth.2016.11.004.

Carr, C. P., Martins, C. M. S., Stingel, A. M., Lemgruber, V. B., & Juruena, M. F. (2013). The role of early life stress in adult psychiatric disorders: a systematic review according to childhood trauma subtypes. *The Journal of Nervous and Mental Disease*, *201*(12), 1007-1020. https://doi.org/10.1097/NMD.0000000000000049.

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders*, *82*(2), 217–225. https://doi.org/10.1016/j.jad.2003.12.013.

Chen, C., Hewitt, P. L., & Flett, G. L. (2019). Adverse childhood experiences and multidimensional perfectionism in young adults. *Personality and Individual Differences*, *146*, 53-57. https://doi.org/10.1016/j.paid.2019.03.042.

Collins, N. L., & Allard, L. M. (2001). Cognitive representations of attachment: The content and function of working models. *Blackwell handbook of social psychology: Interpersonal processes*, *2*, 60–85.

Dargis, M., Newman, J., & Koenigs, M. (2016). Clarifying the link between childhood abuse history and psychopathic traits in adult criminal offenders. *Personality Disorders: Theory, Research, and Treatment*, *7*(3), 221. https://doi.org/10.1037/per0000147.

Daud, A., Klinteberg, B. A., & Rydelius, P. A. (2008). Trauma, PTSD and personality: the relationship between prolonged traumatization and personality impairments. *Scandinavian journal of caring sciences*, *22*(3), 331-340. https://doi.org/10.1111/j.1471-6712.2007.00532.x.

Davis, M. T., Witte, T. K., & Weathers, F. W. (2014). Posttraumatic stress disorder and suicidal ideation: The role of specific symptoms within the framework of the interpersonal-psychological theory of suicide. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(6), 610. http://dx.doi.org/10.1037/a0033941.

de Carvalho, H. W., Pereira, R., Frozi, J., Bisol, L. W., Ottoni, G. L., & Lara, D. R. (2015). Childhood trauma is associated with maladaptive personality traits. *Child abuse & neglect*, *44*, 18-25. http://dx.doi.org/10.1016/j.chiabu.2014.10.013.

Doyle, C., & Cicchetti, D. (2017). From the cradle to the grave: The effect of adverse caregiving environments on attachment and relationships throughout the lifespan. *Clinical Psychology: Science and Practice*, *24*(2), 203-217. https://doi.org/10.1111/cpsp.12192.

Dunn, E. C., Nishimi, K., Powers, A., & Bradley, B. (2017). Is developmental timing of trauma exposure associated with depressive and posttraumatic stress disorder symptoms in adulthood? *Journal of psychiatric research*, *84*, 119–127.

Edwards, V. J., Holden, G. W., Felitti, V. J., & Anda, R. F. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: results from the adverse childhood experiences study. *American Journal of Psychiatry*, *160*(8), 1453–1460.

Erozkan, A. (2016). The Link between Types of Attachment and Childhood Trauma. *Universal journal of educational research*, *4*(5), 1071–1079. https://doi.org/10.13189/ujer.2016.040517.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *14*(4), 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8.

Frederick, J., & Goddard, C. (2008). Living on an island: Consequences of childhood abuse, attachment disruption and adversity in later life. *Child & Family Social Work*, *13*(3), 300–310. https://doi.org/10.1111/j.1365-2206.2008.00554.

Gander, M., Buchheim, A., Bock, A., Steppan, M., Sevecke, K., & Goth, K. (2020). Unresolved attachment mediates the relationship between childhood trauma and impaired personality functioning in adolescence. *Journal of personality disorders*, 1-20.

Granieri, A., Guglielmucci, F., Costanzo, A., Caretti, V., & Schimmenti, A. (2018). Trauma-related dissociation is linked with maladaptive personality functioning. *Frontiers in psychiatry*, *9*, 206. https://doi.org/10.3389/fpsyt.2018.00206.

Greeson, J. K., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake III, G. S., Ko, S. J., ... & Fairbank, J. A. (2011). Complex trauma and mental health in children and adolescents placed in foster care: Findings from the National Child Traumatic Stress Network. *Child welfare*, *90*(6), 91.

Guarnieri, S., Smorti, M., & Tani, F. (2015). Attachment relationships and life satisfaction during emerging adulthood. *Social Indicators Research*, *121*(3), 833-847. https://doi.org/10.1007/s11205-014-0655-1.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of traumatic stress*, *5*(3), 377-391.

Hughes, K., Lowey, H., Quigg, Z., & Bellis, M. A. (2016). Relationships between adverse childhood experiences and adult mental well-being: results from an English national household survey. *BMC public health*, *16*(1), 222. https://doi.org/10.1186/s12889-016-2906-3.

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet Public Health*, *2*(8), e356-e366. https://doi.org/10.1016/S2468-2667(17)30118-4.

Karatzias, T., Shevlin, M., Hyland, P., Brewin, C. R., Cloitre, M., Bradley, A., ... & Roberts, N. P. (2018). The role of negative cognitions, emotion regulation strategies, and attachment style in complex posttraumatic stress disorder: Implications for new and existing therapies. *British Journal of Clinical Psychology*, *57*(2), 177-185. https://doi.org/10.1111/bjc.12172.

LeBouthillier, D. M., McMillan, K. A., Thibodeau, M. A., & Asmundson, G. J. (2015). Types and number of traumas associated with suicidal ideation and suicide attempts in PTSD: Findings from a US nationally representative sample. *Journal of Traumatic Stress*, *28*(3), 183-190. https://doi.org/10.1002/jts.22010.

Mandelli, L., Petrelli, C., & Serretti, A. (2015). The role of specific early trauma in adult depression: a meta-analysis of published literature. Childhood trauma and adult depression. *European Psychiatry*, *30*(6), 665-680. http://dx.doi.org/10.1016/j.eurpsy.2015.04.007.

Marshall, C., Semovski, V., & Stewart, S. L. (2020). Exposure to childhood interpersonal trauma and mental health service urgency. *Child Abuse & Neglect*, *106*, 104464. https://doi.org/10.1016/j.chiabu.2020.104464.

Mauritz, M. W., Goossens, P. J., Draijer, N., & Van Achterberg, T. (2013). Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology*, *4*(1), 19985. https://doi.org/10.3402/ejpt.v4i0.19985.

McCutcheon, V. V., Sartor, C. E., Pommer, N. E., Bucholz, K. K., Nelson, E. C., Madden, P. A., & Heath, A. C. (2010). Age at trauma exposure and PTSD risk in young adult women. *Journal of Traumatic Stress*, *23*(6), 811–814. https://doi.org/10.1002/jts.20577.

Merrick, M. T., Ford, D. C., Ports, K. A., Guinn, A. S., Chen, J., Klevens, J., Metzler, M. M., Jones, C. M., Simon, T. R., Daniel, V. M., Ottley, P., & Mercy, J. A. (2019). Vital signs: Estimated proportion of adult health problems attributable to adverse childhood experiences and implications for prevention—25 States, 2015–2017. *Morbidity and Mortality Weekly Report*, *68*(44), 999. https://doi.org/10.15585/mmwr.mm6844e1.

Mickelson, K. D., Kessler, R. C., & Shaver, P. R. (1997). Adult attachment in a nationally representative sample. *Journal of personality and social psychology*, *73*(5), 1092.

Miniati, M., Callari, A., & Pini, S. (2017). Adult attachment style and suicidality. *Psychiatria Danubina*, *29*(3), 250-259. https://doi.org/10.24869/psyd.2017.250.

Murphy, A., Steele, M., Dube, S. R., Bate, J., Bonuck, K., Meissner, P., Goldman, H., & Steele, H. (2014). Adverse childhood experiences (ACEs) questionnaire and adult attachment interview (AAI): Implications for parent child relationships. *Child abuse & neglect*, *38*(2), 224–233. http://dx.doi.org/10.1016/j.chiabu.2013.09.004.

Negele, A., Kaufhold, J., Kallenbach, L., & Leuzinger-Bohleber, M. (2015). Childhood trauma and its relation to chronic depression in adulthood. *Depression research and treatment*. http://dx.doi.org/10.1155/2015/650804.

Ogle, C. M., Rubin, D. C., & Siegler, I. C. (2013). The impact of the developmental timing of trauma exposure on PTSD symptoms and psychosocial functioning among older adults. *Developmental psychology*, *49*(11), 2191. https://doi.org/10.1037/a0031985.

Pearlman, L. A., & Courtois, C. A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, *18*(5), 449-459. https://doi.org/10.1002/jts.20052.

Poehlmann-Tynan, J., Burnson, C., Runion, H., & Weymouth, L. A. (2017). Attachment in young children with incarcerated fathers. *Development and Psychopathology*, *29*(2), 389. https://doi.org/10.1017/S0954579417000062.

Poole, J. C., Dobson, K. S., & Pusch, D. (2018). Do adverse childhood experiences predict adult interpersonal difficulties? The role of emotion dysregulation. *Child abuse & neglect*, *80*, 123-133. https://doi.org/10.1016/j.chiabu.2018.03.006.

Rahim, M. (2014). Developmental trauma disorder: An attachment-based perspective. *Clinical Child Psychology and Psychiatry*, *19*(4), 548–560. https://doi.org/10.1177/1359104514534947.

Riggs, S. A. (2010). Childhood emotional abuse and the attachment system across the life cycle: What theory and research tell us. *Journal of Aggression, Maltreatment & Trauma*, *19*(1), 5–51. https://doi.org/10.1080/10926770903475968.

Riggs, S. A., & Kaminski, P. (2010). Childhood emotional abuse, adult attachment, and depression as predictors of relational adjustment and psychological aggression. *Journal of aggression, maltreatment & trauma*, *19*(1), 75–104. https://doi.org/10.1080/10926770903475976.

Roazzi, A., Attili, G., Di Pentima, L., & Toni, A. (2016). Locus of control in maltreated children: the impact of attachment and cumulative trauma. *Psicologia: Reflexão e Crítica*, *29*(1), 1-11. https://doi.org/10.1186/s41155-016-0025-9.

Schierholz, A., Krüger, A., Barenbrügge, J., & Ehring, T. (2016). What mediates the link between childhood maltreatment and depression? The role of emotion dysregulation, attachment, and attributional style. *European Journal of Psychotraumatology*, *7*(1), 32652. https://doi.org/10.3402/ejpt.v7.32652.

Serafini, G., Muzio, C., Piccinini, G., Flouri, E., Ferrigno, G., Pompili, M., ... & Amore, M. (2015). Life adversities and suicidal behavior in young individuals: a systematic review. *European child & adolescent psychiatry*, *24*(12), 1423-1446. https://doi.org/10.1007/s00787-015-0760-y.

Spinazzola, J., Van der Kolk, B., & Ford, J. D. (2018). When nowhere is safe: Interpersonal trauma and attachment adversity as antecedents of posttraumatic stress disorder and developmental trauma disorder. *Journal of traumatic stress*, *31*(5), 631-642. https://doi.org/10.1002/jts.22320.

Tedgård, E., Råstam, M., & Wirtberg, I. (2019). An upbringing with substance-abusing parents: Experiences of parentification and dysfunctional communication. *Nordic Studies on Alcohol and Drugs*, *36*(3), 223-247. https://doi.org/10.1177/1455072518814308.

Tussey, B. E., Tyler, K. A., & Simons, L. G. (2018). Poor parenting, attachment style, and dating violence perpetration among college students. *Journal of interpersonal violence*, 0886260518760017. https://doi.org/10.1177/0886260518760017.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress: Official Publication of the International Society for Traumatic Stress Studies*, *18*(5), 389-399. https://doi.org/10.1002/jts.20047.

van der Kolk, B. A., Pynoos, R. S., Cicchetti, D., Cloitre, M., D'Andrea, W., Ford, J. D., & Teicher, M. (2009). Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V. *Unpublished manuscript. Verfügbar unter: http://www. cathymalchiodi. com/dtd_nctsn. pdf (Zugriff: 20.5. 2011)*.

Voestermans, D., Eikelenboom, M., Rullmann, J., Wolters-Geerdink, M., Draijer, N., Smit, J. H., ... & van Marle, H. J. (2020). The Association Between Childhood Trauma and Attachment Functioning in Patients With Personality Disorders. *Journal of Personality Disorders*, 1-19.

Waters, E., Merrick, S., Treboux, D., Crowell, J., & Albersheim, L. (2000). Attachment security in infancy and early adulthood: A twenty-year longitudinal study. *Child development*, *71*(3), 684–689.

Whiteman, S. E., Kramer, L. B., Petri, J. M., & Weathers, F. W. (2019). Trauma type and suicidal ideation: The mediating effect of cognitive distortions. *Traumatology*. http://dx.doi.org/10.1037/trm0000192.

Widom, C. S., Czaja, S. J., Kozakowski, S. S., & Chauhan, P. (2018). Does adult attachment style mediate the relationship between childhood maltreatment and mental and physical health outcomes? *Child abuse & neglect*, *76*, 533-545. https://doi.org/10.1016/j.chiabu.2017.05.002.

Wildschut, M., Swart, S., Langeland, W., Smit, J. H., & Draijer, N. (2018). Clinical profiles of survivors of childhood trauma and neglect: Personality or trauma oriented. *Mental Health and Family Medicine Ltd*, *13*, 681–688.

Wilson, R. S., Krueger, K. R., Arnold, S. E., Barnes, L. L., de Leon, C. F. M., Bienias, J. L., & Bennett, D. A. (2006). Childhood adversity and psychosocial adjustment in old age. *The American Journal of Geriatric Psychiatry*, *14*(4), 307-315. https://doi.org/10.1097/01.JGP.0000196637.95869.d9.

Wonderlich, S. A., Crosby, R. D., Mitchell, J. E., Thompson, K., Smyth, J. M., Redlin, J., & Jones-Paxton, M. (2001). Sexual trauma and personality: Developmental vulnerability and additive effects. *Journal of Personality Disorders*, *15*(6), 496–504.

Narcotics Addiction in a Rural Upper Cumberland Tennessee Community

Sam T. Barnes
Retired Medical Doctor

Mark A. Loftis
Tennessee Tech University

Mason Hale
Belmont University

This study examined the nature of narcotics addiction in the Upper Cumberland (UC) region in middle Tennessee. Researchers aimed to investigate the narcotics addiction recovery process and potential barriers associated with recovery and treatment. Data was collected using a self-report survey completed by voluntary members of Narcotics Anonymous in the UC region. The survey contained questions about participants' demographics, exposure to narcotics, recovery process, and perceptions around narcotics availability. Survey responses were examined, and informative profiles of recovering males and females were synthesized. Barriers associated with narcotics recovery and treatment were also identified. Based on the informative profiles and barriers synthesized, findings suggest the need for further research to explore the nature of narcotics addiction as well as the nature of narcotics rehabilitation treatment approaches to determine the most effective treatments for those in the addiction recovery process.

The Narcotics Epidemic

Over the past two decades, the world has witnessed a tremendous surge in the misuse of prescription narcotics. In 2006, the International Narcotics Control Board advised that prescription medications containing narcotic or psychotropic drugs were becoming the drugs of choice for many people who use drugs. They advised that the worldwide misuse of prescription drugs could surpass illicit drug use. In 2011, the International Narcotics Control Board reported that narcotics misuse was rising rapidly with more people abusing prescription narcotics than heroin, cocaine, and ecstasy combined (Manchikanti et al., 2013). Now, prescription narcotics misuse is an evident major health concern that affects millions of people worldwide (Bipartisan Policy Center, 2019). Although much research attention has been devoted to substance misuse research across different disciplines, it seems that the globe is losing its grip on the war against drugs (Vadivelu et al., 2018).

The narcotics misuse crisis is most prevalent in the United States of America (US). The death rate from an opioid overdose in the US (which includes prescription opioids, heroin, and synthetic opioids such as Fentanyl) is now statistically more likely than death by an automobile accident. The number of deaths from opioid drug overdoses steadily rose from 2012-2017. Additionally, from 2012-2014, the percentage of overdose deaths that involved opioids increased by around two percent. In 2015, the percentage increased by nearly 10 percent and then rose at a rate of three to four percent in 2016-2017 (Bipartisan Policy Center, 2019). There were 47,096 deaths from opioid overdoses reported in 2018, and 50,178 deaths from opioid overdoses reported in 2019 continuing to show the steady increase in opioid overdose deaths across the US (National Vital Statistics System, 2024). From April 2020 to April 2021 overdose deaths in the US rose 28.5 percent to 100,306 deaths, and 75,673 of those deaths resulted from opioids (CDC, 2021b). From June 2023 to June 2024 overdose deaths have fell 16.6 percent; however, there were 87.3 percent more overdose deaths reported in June 2024 than in June 2015 (National Vital Statistics System, 2024)

This epidemic is costing the US and other countries not only a larger number of human lives but a large number of federal dollars as well. To combat the drug epidemic, the US federal government has released funding and implemented new policies and procedures to monitor drug use and prescription narcotics. In 2017, the US dedicated a total of $3.3 billion towards federal opioid funding. In 2018, funding increased by 124 percent to $7.4 billion. Appropriations were divided among the Department of Health and Human Services, Office of National Drug Control Policy, Department of Justice, Veteran Affairs, Homeland Security, and Department of Labor. The divisions that received the most funding were Health and Human Services (Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health), the Department of Justice, and Veteran Affairs (Bipartisan Policy Center, 2019).

The Narcotics Epidemic in Tennessee

During the COVID-19 pandemic, the availability of recovery meetings decreased in rural Appalachia, where recovery resources have historically been scarce (Hedrick & Clements, 2023). Recovering individuals transitioned to telehealth services during COVID-19, which proved to be a more difficult therapeutic environment for mental health professionals to maintain than presenting in person for treatment (Wilson & Brown, 2024). Telehealth options are an important modality for extending services to rural communities (Weinzimmer et al., 2021). However, barriers and disparities remain in providing recovery services to rural communities (Hargons et al., 2023; Weinzimmer et al., 2021; Wilson & Brown, 2024). Rural settings comprise 93% of the state of Tennessee in which 22% of Tennessee's population reside (Tennessee Department of Health, n.d.; USDA Economic Research Service, 2024).

Tennessee has had one of the highest rates of opioid prescriptions per 100 people in the US. Since 2003, Tennessee has seen increases in overdose deaths involving prescription opioids (Bipartisan Policy Center, 2019). In 2014-2015, Tennessee had a 13.8 percent rate increase in overdose deaths (Rudd et al., 2016). Further, overdose deaths from narcotic opioids grew from 2015-2017 by 19 percent,

13 percent, and seven percent, respectively. In 2006, 48 percent of drug overdoses involved an opioid narcotic, and by 2017, that rate climbed to 71 percent. Tennessee experienced a statistically significant 46.2 percent increase in drug overdoses from 2019-2020 which ranked sixth within the US (CDC, 2021a). Even more recently, 80 percent of overdose deaths in Tennessee involved opioids in 2021 (Tennessee Department of Health Office of Informatics and Analytics, 2022). To assist with the state's evident issue, federal grants to Tennessee's opioid epidemic almost doubled from $63.6 million in 2017 to $114.6 million in 2018 (Bipartisan Policy Center, 2019). Tennessee is currently expected to receive more than $600 million between 2022 and 2040 from a legal settlement involving four companies and their role in the opioid crisis (Skrmetti, n.d.).

The counties in Tennessee where opioid deaths are concentrated are Shelby, Davidson, and Knox Counties; these counties include the high-population geographic cities of Memphis, Nashville, and Knoxville (Bipartisan Policy Center, 2019). Additionally, the Upper Cumberland (UC) region in between middle and east Tennessee is among the highest areas of prescription narcotic overdoses (Rudd et al., 2016). For instance, in 2015, there were 15 deaths in Putnam County alone from a drug overdose, and 12 of those deaths involved an opioid narcotic (Tennessee Department of Health Office of Informatics and Analytics, 2017). This study specifically targeted the UC region in Tennessee.

Potential Causes of the Epidemic

One contributing factor in the opioid crisis is that the crisis has been accelerated by physicians' overprescribing highly addictive opioid narcotics. In 2018, Tennessee was responsible for writing 81.8 opioid prescriptions for every 100 persons, which is significantly higher than the national average rate of 51.4 prescriptions for every 100 persons (TN-Opioid-Involved Deaths and Related Harms, 2020). Of a surveyed sample in Putnam County, Tennessee, 77 percent (59 out of 76 physicians) of community doctors who had encountered patients claiming chronic pain were immediately referred to pain clinics. Further, the majority of these physicians reported that they rationally thought opioids could be prescribed chronically, or for longer than three months. These results suggest that narcotics are a common treatment for pain management in this county of Tennessee. In addition, few physicians were monitoring the Tennessee Controlled Substance Monitoring Database reports generated from nurse practitioners and physician assistants that they supervised or employed (Barnes, Talmage & Guimaraes, 2015).

As of December of 2023, all states in the US have implemented state-level prescription drug monitoring programs to manage the opioid crisis (Federation of State Medical Boards, 2024). These regulatory policies implemented pain clinic regulation as well as the requirement of clinicians to review prescriptions through drug monitoring data programing, such as the Tennessee Controlled Substance Monitoring Database. In some instances where state-level policies have been implemented, noticeable decreases in opioid prescribing were observed. In Ohio, an 85 percent decrease in per capita opioid prescribing was noted as well as a 62 percent decrease in Kentucky and an 80 percent decrease in Florida (Schuchat et al., 2017).

Method

Tennessee Technological University's Institutional Review Board approved this research as exempt. The exempt status was chosen because the researchers examined secondary data, which included private/restricted information with no identifiable information. Based on the university's Institutional Review Board level four exemption criteria, consent was not required for using archived data which was gathered at a medical clinic. This study is the first examination of this data.

This study examined the nature of narcotics addiction in the UC region in middle Tennessee. Researchers aimed to investigate the narcotics addiction recovery process and potential barriers associated with recovery and treatment. The UC region of middle Tennessee consists of the following 14 counties: Cannon, Clay, Cumberland, DeKalb, Fentress, Jackson, Macon, Overton, Pickett, Putnam, Smith, Van Buren, Warren, and White (Tennessee Center for Rural Innovation, n.d.). Researchers utilized and analyzed information regarding participants' demographic characteristics, exposure to narcotics, addiction to narcotics, time in recovery, potential lapse or relapse(s), and narcotics availability as well as sources of narcotics and any previous medical, mental health, or rehabilitative treatments attempted.

In this study, the inconsistency in monitoring opioid prescriptions hindered the ability to properly address the region-specific demands of the UC. Without the inclusion of pain clinics in the study, further research is necessary to understand and address the opioid-overprescribing epidemic. Efforts were made to identify the standard of care for the community as well as knowledge or training of physicians in the diagnosis and treatment of addiction; when results of this study indicated deviations from evidence-based guidelines and a low prevalence of addiction training, the authors turned to recovering narcotic addicts to assess the sources of these opioids. The authors sought to better understand the recovery trajectories of people who use opioids in the UC community.

Participants

Participants included 73 Narcotics Anonymous members in the UC region. Members of Narcotics Anonymous recover from the effects of their addiction by completing a 12-step program that emphasizes reliance on social support and a higher power, although participation does not require religious involvement (Krentzman et al., 2010). This study was conducted without violation of the 12 Traditions of Narcotics Anonymous and its members who volunteered for the survey. Participation in this survey was designed carefully, as researchers evidenced the validity of the sample by conceptualizing personal characteristics commonly associated with individuals. This sample reflects a qualified, honest, and motivated population. Participants are qualified in that they provide insight to study the effects of addiction and addiction recovery, participants are honest because honesty is required for addiction recovery, and they are motivated because they have experience suffering the scourge of addiction (Barnes, Talmage & Guimaraes, 2015).

Materials and Procedures

Data was collected using a self-report survey. The survey consisted of 22 questions about participants' demographic characteristics, exposure to narcotics, recovery process, and perceptions around narcotics availability [See Appendix]. As many participants revealed that they also had dealt drugs in the past, researchers also asked questions around the nature of selling drugs in addition to buying drugs. Through convenience sampling, paper surveys were provided to participants at various times before and after scheduled NA meetings. Upon completion, participants sealed surveys in an envelope and submitted the answers to the data gatherer.

Results

Survey answers were analyzed by the researchers using Microsoft Excel. The survey's results are categorized into four sections: demographics, exposure to narcotics, addiction recovery, and perceptions around narcotics availability.

Demographics

The first two survey questions asked the participant's age and gender. Of the surveyed participants, 64 percent of the subjects were male, and 36 percent were female. The mean age of the combined participants was 36 years of age. For females, the mean age was 31, and for males, the mean age was 38. The last survey question asked if the participant's mother used narcotics during her pregnancy with the participant. Five participants' mothers were confirmed to have used narcotics during pregnancy with the participant, and one participant's mother was suspected of narcotics misuse during pregnancy. The remaining participants confirmed that their mothers had not used narcotics during pregnancy.

Questions 15, 16, 17, and 18 asked about the participant's past arrests and incarcerations. Seventeen participants reported that they had been arrested with seven being arrested on a singular occasion and ten being arrested on multiple occasions. All participants who reported arrest also reported incarceration. Questions 7, 20, and 21 asked about the participant's participation in selling, trading, and/or dealing drugs as well as the intent behind their participation. Fifty-one of the participants had sold drugs, and 25 of those participants sold drugs primarily with the intent of supporting their habit through obtaining money. Alternatively, participants also sold drugs to obtain additional money not to spend on drugs, to obtain sex, and to avoid physical threats.

Exposure to Narcotics

Questions 3, 5, 6, 8, and 11 targeted exposure to narcotics. More specifically, questions targeted age and nature of exposure and the length of time it took for participants to become addicted to narcotics after first exposure. A cross-tabulation was also performed between participants' gender and age of first exposure to narcotics (see Table 1).

Nature of Exposure

Question 5 asked about the specific drug or drugs to which participants were first exposed. The majority of participants were first exposed to narcotics by means of prescription opioids. Participants were also asked to identify their specific drugs of choice in question 11.

Age of Exposure

Question 3 asked about participants' ages when they were first exposed to narcotics. The mean age of participants' first exposure to narcotics is 17.5 years old. The mean age for males was 18.12 and 16.46 for females.

Length of Exposure until Addiction

Question 6 also asked about length of time from participants' first exposure to narcotics to the time they became addicted. For the purpose of this study, addiction is operationally defined as drug use that is a daily compulsive engagement for rewarding stimuli despite negative and/or adverse consequences. In males, 57 percent of participants were addicted within one year. In females, 41 percent of participants were addicted within one year (see Table 2).

Addiction Recovery

Question 4 asked about the length of time participants had been in narcotics recovery. Participants' times in recovery ranged from six months to 27 years. Otherwise, 65 percent of the surveyed population had been in recovery from six months to one year. Some survey questions asked about the number of times participants had experienced a lapse or relapse in their narcotics recovery. Seventy-six percent of the population reported that they had relapsed from recovery at least one time prior to this attempt to "get clean."

Perceptions of Narcotics Availability

Questions 5, 8, 9, 10, and 13 revealed actual and perceived narcotics availability in the region. Questions 5, 8, and 9 asked about the distribution sources of participants' narcotics. Most participants (38%) reported that they obtained narcotics from a friend. Twenty-eight percent of participants reported that they obtained narcotics from a physician as a result of injury. Fourteen percent of participants reported that they obtained narcotics from a personal medical prescriber such as a primary care physician. Parents (8.45%) and illicit drug dealers (8.45%) were the fourth most common reported sources of narcotics in this study. Additionally, 2.8 percent of participants reported that they obtained narcotics from a physician's clinic known as a pain clinic.

Furthermore, Question 11 revealed that 89 percent of drug dealers are thought to be local drug dealers, whereas 11 percent are thought to be drug dealers from out of town. Similarly, Question 6 asked about participants' perceptions of the most common source of prescription narcotics on the street. Sixty-one percent of participants reported that street narcotics mostly originate from pain clinics, 20 percent reported that physicians mostly prescribe street narcotics, and 19 percent reported that the most common source of narcotics on the street was an "other" category.

Opiate Drug Dealing

Another interesting finding worth noting is that a majority of the participants in recovery had also dealt narcotics themselves in addition to using. Question 4 targeted this finding. Seventy percent of participants (51 out of 73) reported that they had dealt drugs.

Thirty-one of those participants were male, and 20 were female. In other words, 69 percent (31 of 45) of male participants dealt drugs, and 72 percent (20 of 28) of female participants dealt drugs.

Recoveree Profiles

Through various stories, remarks, and survey answers, this study painted a vignette of individuals recovering from narcotics addiction in the Putnam County, Tennessee, area. Profiles for both male and female recoverees were synthesized. Previous research indicated a lack of knowledge regarding awareness of diagnosis and treatment of addiction, and physician awareness could increase the likelihood of effective rehabilitation treatment.

Profile of a Recovering Male

At 36 years of age, he has been in recovery for almost one year, despite a lapse. His first exposure to prescription drugs was at age 18, and he became addicted to drugs one year later. In addition to his use, he sold drugs for the purpose of supporting his addiction and obtaining enough money to buy his next illegal drug. He purchased his drugs from local dealers who were the next step up in a chain of dealers, but he was under the impression that the prescription narcotics on the street originated from pain clinics. He has no knowledge of fake pills.

Profile of a Recovering Female

At 31 years of age, she has been in recovery for almost one year, despite a lapse. Her first exposure to prescription drugs was at the age of 16 and was often legitimate use. Five years later, at the age of 21, she became addicted to drugs. In addition to her use, she sold drugs for the purpose of supporting her addiction. She purchased her drugs from local dealers but was under the impression that the prescription narcotics on the street originated from pain clinics. She has no knowledge of fake pills.

Discussion

While 60 percent of the sample assumed that most prescription drugs on the street came from pain clinics, the assumption that pain clinics are the majority source of illicit prescription opioids used in the community is not entirely supported. Only two percent of the respondents who reported dealing drugs revealed that their prescriptions originated from pain clinics. These two responses appear conflicting in juxtaposition, but the proposed chain of drug dealing may fill in the missing link. Researchers found that the top of the drug dealing chain is often comprised of elderly, non-addicted, “chronic pain patients” who have sold their prescription medications to support their income. It seems that some pain clinic patients who are prescribed opioids may be resilient enough to their pain that they may be willing to endure their pain without using their prescription to alleviate financial strain.

This step is the first step in a series of relationships between pain clinic patients and potential people addicted to narcotics. To illustrate this drug dealing chain, Barnes and colleagues (2015) reflected on the following story shared by one of the participants. This participant was an elderly woman suffering from chronic arthritis. She qualified for chronic pain treatment at her local pain clinic. Treatment

was initiated by the administering of local injections to relieve pain temporarily. Following the injections was a monthly narcotics prescription of hydrocodone. Her prescription consisted of 120 pills monthly. The participant began working with one of her children to sell the prescription on the street.

The participant's child revealed that they knew others who would purchase the pills at about $1 per milligram ($5-10 per pill). Therefore, the participant was able to double her monthly income, earning about $800 a month from selling her prescription through her child on the streets. In order to pass the drug test administered by the pain clinic, the participant saved three pills from each monthly prescription to consume prior to her next appointment. If the participant did not save three of the pills for consumption, the pain clinic would assume she no longer needed the prescription for her arthritis. Testing positive for opiates ensured the maintenance of her pain clinic contract and continuous prescription for narcotic opioids.

Limitations

Limitations for this study include responses by respondents about their mother's use of narcotics will they were in utero. Their response may be accurate, but their knowledge of that situational substance use may be hearsay and not be verifiable. Another limitation of this study is limited number of participants for this study. The data that was retrievable from the archival source had useful information for this systematic examination but limited depth and breadth for a deeply rich qualitative analysis.

Conclusion

This study concludes two primary theories around narcotics addition. First, individuals in recovery tend to match a certain profile. Second, individuals in recovery do not generally receive adequate medical or rehabilitation treatment to assist in recovery. These two theories catalyze the conceptualization of a bigger theory: individuals in recovery will likely experience a significant benefit from receiving drug rehabilitation treatment from medical and mental health professionals who have extensive knowledge about drug misuse and recovery, including knowledge on drug exposure, length of use and/or recovery, lapse or relapses in recovery, sources of drugs, and adverse effects of prescription drugs.

Moreover, individuals struggling with substance use may be more recognizable to a medical or mental health professional when assessing or diagnosing patients by utilizing the characteristic profiles of the recovering males and females synthesized in this study. In order to address the lack of addiction knowledge in physicians, physicians need to be educated in the diagnosis and treatment of chronic pain, and especially in the diagnosis and treatment of addiction. Furthermore, physicians need to be aware of the current evidence-based guidelines for chronic pain treatment with opioids, as the standard of care defined by current practice patterns seem inconsistent with existing guidelines. An exploration of best-care practices in comparison to actual drug assessment practices could address the root of the problem.

In psychiatric and mental health settings, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) bases the diagnosis of substance use on a pathological pattern of behaviors related to the use of the substances. These behaviors are categorized into criteria that fit within groups of impaired control, social impairment, risky drug use, and other pharmacological criteria. Physicians' attainment of addiction history knowledge, including recovery history and behavior history related to impaired control, social impairment, and risky drug or alcohol use (Barnes et al., 2015). In medical settings, the NIDA-Modified Assist drug screening tool is an evidence-based tool recommended to identify risky substance use in adult patients (NIDA, 2020). Furthermore, the American Psychological Association is encouraging the use of emerging measures adapted from the NIDA-Modified Assist to assess clients and monitor treatment progress regarding substance use (Zgierska et al., 2014).

Implications for further research include an assessment of actual practices being utilized by physicians in the UC area as well as pain clinics and nurse practitioners or physician assistants who may be prescribing narcotics. In short, accurate and thorough risk assessments around substance use could increase professional knowledge about rehabilitation and recovery. The Tennessee Department of Health's mission statement is "to protect, promote, and improve the health and prosperity of people in Tennessee" (Tennessee Department of Health, 2017, p. 3). This mission applies to everyone in Tennessee, including individuals who are struggling with narcotics addiction.

The overall vision and goal for Tennessee's communities is to implement collaboration, respect, integrity, compassion, and excellence in preventing prescription opiate misuse. Additionally, a goal is to combat the distribution of illicit opioids to people suffering with addiction as well as provide easy access to life-saving strategies, treatments, and programs for all. Surveys such as this are vital in understanding the damage and destruction that prescription narcotics have on our communities. Therefore, continued surveys and studies regarding narcotics addiction are needed to further our knowledge and understanding of the opioid crisis as well as possible ameliorations or solutions to the problem. In the end, addictions research is of paramount importance because addiction is a prevalent concern on not only state and national levels but on a global scale as well.

References

Barnes, S., Talmage, J. B., & Guimaraes, T. (2015). Physician's Narcotic Prescribing Practice Patterns of Putnam County, Tennessee1. *Tennessee Medicine E-Journal, 1*(2), 4.

Bipartisan Policy Center. (2019, March). *Tracking federal funding to combat the opioid crisis*. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf

CDC. (2021a, February 16). *2019-2020 drug overdose death rate percent change map*. Center for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/deaths/2019-2020-increase.html

CDC. (2021b, November 17). *Drug overdose deaths in the U.S. top 100,000 annually*. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm

Federation of State Medical Boards. (2024, May). *Prescription drug monitoring programs: State-by-state overview*. https://www.fsmb.org/siteassets/advocacy/key-issues/prescription-drug-monitoring-programs-by-state.pdf

Hargons, C. N., Benner, K. E., & Wyman-Bookwalter, C. (2023). Identifying and addressing barriers to effective substance misuse treatment in rural settings. *Journal of Rural Mental Health, 47*(4), 201-210. https://doi.org/10.1037/rmh0000236

Hedrick, M. J., & Clements, A. D. (2023). Loss of rural Appalachian recovery meetings from before to after COVID-19. *Journal of Rural Mental Health, 47*(3), 192-198. https://doi.org/10.1037/rmh0000235

Krentzman, A. R., Robinson, E. A. R., Moore, B. C., Kelly, J. F., Laudet, A. B., White, W. L., Zemore, S. E., Kurtz, E., & Strobbe, S. (2010). How alcoholics anonymous (AA) and narcotics anonymous (NA) work: Cross-disciplinary perspectives. *Alcoholism Treatment Quarterly*, *29*(1), 75-84. https://doi.org/10.1080/07347324.2011.538318

National Vital Statistics System. (2024, November 3). *Provisional drug overdose death counts*. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

NIDA. (2020, April 3). *Tennessee: Opioid-involved deaths and related harms*. National Institute of Health. https://nida.nih.gov/download/21986/tennessee-opioid-involved-deaths-related-harms.pdf?v=370e0e5a41e4212703c9a63e0f8f0161

Manchikanti, L., Boswell, M. V., & Hirsch, J. A. (2013). Lessons learned in the abuse of pain-relief medication: a focus on healthcare costs. *Expert Review of Neurotherapeutics*, *13*(5), 527-544. https://doi.org/10.1586/ern.13.33

Rudd, R. A., Aleshire, N., Zibbell, J. E., & Gladden, M. R. (2016, January 1). Increases in drug and opioid overdose deaths - United States, 2000–2014. *Morbidity and Mortality Weekly Report (MMWR), 64*(50), 1378-1382. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm

Schuchat, A., Houry, D., & Guy, G. P. (2017, August 1). New data on opioid use and prescribing in the United States. *Journal of the American Medical Association, 318*(5), 425-426. https://doi.org/10.1001/jama.2017.8913

Skrmetti, J. (n.d.). *Opioid settlements: Distributors and Janssen/J&J settlements*. Office of the Attorney General: State of Tennessee. https://www.tn.gov/attorneygeneral/working-for-tennessee/filings-of-interest/opioids.html

Tennessee Center for Rural Innovation. (n.d.). *Service area*. Tennessee Tech University. https://www.tntech.edu/innovation/ruralinnovation/servicearea.php

Tennessee Department of Health (n.d.). Rural areas. https://www.tn.gov/health/cedep/environmental/healthy-places/healthy-places/land-use/lu/rural-areas.html

Tennessee Department of Health. (2017). *Healthier people, thriving communities: Our vision for Tennessee: Annual report 2017*. https://www.tn.gov/content/dam/tn/health/documents/annual-reports/FINAL_2017%20TDH%20Annual%20Report.pdf

Tennessee Department of Health Office of Informatics and Analytics. (2022, November 7). *2021 Tennessee drug overdose deaths*. TN Department of Health. https://www.tn.gov/content/dam/tn/health/documents/pdo/2021_Tennessee_Drug_Overdose_Deaths.pdf

Tennessee Department of Health Office of Informatics and Analytics. (2017). *Data brief: Drug overdose in Putnam County, TN 2012-15*. TN Department of Health. https://www.tn.gov/content/dam/tn/health/documents/pdo/Putnam_Brief15.pdf

USDA Economic Research Service. (2024, February 7). *State fact sheets: Tennessee*. U.S. Department of Agriculture. https://data.ers.usda.gov/reports.aspx?StateFIPS=47&StateName=Tennessee&ID=17854

Vadivelu, N., Kai, A. M., Kodumudi, V., Sramcik, J., & Kaye, A. D. (2018). The opioid crisis: A comprehensive overview. *Current Pain and Headache Reports*, *22*(3), 16. https:/doi.org/10.1007/s11916-018-0670-z

Weinzimmer, L. G., Dalstrom, M. D., Klein, C. J., Foulger, R., & de Ramierz, S. S (2021). The relationship between access to mental health counseling and interest in rural telehealth. *Journal of Rural Mental Health, 45*(3), 219-228. https://doi.org/10.1037/rmh0000179

Wilson, A. M., & Brown, A. R. (2024). Barriers to utilizing substance use disorder treatment and harm reduction services in Appalachia. *Journal of Rural Mental Health, 48*(1), 15-25. https://doi.org/10.1037/rmh0000248

Zgierska, A., Amaza, I. P., Brown, R. L., Mundt, M., & Fleming, M. F. (2014). Unhealthy drug use: How to screen, when to intervene. *The Journal of Family Practice*, *63*(9), 524-530. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4532724/

Tables

Table 1

Gender and First Source of Narcotics Cross Tabulation

Source of first narcotic	Male		Female		Full sample	
	n	%	*n*	%	*n*	%
Friend	13	18.84	13	18.84	26	37.68
Parents	4	5.80	2	2.90	6	8.70
Dealers	5	7.25	1	1.45	6	8.70
Pain clinics	1	1.45	1	1.45	2	2.90
Injury	14	20.29	5	7.25	19	27.54
Private MD	7	10.14	3	4.35	10	14.49
Total	44	63.77	25	36.23	69	100.00

Note: A Chi-Square test of independence showed that there was no significant association between gender and the source of participants' first narcotic, χ^2 (5, N=69) = 4.29, p = 0.51. The Chi-Square approximation may be inaccurate – expected frequency less than 5.

Table 2

Gender Differences of Time from Narcotic Exposure until Reported Addiction

Time from exposure to reported addiction	Male		Female	
	n	%	*n*	%
1 Week – 1 Month	14	28	8	16
2 Months – 6 Months	6	12	2	4
7 Months – 1 Year	3	6	2	4
2 Years – 5 Years	5	10	5	10
6 Years – 10 Years	1	2	1	2
10 Years <	2	4	1	2

Appendix

Self-Report Survey

1. What is your gender?
2. What is your age?
3. What age did you first obtain a prescription drug?
4. How long have you been in recovery?
5. What was the source of your first narcotics?
6. How long did you use before you became addicted?
7. Did you ever sell prescription drugs to support your addiction?
8. Where did you get your supply of narcotics?
9. What is the source of most prescription drugs on the street?
10. Do you think fake prescriptions are a big source of narcotics?
11. What is your prescription drug of choice?
12. What is the most popular prescription drug on the street?
13. Are most dealers local or out of town?
14. Have you ever relapsed?
15. Have you ever been arrested?
16. How many times have you been arrested?
17. Have you ever been incarcerated?
18. Have many times have you been incarcerated?
19. Have you ever dealt drugs?
20. Why did you deal drugs? – money, sex, support habit, popularity, physical threats
21. What was the source of the narcotics you sold or traded?
22. Did your mother use narcotics during her pregnancy with you?

Running as a Therapeutic Treatment for Trauma

Natae Feenstra
Kristin Page
Sarah Hensley
Laura Schmuldt
University of the Cumberlands

Trauma

Approximately 70% of adults have experienced a traumatic event (National Council for Behavioral Health, 2013). Survivors of trauma often suffer long-term effects related to physical, mental, spiritual, and emotional health as well as detriments to overall functioning (Substance Abuse and Mental Health Services Administration, 2014). Physiologically, trauma relates to is cancer, heart disease, high blood pressure, diabetes, and chronic obstructive pulmonary disease (COPD) (National Council for Behavioral Health, 2013; Substance Abuse and Mental Health Services Administration, 2014). Psychophysiology, psychology and physiology as combined behavior (Porges, 2007), shows trauma negatively impacts heart rate variability (van der Kolk, 2014), polyvagal processes (Porges, 2007), and function of the corpus collosum (Ahmed et al., 2012; Graziano et al., 2019; Rinne-Albers et al., 2015; Zhang et al., 2015). Therefore, trauma should be treated with a psychophysiological approach, as it is of both the mind and body.

Bilateral Stimulation

EMDR is an empirically supported psychotherapy method (Shapiro, 1989; Shapiro, 2014) documented as an effective treatment of trauma disorders (Amano & Toichi, 2016; National Center for PTSD, 2018; Nijdam & Olff, 2016; World Health Organization, 2014) using bilateral stimulation (BLS) with simultaneous psychotherapy (Amano & Toichi, 2016). BLS is alternating sensory stimulation and can be tactile, auditory, or visual (Amano & Toichi, 2016; Nijdam & Olff, 2016). EMDR addresses trauma by quickly integrating traumatic memories and reprocessing the traumatic experiences (Shapiro, 2014). EMDR has been found to be an effective treatment for trauma even when talk therapy has been omitted (van der Kolk, 2014).

Movement

Body movement is naturally BLS, and exercise/physical activity benefits mental health.

As a form of BLS, movement decreases distressing memories (van der Kolk, 2015), PTSD (Harte et al., 2013; Nilsson et al.,

2019; Norbrandt et al., 2018), interpersonal trauma (Chen et al., 2020), depression (Donaghy, 2007; Doyne et al., 1987; Nagata et al., 2020; Norbrandt et al., 2018; Nystrom et al., 2019), symptoms of bipolar disorder (Kazemi et al., 2018), and the need for psychotropic medications (Nilsson et al., 2019). Movement and exercise engage the polyvagal system to process stress (Lucas et al., 2018) and regular participation increases endorphins through an increase of neural blood flow (Donaghy, 2007; Nagata et al. 2020).

Individuals describe feeling better during and after exercise (Griest et al., 1979). In addition to reactive treatment, physical activity is a proactive treatment and protects from the development of future mental disorders (Siefken et al., 2019). Intensity is a consideration too, as intensity of exercise has a positive impact on mental health (Flehr et al., 2019; Harte et al., 2013).

Running

Running is exercise/physical activity; therefore, the previous research applies. Research specific to running shows it improves psychological problems (Feng et al., 2020). Consistent running triggers an unconscious phenomenon (Leer, 1980), due to the surge of freshly oxygenated blood to the brain (Kostrubala, 1976). Running causes the brain to shift between conscious and unconscious, association and dissociation (Leer, 1980), both of which are beneficial to mental health. Association is awareness and purposeful attention- like mindfulness. Mindfulness combined with physical activity is more effective than physical activity alone in reduction of ruminations (Shors et al., 2018). Association, focused attention, is used by runners as distraction while running (Greist et al., 1979; Leer, 1980). Runners unanimously reported

altered consciousness and self-hypnosis (Solomon & Bumpus, 1978). These associative states and runner's high were found comparable to Maslow's peak experience (Solomon & Bumpus, 1978), significantly beneficial to the runner's mental state.

Dissociation of the right brain hemisphere is activated by consistent, prolonged running and releases intuition, creativity, and an emotional surge (Leer, 1980). This happens particularly in slow, long-distance running (Kostrubala, 1976). Dissociation aids in relaxation (Barbieri, 2008). The physical repetition of running accesses the unconscious and a positive impact on memory (Kostrubala, 1976). Ultimately, the natural BLS produced by running is beneficial to the runner's mental health.

Outdoor Running.

Mental health may be additionally improved through the ecotherapy component of running outdoors. The exposure to nature correlates with prevention and alleviation of mental health disorders (Buckley & Brough, 2017), calming emotions and aiding mental health (Sackett, 2010). Exposure to nature for as little as ten minutes is enough to make a significant positive, psychological impact (Meredith et al., 2020) and increased exposure to nature showed more improvements (Buckley & Brough,

2017). Green exercise compared to indoor exercise shows superior mental health benefits (MIND, 2007). More specifically, nature exposure is beneficial for trauma treatment (Song et al., 2016). Finally, when considering accessibility, nature provides therapeutic benefits that are accessible, affordable (Song et al., 2016), and often free (Summers & Vivian, 2018).

Method

This quantitative, cross-sectional study examined running as a therapeutic treatment for trauma; specifically, if runners' trauma symptoms were comparable to individuals whocompleted EMDR. The Trauma History Questionnaire (THQ) (Hooper et al., 2011) was used to confirm the experience of trauma. A Comparison Group was included. These were participants who had experienced trauma, did not participate in exercise, and had not participated in psychotherapy. Runners were found to have a significant difference among these groups, so a post hoc analysis was administered to determine the effect size. Predictor variables of run setting, mileage per week, number of days running per week, and number of years running were investigated to determine what aspects of running uniquely impact trauma symptoms.

Sampling and Data Collection

Participants were at least 18 years old and of various demographics. The sample was made up of three groups totaling 265 participants. Per an initial statistical power analysis, 92 participants per group (276 total) was the sample requirement for a medium effect size. The common factor was the individuals had experienced trauma at least one year prior to participation in the study. The experience of trauma was identified by self-report on the THQ.

Group 1 was made up of 92 runners who had experienced trauma at least one year prior. Running experience was validated by self-report on a runner survey. Trauma experience was verified by self-report on the THQ. Individuals must have participated in an average of three runs per week for the past year and be associated with an amateur running group. Participants were recruited via social media.

Group 2 was made up of 81 individuals who had completed EMDR 12 weeks prior and experienced trauma at least one year prior. The trauma experience was verified by self-report on the THQ. Participants were recruited from trauma or EMDR groups via social media and by contacting EMDR practitioners to share the survey. Participants must not have been running or participating in any exercise regimen (30 minutes, three times per week) for the year prior. Participants were recruited via social media.

Group 3 was made up of 92 individuals who had experienced a trauma at least one year prior, had not participated in any exercise regimen (30 minutes, three times per week) in the past one year, and had never participated in any type of psychotherapy. The trauma experience was verified by self-report on the THQ. Participants were recruited via social media.

Participants first completed a short demographic inquiry via online survey, questions about their trauma experience were included. The THQ was accessed via online survey. The THQ is often used as a trauma screening assessment and is intended to gather self-reported information on lifetime exposure to traumatic events (Hooper et al., 2011). The THQ is comprised of 24 questions in a yes or no format. Each item inquires whether the participant experienced the event and, if so, how many times and their age. Regarding sexual and physical trauma, the participant reported if the experience was repeated and frequency. The participants were given the opportunity to report an experience not identified in the other items. Since the THQ is a data collection tool, there is no standard scoring method. The tool was designed to meet the needs of individual projects. Total scores were calculated by adding identified occurrences in the subsections and for the total questionnaire.

The test-retest reliability of the THQ is fair to excellent (Hooper et al., 2011). The stability coefficients range from .51 to .91 when discriminating between specific events. Evidence of construct, content, and cultural validity has been established. Since the THQ is not a traditional standardized assessment, traditional statistical methods are not applicable to confirm validity. Content validity is supported due to item similarities between the THQ and other compilation assessments (Hooper et al., 2011). Comparative studies of the THQ with similar, validated trauma-identifying instruments were conducted with results expressing significant correlations. As a screening tool, and not a measurement tool, the omission of known alpha and omega facts were not of concern.

The Trauma Symptom Checklist 40 (TSC-40) was accessed via online survey. TSC-40 is a scale designed to evaluate the symptomology of traumatic experiences. It is a self-report instrument consisting of 40 items under six subscales and an overall score (Briere & Runtz, 1989). Each symptom is rated on a four-point scale ranging from O ("never") to 3 ("often") over the past one month. The TSC-40 is a relatively reliable measure with a typical subscale alpha range from .66 to .77, the full scale is more reliable and has a higher average alpha range
from .89 to .91.

Participants in the Runner Group accessed an online runner survey about aspects of their running experiences. This included independent variables of the study: run setting, mileage ran per week, number of days running per week, and number of years they have been running. Run setting was defined as indoor or outdoor, and participants provided a number for indoor runs completed per week and outdoor runs completed per week. All other items had a blank space provided for a numerical answer which provided a continuous variable for study utilization.

Afterward, participants received debriefing, resources, and study purpose was disclosed.
The researcher's contact information was provided for study results. Since traumatized individuals are considered a risky

population, mental health resources and referral information were provided.

Statistical Analysis

JASP (Version 0.14.0) (JASP TEAM, 2020) was used for statistical calculations. A one way analysis of variance (ANOVA) compared the effect of running and EMDR to a Comparison

Group on overall trauma symptoms on the TSC-40. The level of risk was set at $p<0.05$ to avoid a Type I error. Significance was found and post hoc comparisons using the Tukey HSD test was conducted to indicate where significance existed among the groups. Risk level was set at $p<0.05$. Since significance was found, effect size was calculated. Multiple regression analyses assessed the semi partial correlation between the aspects of running (run setting, mileage per week, days running per week, years running) and runners' overall score on the TSC-40. The level of risk was set at $p<0.05$ for all.

Results

A one-way between subjects ANOVA compared trauma symptom scores between the Runner Group, the EMDR Group, and the Comparison Group. As shown in Table 1, TSC-40 scores were calculated for the three groups: Comparison Group (M=44.609, SD=20.981), EMDR Group (M=53.914, SD=l 7.617), Runner Group (M=36.043, SD=20. 296). Due to an unequal sample size in the EMDR Group (n=81) compared to the Runner Group (n=92) and the Comparison Group (n=92), a test for variance was applied. As shown in Table 2, Levene's test showed the variance in trauma symptoms scores was not equal (F2,2ss=l.611,p=.202). As shown in Table 3, the Brown-Forsythe test (F2, 260_944=17.826, p<.001, TJ/=.118) and Welch test (F2, l 74.606=19.266, p<.001, T]p2=.118) for homogeneity corrections was applied. These tests support, despite an unequal sample size, there was no homogeneity violation.

As predicted and shown in Table 4, Post hoc comparisons using the Tukey HSD test indicated the mean score for the Runner Group (M=36.043, SD= 20.296) was negatively and significantly different compared to the EMDR Group (M=53.914, SD= 17.617), t(92)=5.933, p<.001 and the Comparison Group (M=44.609, SD= 20.981), t(92)=2.939,p=.01. Scores from the EMDR Group (M=53.914, SD=l 7.617) did not negatively differ from the Comparison Group (M=44.609, SD=20.981), t(81)=-3.089, p=.006 but were significant.

Cohen's d analysis for effect size between the Runner Group and the Comparison Group (d=.48) reveals a medium effect. Cohen's d analysis for effect size between the Runner Group and the EMDR Group (d=.94) reveals a large effect. Cohen's d analysis for effect size between the Comparison Group and the EMDR Group (d=.94) reveals a medium effect.

As shown in Tables 5 and 6, multiple regression analysis tested if run setting (indoor or outdoor) significantly

predicted scores on the TSC-40. It was predicted that outdoor running would negatively and significantly predict scores on the TSC-40. This prediction was not supported. In Table 9, results of the regression indicated no significance for outdoor running (B=-1.185,Fs,s6= -.798,p=.427) or indoor running (B=-2.438,Fs,s6=-l.073,p=.286). In Table 10, a semi partial correlation for outdoor running (s,r=-0.086) and indoor running (s,r=-0.115)
indicated no unique contribution to the variance. Outdoor running was not a predictor variable of TSC-40 scores for the Runner Group.

As shown in Tables 5 and 6, multiple regression analysis tested if runners' weekly mileage significantly predicted scores on the TSC-40. It was predicted that greater weekly mileage would negatively and significantly predict scores on the TSC-40. This prediction was not supported. In Table 9, the results of the regression indicated no significance for weekly mileage (B=0.115, Fs,s6= .544, p=.588). In Table 10, a semi partial correlation for weeklymileage (s,r=-0.059) indicated no unique contribution to the variance. Weekly mileage was not a predictor variable of TSC-40 scores for the Runner Group.

In Tables 5 and 6, multiple regression analysis tested if runners' number of days running per week significantly predicted scores on the TSC-40. It was predicted that greater number of days running would negatively and significantly predict scores on the TSC-40. This prediction was not supported. In Table 9, the results of the regression indicated no significance for number of days running (B=1.109, *Fs,s6*= .360,p=.72). In Table 10, a semi partial correlation for the number of days per week running (s,r=-0.039) indicated no unique contribution to the variance. Number of days running per week was not a predictor variable ofTSC-40 scores for the Runner Group.

In Tables 5 and 6, multiple regression analysis tested if runners' years running significantly predicted scores on the TSC-40. It was predicted that greater number of years running would negatively and significantly predict scores on the TSC-40. This prediction was not supported. In Table 7, the results of the regression indicated no significance for number of years running (B=-0.300, *Fs,s6*= .-1.265, *p=.209).* In Table 8, a semi partial correlation for the number of years running (s,r=-0.135) indicated no unique contribution to the variance. Number of years running was not a predictor variable of TSC-40 scores for the Runner Group.

Discussion

The purpose of this study was to investigate if running would decrease trauma symptoms.
A secondary exploration was to investigate if aspects of running such as run setting (indoor or outdoor), weekly mileage, days running per week, and years running, were predictor variables of decreased trauma symptoms. It was hypothesized that scores of the Runner Group and EMDR Group would negatively and significantly differ from scores of the Comparison Group on the

TSC-40. The hypothesis was not supported because both groups did not negatively and significantly differ from the Comparison Group. The EMDR Group scores did not negatively and significantly differ from the Comparison Group scores. On the contrary, the EMDR Group reported greater scores than the Comparison Group. However, the Runner Group scores did negatively and significantly differ from both groups.

The EMDR Group scores were unexpected and possibly related to lack of random assignment for this study. It is possible participants seeking EMDR had a more severe trauma experience than participants in the Comparison Group who experienced a trauma but sought no psychotherapy. The trauma screener used only identified a trauma but did not rate or categorize it by impact or severity.

When looking at the groups individually, in contrast to the Comparison Group, a mixed result was identified. As predicted, scores from the Runner Group did negatively and significantly differ from scores from the Comparison Group, at a medium effect. This supports the hypothesis and existing literature regarding running and mental health. Though the existing literature links running to more general or other mental health benefits, this result specifically supports running as a viable therapeutic treatment for trauma. This study is the first of its kind to explore the specific relationship between running and trauma.

When comparing the trauma scores of the Runner Group to the EMDR Group, the data indicates a significant negative difference between these groups and a large effect size. It is possible that lack of random assignment is a limitation for these numbers. An additional consideration is the unequal sample size, although the tests for homogeneity showed no violation. Therefore, assuming equal sample sizes could be found, the significance could be even greater. These results support running as a viable therapeutic treatment for trauma and indicates running, under prescribed conditions, is more effective than EMDR for reducing trauma symptoms.

It was hypothesized that outdoor running would negatively and significantly predict scores on the TSC-40. This hypothesis was not supported. Despite that running was a significant predictor of trauma symptom scores, compared to the EMDR Group and the Comparison Group, outdoor running was not a predictor variable of significance. Of the 92 Runner Group participants, 50% of the population ran outdoors more than indoors and vice versa. This sampling difference was purposeful to provide validity for this hypothesis. It has been documented that outdoor running is beneficial for mental and physical health. This study supports that the run setting, outdoor or indoor, is not a significant predictor variable of the decrease in trauma symptom scores.

It was hypothesized a greater weekly mileage would negatively and significantly predict scores on the TSC-40. This hypothesis was not supported. Despite that running was a significant predictor of trauma symptom scores compared to the

EMDR Group and the Comparison Group, greater weekly mileage was not a predictor variable of significance. It is documented that running is beneficial for mental and physical health related to distance running (Feng et al., 2020; Kostrubala & Kostrubala, 2013) and related to vigorous exercise (Harte et al., 2013), hence the question was asked if greater weekly mileage would be a variable. This study indicates greater weekly mileage, and the number of weekly miles accumulated, are not significant predictor variables of the decrease in trauma symptom scores.

It was hypothesized that a greater number of days running per week would negatively and significantly predict scores on the TSC-40. This hypothesis was not supported. Despite that running was a significant predictor of trauma symptom scores compared to the EMDR Group and the Comparison Group, a greater number of days running per week was not found as a predictor variable of significance. Since literature emphasizes the mental health benefits of prolonged intensity of exercise (Flehr et al., 2019), this study asked if more days of running was a predictor variable. This study indicates a greater number of days running per week, or running over three days per week, is not a significant predictor variable of lower trauma symptom scores. As qualifying criterion for this study, runners had to be running a minimum of three days per week. Therefore, running three, four, five, six, or seven days per week were not predictors of lower trauma symptoms scores. It was not studied whether running one or two days per week was significant.

It was hypothesized that a greater number of years running would negatively and significantly predict scores on the TSC-40. This hypothesis was not supported. Despite that running was a significant predictor of trauma symptoms scores compared to the EMDR Group and the Comparison Group, a greater number of years running was not a predictor variable of significance. It is documented that running is beneficial for mental and physical health and

number of years running could be linked to an increased intensity of running, like studies on intensity or vigor of exercise (Flehr et al., 2019; Harte et al., 2013). This provided the inquiry whether more years running would be a predictor variable. This study indicates a greater number of years running, or the number of years running over one year, is not a significant predictor variable of the decrease of trauma symptom scores. As a qualifying criterion for this study, runners had to be actively running for a minimum of one year. It was not studied whether running less than one year would be significant.

Strengths and Limitations of the Study

The strengths of this study lie in the numbers gathered, access to the participants, and the method. The online format is credited for recruitment. Despite a slightly unequal sample size, the numbers did not violate the risk of homogeneity.

There are limitations, such as study design and lack of random assignment. There may be such limitations as participants' perceived trauma severity. Though participants qualified for the study based on criteria from the THQ, there was no

consideration for perceived trauma severity. A longitudinal study with pretest and posttest measures could present more reliable data. Also, as a quantitative study, there is no existing data on the lived experience of these qualifying participants. Qualitative data would provide beneficial information.

Unequal sample size is another limitation. Despite a research effort to recruit participants for the EMDR Group, the sample lacked 11 participants to meet the ideal number for statistical power. This concern was quelled by using a test for homogeneity. The insignificant value calculated did not violate assumptions, therefore the data was considered sufficient use for statistical reporting.

Another limitation is demographics. The data shows that 89% of the total participants identified as female and 88% identified as white. When identifying participants for the EMDR Group, the criteria required completing EMDR within the last 12 weeks. The term 'completion' did not specify the cause of completion, which could range from release by the provider, discontinuation by the client, or disruption in services based on factors unknown.

A further limitation may lie in the Runner Group. A study criterion was that the runner be a part of an online amateur run club or group, intended for runner identification. It may be possible that a strong, perceived identity as a 'runner' could be a mediating factor for fewer trauma symptoms. In support of this, Carless (2008) reported an individual with severe mental illness who improved by the adoption of a runner and athlete identity. Also, the purpose of running was not explored, meaning there could be differences exist between runners that run for mental health purposes versus runners that run for physical health purposes.

Even though no variables proved to be significant predictors of lower trauma symptom scores, it is possible the predictor variable inquiries were too limited. A variable to explore is running pace. Runners run at various paces, sometimes engage in vigorous exercise, and sometimes use slow, long-distance paces. These characteristics impact mental health, and this study may have been limited by excluding these as predictor variables.

Conclusion

This quantitative cross-sectional study investigated running as a therapeutic treatment for trauma. An ANOVA was used to explore if, for individuals who had experienced trauma, running would negatively and significantly decrease a self-report of trauma symptoms assessed by the TSC-40 compared to EMDR and no treatment. Additionally, aspects of running such as the run setting (indoor or outdoor), mileage, days per week running, and years running, were

investigated as potential predictor variables of trauma symptoms scores. Three groups were utilized: Runner Group (n=92), EMDR Group (n=81), and Comparison Group (n=92). Due to unequal sample sizes in the EMDR Group that might have affected

statistical power, a test for risk of homogeneity was implemented. No violation of homogeneity was found, therefore analysis moved forward.

All hypotheses were rejected. In the three-way comparison, scores from the Runner Group and the EMDR Group did not both negatively and significantly differ from the scores of the Comparison Group. However, significance was found between the Runner Group and both the other groups for trauma scores. Data showed a significant and negative difference between the Runner Group trauma scores and the Comparison Group trauma scores at a medium effect size. Data showed a significant and negative difference between the Runner Group trauma scores and the EMDR Group trauma scores at a large effect size. This study supports running as a therapeutic treatment for trauma. Additionally, no aspects of running were predictor variables of trauma symptom scores. Since no predictor variables were significant, it further supports the simple act of running, likely due to the innate bilateral stimulation, lowers trauma symptoms.

References

Amano, **T.,** & Toichi, M. (2016). The role of alternating bilateral stimulation in establishing positive cognition in EMDR therapy: A multi-channel near-infrared spectroscopy study. *PloS ONE, 11(10).* doi:10.1371/journal.pone.0162735

Barbieri, J. L. (2008). The URGES approach: Urge reduction by growing ego strength (URGES) for trauma/addiction treatment using alternate bilateral stimulation, hypnotherapy, ego state therapy and energy psychology. *Sexual Addiction & Compulsivity, 15(2),* 116-138. doi:10.1080/10720160802035584

Briere, J. N. & Runtz, M. G. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence, 4,* 151-163. https://doi.org/10.1177/088626089004002002

Buckley, R. C., & Brough, P. (2017). Nature, eco, and adventure therapies for mental health and chronic disease. *Frontiers in Public Health, 5,* 1-4. doi:10.3389/fpubh.2017.00220

Carless, D. (2008). Narrative, identity, and recovery from serious mental illness: A life history of a runner. *Qualitative Research in Psychology,* 5(4), 233-248. doi:10.1080/14780880701826101

Chen, R., Peng, K., Liu, J., Wilson, A., Wang, Y., Wilkinon, M. R., Wen, S., Cao, X., & Lu, J. (2020). Interpersonal trauma and risk of depression among adolescents: The mediating and moderating effect of interpersonal relationship and physical exercise. *Frontiers in Psychiatry, 11.* doi:10.3389/fpsyt.2020.00194

Donaghy, M. E. (2007). Exercise can seriously improve your mental health: Fact or fiction? *Advances in Physiotherapy, 9(2),* 76-88. doi:10.1080/14038190701395838

Feng, B., Zhou, P., Dong, H., & Wang, J. (2020). Influence oflong-distance running on mental health and positive sports emotions of college students. *Revista Argentina De Clinica Psicologica, 29(2),* 685-691. doi:10.24205/03276716.2020.296

Flehr, A., Barton, C., Coles, J., Gibson, S. J., Lambert, G. W., Lambert, E. A., Dhar, A. K., & Dixon, J. B. (2019). #MindinBody - Feasibility of vigorous exercise (Bikram yoga versus high intensity interval training) to improve persistent pain in women with a history of trauma: A pilot randomized control trial. *BMC Complementary and Alternative Medicine, 19(1*). doi:10.1186/s12906-019-2642-1

Graziano, R., Bruce, S., & Paul, R. (2019). The corpus callosum and PTSD severity. *Journal of Interpersonal Violence,* 1-15. doi:10.1177/0886260519835007

Harte, C. B., Vujanovic, A. A., & Potter, C. M. (2013). Association between exercise and posttraumatic stress symptoms among trauma-exposed adults. *Evaluation & the Health Professions, 38(1),* 42-52. doi:10.l 177/0163278713494774

Hooper, L. M., Stockton, P., Krupnick, J., & Green, B. L. (2011). The development, use, and psychometric properties of the trauma history questionnaire. *Journal of Loss and Trauma, I 6,* 258-283. https://doi.org/10.1080/15325024.2011.572035

JASP Team (2020). *JASP* (Version 0.14.1) [Computer Software].

Kazemi, R., Rostami, R., Khomami, S., Baghdadi, G., Rezaei, M., Hata, M., Aoki, Y., Ryouhei, I., Iwase, M., & Fitzgerald, P. B. (2018). Bilateral transcranial magnetic stimulation on DLPFC changes resting state networks and cognitive function in patients with bipolar depression. *Frontiers in Human Neuroscience, 12.* doi:10.3389/fnhum.2018.00356

Kostrubala, T. (1976). *The joy of running.* New York, NY: Pocket Books.

Kostrubala, T. & Kostrubala, T. (2013). *The joy of running 2: Paleo-analysis & running therapy.* Santa Fe, NM: Saint Nicholas Productions LLC.

Leer, F. (1980). Running as an adjunct to psychotherapy. *Social Work,* 25(1), 20-25. doi:10.1093/sw/25.1.20

Lucas, A. R., Klepin, H. D., Porges, S. W., & Rejeski, W. J. (2018). Mindfulness-based movement: A polyvagal perspective. *Integrative Cancer Therapies,* 17(1), 5-15. doi:10.1177/1534735416682087

Meredith, G. R., Rakow, D. A., Eldermire, E. R., Madsen, C. G., Shelley, S. P., & Sachs, N. A. (2020). Minimum time dose in nature to positively impact the mental health of college aged students, and how to measure it: A scoping review. *Frontiers in Psychology, 10.* doi:10.3389/fpsyg.2019.02942

Nagata, S., McCormick, B., & Austin, D. (2020). Physical activity as treatment for depression in recreation therapy: Transitioning from research to practice. *Therapeutic Recreation Journal,* 54(1), 77-91. doi:10.18666/trj-2020-v54-il-9745

National Center for PTSD. (2018, August 10). *Eye movement desensitization and reprocessing (EMDR) for PTSD.* Retrieved May 25,

2020, from

https://www.ptsd.va.gov/understand_tx/emdr.asp

National Council for Behavioral Health. (2013, May). *Trauma-informed services.* Retrieved June 04, 2020, from https://www.thenationalcouncil.org/wp-content/uploads/2013/05/Trauma infographic.pdf?daf=375ateTbd56

Nijdam, M. **J.,** & Olff, M. (2016). Erasing memory traces of trauma with eye movement desensitization and reprocessing therapy. *European Journal of Psychotraumatology,* 7(**1**), 32545. doi:10.3402/ejpt.v7.32545

Nilsson, H., Saboonchi, F., Gustavsson, C., Malm, A., & Gottvall, M. (2019). Trauma-afflicted refugees' experiences of participating **in** physical activity and exercise treatment: A qualitative study based on focus group discussions. *European Journal of Psychotraumatology, 10(1),* 1699327. doi:10.1080/20008198.2019.1699327

Nystrom, M. B., Hassmen, P., Sorman, D. E., Wigforss, T., Andersson, G., & Carlbring, **P.** (2019). Are physical activity and sedentary behavior related to depression? *Cogent Psychology,* 6(1). doi:10.1080/23311908.2019.1633810

Porges, S. W. (2007). The polyvagal perspective. *Biological Psychology,* 74(2), 116-143. doi:10.1016/j.biopsycho.2006.06.009

Rinne-Albers, M.A., van der Werff, S. **J.,** van Hoof, M., van Lang, N. D., Lamers Winkelman, F., Rombouts, S. A., Vermeiren, R.R., & van der Wee, N. **J.** (2015).

Abnormalities of white matter integrity in the corpus callosum of adolescents with PTSD after childhood sexual abuse: A DTI study. *European Child & Adolescent Psychiatry,* 25(8), 869-878. doi:10.1007/s00787-015-0805-2

Sackett, C. (2010). Ecotherapy: A counter to society's unhealthy trend? *Journal of Creativity in Mental Health,* 5(2), 134-141. doi:10.1080/15401383.2010.485082

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress, 2(2),* 199-223. doi:10.1002/jts.2490020207

Shapiro, F. (2014). The role of eye movement desensitization and reprocessing (EMDR) therapy in medicine: Addressing the psychological and physical symptoms stemming from adverse life experience. *The Permanente Journal,* 71-77. doi:10.7812/tpp/13-098

Shors, T. J., Chang, H. Y., & Millon, E. M. (2018). MAP training my brain™: Meditation plus aerobic exercise lessens trauma of sexual violence more than either activity alone. *Frontiers in Neuroscience,* 12.doi:10.3389/fnins.2018.00211

Siefken, K., Junge, A., & Laemmle, L. (2019). How does sport affect mental health? An investigation into the relationship of leisure-time physical activity with depression and anxiety. *Human Movement, 20(1),* 62-74. doi:10.5114/hm.2019.78539

Solomon, E.G., & Bumpus, A. K. (1978). The running meditation response: An adjunct to psychotherapy. *American Journal of Psychotherapy, 32(4),* 583-592. doi:10.1176/appi.psychotherapy.1978.32.4.583

Song, C., Ikei, H., & Miyazaki, Y. (2016). Physiological effects of nature therapy: A review of the research in Japan. *International Journal of Environmental Research and Public Health, 13(8),* 781-794. doi:10.3390/ijerpHypothesis308078 l

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA 's concept of trauma and guidance for a trauma-informed approach.* HHS Publication No. (SMA) 14- 4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Summers, J. K., & Vivian, D. N. (2018). Ecotherapy-A forgotten ecosystem service: A review. *Frontiers in Psychology, 9,* 1-13. doi:10.3389/fpsyg.2018.01389

van der Kolk, **B.** (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma.* New York, NY: Penguin Books.

Zhang, Y., Li, H., Lang, X., Zhuo, C., Qin, W., & Zhang, Q. (2015). Abnormality of the corpus callosum in coalmine gas explosion related posttraumatic stress disorder. *PLoS ONE, 10(3),* 1-10. doi:10.1371/joumal.pone.0121095

Get Moving: Utilizing Walk and Talk in Counseling Supervision

Natae Feenstra
Melissa J. Ostrander
Kaitin O. McIntosh
Liberty University

Introduction to Walk and Talk

Walk and talk is a counseling technique utilized for its movement-initiated mental health benefits (Greenleaf et al., 2023). As described in the title, walk and talk occurs when the counselor and client engage in talk therapy while walking together. Evidence-based research supports the use of walk and talk for therapeutic benefit to both the client (Charbonneau et al., 2017; Greenleaf et al., 2023; Newman & Gabriel, 2022) and the counselor (Revell & McLeod, 2017). The rhythm of movement while walking and talking increases thought processing (Greenleaf et al., 2023). Other benefits include feeling more comfortable in the setting and mind-body connection facilitation (Greenleaf et al., 2023). Further, the organic nature of walk and talk, including side-by-side placement, decreased eye contact, and lay clothing decreases the power differential between the counselor and client (Sachs & Buffone, 1984).

The technique of walk and talk should expand beyond the counselor/client relationship, as the benefits are also applicable to the supervisory relationship. The use of counseling techniques for counselor supervision has been, and still is, professional best practice (Banker & Goldenson, 2021; Cigrand et al., 2014; Scholl & Smith-Adcock, 2008; Wessler & Ellis, 1983). During the pandemic, the walk and talk technique was effectively used in other health disciplines for clinical supervision. This technique created a safe space for the supervisee and aided in relationship building (Addy et al., 2021). Counseling supervisors should consider the technique of walk and talk as another tool in their supervision toolbox while being mindful of ethical practice.

Ethical Considerations for Walk and Talk in Supervision

Currently, there is no certification required for the use of walk and talk; however, a certification exists for counselors who desire further training in the theory and technique (Saremi, 2023). Walk and talk counseling and supervision takes place in public settings, such as a park, nature path, or walking trail, potentially raising the ethical concern of confidentiality. Supervision ethics, found in Section F of the ACA Code of Ethics, does not discuss confidentiality since the supervisor usually has access to

the supervisees' client information. However, section B discusses the limits surrounding confidentiality to others outside of the supervisory relationship. B.3.c. states "counselors discuss confidential information only in settings in which they can reasonably ensure client privacy" (American Counseling Association [ACA], 2014).

Addressing expectations for the supervisory relationship is standard practice at the onset of supervision (Koruk & Kara, 2019). Walk and talk expectations must also be established, including the responsibility to uphold confidentiality and protect client information while close to others. It is recommended that walk and talk supervision not discuss identifiable client information that could be overheard. The supervisor and supervisee should take precautions to choose low-populated walking locations. Additionally, expectations should be discussed on how the supervisor and supervisee will proceed to protect confidentiality when approaching others while walking.

Modeling Wellness through Walk and Talk

In addition to ethical considerations in supervision, supervisors must also be mindful of the ethical obligation to model wellness and self-care to supervisees (ACA, 2014; Branco & Patton-Scott, 2020; Lenz & Smith, 2010). Counselors are mandated to monitor their well-being and engage in self-care as part of their professional responsibilities (ACA, 2014). Supervision serves to evaluate supervisees' self-care practices as well as their wellness in general as they grow as new professionals (Callendar & Lenz, 2018).

Modeling wellness during supervision for supervisees may increase wellness resulting in higher levels of wellness for the supervisor, the supervisee, and the client (Branco & Patton-Scott, 2020). The Wellness Model of Supervision (WELMS) postulates the need for supervisors to model wellness, evaluate supervisee wellness, and work collaboratively and non-judgmentally with supervisees as they develop personal wellness plans (Lenz & Smith, 2010). Walk and talk supervision is a practical way to take experiential wellness modeling a step further within the physical domain of wellness. By promoting this specific component of wellness within supervision, supervisors can model through action the importance of self-care (Lenz & Smith, 2010; Branco & Patton-Scott, 2020) while increasing the efficacy of supervision (Addy et al., 2021).

References

Addy, T., & Nash, S. (2021). P-192 The development of 'Walk and talk' supervision for clinical staff within a hospice working throughout the pandemic. BMJ Supportive & Palliative Care, 11(2), A78, https://doi.org/10.1136/spcare-2021-Hospice.208 American Counseling Association (2014). ACA Code of Ethics. Alexandria, VA: Author.

Banker, J. E., & Goldenson, D. (2021). Mindfulness practices in supervision: Training counselors' experiences. The Family Journal, 29(1), 17-23, https://doi.org/10.1177/1066480720954204

Branco, S. F., & Patton-Scott, V. (2019). Practice what we teach: Promoting wellness in a clinical mental health counseling masters program. Journal of Creativity in Mental Health, 15(3), 405–412. https://doi.org/10.1080/15401383.2019.1696260

Callender, K. A., & Lenz, A. S. (2018). Implications for wellness-based supervision and professional quality of life. Journal of Counseling & Development, 96(4), 436-448. https://doi.org/10.1002/jcad.12225

Charbonneau, T., Mishka, L., & Estefan, A. (2017). Making walk and talk therapy a reality in Calgary, Journal of Transport & Health, 7, https://doi.org/10.1016/j.jth.2017.11.074

Cigrand, D. L., Wood, S. M., & Duys, D. (2014). Use of solution-focused tenets and techniques in school-based site supervision. Journal of School Counseling, 12(15), https://files.eric.ed.gov/fulltext/EJ1034761.pdf

Greenleaf, A. T., Williams, J. M., Leibsohn, J. P, & Walther, B. (2023). "Put on your walking shoes": A phenomenological study of clients' experience of walk and talk therapy. Journal of Creativity in Mental Health, 1-16, https://doi.org/10.1080/15401383.2023.2247318

Koruk, S., & Kara, A. (2019). Supervision models in psychological counseling. Eskişehir Osmangazi Üniversitesi Sosyal Bilimler Dergisi, 20, 51-63.https://doi.org/10.17494/ogusbd.54825

Lenz, A. S., & Smith, R. L. (2010). Integrating wellness concepts within a clinical supervision model. The Clinical Supervisor, 29(2), 228–245. https://doi.org/10.1080/07325223.2010.518511

Newman, E., & Gabriel, L. (2022). Investigating clients' experiences of walk and talk counseling. Counselling & Psychotherapy Research, 23(1), 125-133. https://doi.org/10.1002/capr.12567

Revell, S., & McLeod, J. (2017). Therapists' experience of walk and talk therapy: A descriptive phenomenological study. European Journal of Psychotherapy & Counselling, 19(3), 267- 289. https://doi.org/10.1080/13642537.2017.1348377

Sachs, M. L., & Buffone, G. W. (1984). Running as therapy: An integrative approach. Lincoln, NB: University of Nebraska Press.

Scholl, M. B., & Smith-Adcock, S. (2008). Using psychodrama techniques to promote counselor identity development in group supervision. Journal of Creativity in Mental Health, 2(1), https://doi.org/10.1300/J456v02n01_03

Saremi, S. (2023). Get certified: The run walk talk® level 1 practitioner training. Run Walk Talk. https://www.runwalktalk.com/certification

Wessler, R. L., & Ellis, A. (1983). Supervision in counseling: Rational-emotive therapy. The Counseling Psychologist, 11(1), 43-49, https://doi.org/10.1177/0011000083111