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Motivated But Challenged: Counselor Educators' Experiences Teaching About Social Determinants of Health

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Abstract

A phenomenological study was conducted to understand eight counselor educators' experiences teaching about social determinants of health. The analysis yielded three themes: educator identity, motivations, and challenges. Implications for counselor educators preparing future counselors to be leaders in multiculturalism, social justice, and advocacy are provided.

Keywords

social determinants of health, counselor education, phenomenology, social justice

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Introduction

Preparing counselors in training (CITs) to address access and equity issues and other social justice topics, including social determinants of health (SDOH) challenges, is an important part of a counselor educators' responsibility (Pieterse, 2009; Ratts et al., 2016). Moreover, counselor educators' personal and professional experiences contribute to the variability of education CITs receive within multicultural social justice training (MSJT; Flores et al., 2014; Magnuson et al., 2006; Motulsky et al., 2014). Despite the importance and social justice implications of preparing CITs to address SDOH challenges faced by clients (Andermann, 2016; Author & Brookover, 2021; Ratts et al., 2016), researchers have yet to explore counselor educators' experiences with this endeavor. Thus, the current study examined counselor educators' experiences teaching about equity and access related specifically to SDOH.

Equity, Access, and the Conditions of Daily Life

Social justice-minded counselors are committed to engagement in sociopolitical action to eliminate wellness barriers and promote equity and access in their communities (Ratts et al., 2016). SDOH are conditions in the environments in which individuals are born, live, learn, work, play, worship, and age that affect a wide range of health outcomes (Adler et al., 2016; WHO, 2008). SDOH encompass five domains in which equity and access cause health and education disparities between people in the population, including: (a) economic stability (e.g., poverty and food insecurity), (b) education (e.g., high school graduation and education in early childhood), (c) health and healthcare (e.g., health insurance and access to health care), (d) neighborhood and built environment (e.g., neighborhood crime and housing quality), and (e) social and community context (e.g., immigration status and social support; Office of Disease Prevention and Health

Promotion, 2020; WHO, 2008). Adler and Stewart (2010) reviewed numerous studies on the effects of socioeconomic status on health, also concluding that complex interactions between various SDOH inextricably influence health outcomes for individuals and communities. The World Health Organization's (WHO) Commission on SDOH (CSDH; 2008) provided three broad recommendations for addressing SDOH-related challenges: (1) "improve daily living conditions; (2) tackle the inequitable distribution of power, money, and resources; [and] (3) measure and understand the problem and assess the impact of action" (p. 44). Moreover, the CSDH emphasized the existence of innumerable inequities and disparities in health and wellbeing internationally, influenced by factors such as economic and government policies, structural inequity, and daily living conditions, among various others. Researchers have also acknowledged an increase in awareness of the need for assistance beyond medical care alone for improvements to Americans' general health and living conditions (Braveman et al., 2011).

Equity related to SDOH ensures inclusive participation within each of these aforementioned domains. An equity focus would work to remove barriers to equal participation (Berry, 2016). For example, in education, equity would ensure that all children had access to quality education, including teachers, facilities, and opportunities. Similarly, access related to education, would include schools providing additional support to all students to ensure equitable participation indiscriminate of socioeconomic status or personal demographic characteristics (Hayton & Paczuska, 2003; Taylor et al., 2019). Equity, access to resources, power, and privilege influence SDOH and are the primary drivers of health and wellness inequities worldwide (Andermann, 2016).

Teaching about Social Determinants of Health

SDOH is emerging as a new topic in the education of health professionals (Thibault, 2020) as well as in training for professional counselors (Author, 2020; Author & Brookover, 2021). SDOH is cross-sectional and embedded in two macro-contents. First, SDOH includes scholarship from the study of multicultural issues, advocacy, and social justice (Jones & Tang, 2015). Second, SDOH takes research and practice from the corpus of knowledge on interprofessional studies (Cheng et al., 2020). Indeed, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP), while not specifying the SDOH directly, implicitly inserts the content into these two macro contents: interprofessional studies and social-cultural diversity. Social and cultural diversity is essential to counseling and is embedded in one of the eight core CACREP standards. CACREP standards indicate that students should be exposed to theories and models of multicultural counseling, cultural identity development, social justice, and advocacy (CACREP, 2016).

In the healthcare education literature, professors' political engagement, professional growth, social responsibility, and practical applications are noted motivations for educating students about SDOH in the classroom (National Academies of Sciences, Engineering, and Medicine, 2016; Sharma et al., 2018). These findings are similar to studies that highlight counselors' and similar professionals' motivation for incorporating multicultural and social justice theories (DeBlaere et al., 2019; Odegard & Vereen, 2010; Vera & Speight, 2003). In a study that examined the motivations of counselor educators, Odegard and Vereen (2010) found that counselor educators' desire to confront oppression and racism were the primary reasons they discussed MSJT in the counseling classroom. Moreover, Meili and colleagues (2011) suggested that promoting altruism, social accountability, and other values underpinning the concerns

around SDOH helps encourage medical students to effectively apply these values when working in underserved areas.

Another potential motivating factor to discuss SDOH in healthcare professions is the potential for practical application. Indeed, Schoenthaler et al. (2019) suggested that awareness of SDOH in practice settings promotes building rapport with patients. Although there are multiple motivations for integrating SDOH, there are also challenges with integrating SDOH-related material, including already heavy workloads (O'Meara et al., 2017; 2019) and extant curriculum devoid of information on health equity (Mogford et al., 2011). In the realm of counseling, Author and Brookover (2021) interviewed 11 elementary, middle school, and high school school counselors and found that school counselors are qualified to address SDOH needs with their students, but there is a clear lack of training regarding the skills needed to do so in master's training programs. Similarly, through a phenomenological exploration of school counseling interns' experiences with addressing SDOH challenges, Author et al. (2021) noted a gap between participants' knowledge of social justice and SDOH challenges and practical action to address such challenges. These aforementioned studies reveal a gap in the literature regarding counselor educators' experiences teaching about concrete equity and access challenges, which is SDOH. Indeed, the literature suggests the importance of understanding motivations for teaching and calls for increased exploration (Han & Yin, 2016; Hoy, 2008).

Despite an increasing interest in SDOH in health professions, the lack of literature about SDOH in counselor education when compared to other health professions, such as nursing (Lee & Willson, 2020; Murray, 2021; Ogbolu et al., 2019) and medicine (Chang et al., 2017; Ludwig et al. 2020; Martinez et al., 2105), is apparent. This dearth of literature may have a negative

impact on the future of the counseling field, particularly related to interventions to address social inequity and in interprofessional collaboration, both of which are becoming essential areas of knowledge and skill for health professionals (Andermann, 2016). Given the counseling profession's emphasis on social justice and advocacy, counselor educators are well-positioned to prepare future counselors to address the social justice-related needs in their communities and professional contexts (Ratts et al., 2016). Thus, analyzing counselor educators' experiences of teaching CITs about SDOH is an essential step for including this competency into counselor education curricula and helping future practitioners enter the field to be prepared to address this vital area in their practice. Therefore, the purpose of this study was to understand the experiences of counselor educators teaching about SDOH. We conducted a phenomenological study through a social constructionist lens to answer the following research question: "What are the experiences of counselor educators who include SDOH content in their curriculum?"

Method

We conceptualized the present study through a social constructionist paradigm. Social constructionism maintains that meaning is created through human interaction, including culture, time, and various environmental factors (McAuliffe, 2011). Moreover, the theory posits that all human beliefs and thoughts are influenced by social interactions, contexts, and environments, and that "individual meaning-making is socially constructed" (McAuliffe, 2011, p. 5). Thus, we conducted a phenomenological study guided by a social constructionist paradigm to gain an understanding of the experiences of counselor educators teaching about SDOH. The use of the phenomenological approach allowed for us to gain an understanding of the essence of lived experiences of counselor educators that teach about social determinants of health. The purpose

of this study is to contribute to a sparse area of the literature concerning social justice and advocacy training for future counselors; namely, how counselor educators experience engaging in such work, thereby preparing future counselors for the social justice work of addressing clients' SDOH-related challenges.

Participants and Procedures

The human subjects Institutional Review Board approved this study in the Fall of 2019 and recruitment began shortly after. We utilized criterion (Heppner & Heppner, 2004) and snowball sampling (Handcock & Gile, 2011) techniques to recruit participants that represented different Association for Counselor Education and Supervision (ACES) regions who met the following criterion: (1) identifies as a counselor educator, (2) at least one year of experience as an instructor at a CACREP accredited program, (3) experienced teaching in at least one of the eight core counselor education curriculum areas, and (4) self-identified as including modules related to SDOH in the counseling curriculum. For the purposes of this study, the following definition of SDOH was provided to participants at the beginning of their respective interviews: "Social determinants of health are the economic and social conditions that influence individual and group differences in health status. Examples of SDOH include income inequality, food insecurity, housing instability, and inequitable access to healthcare" (Office of Disease Prevention and Health Promotion, 2020).

The sampling method was appropriate for thematic analysis (TA) as a specific population was identified that would have the most information-rich cases for the current study (Patton, 2014). We emailed department chairs and specific faculty in 12 states, representing each ACES region. Eight counselor educators of six different universities and two ACES regions (SACES

and NARACES) that currently teach in counseling programs participated in this study. The sample was racially and ethnically diverse, including four African-American, one Latinx, and three white individuals. Two genders were represented: four men and four women. Participants represented the college, mental health, and school counseling specialty areas as well as all ranks and institution types (R1-R3). Refer to Table 1 for detailed participant information.

Table 1

Participant demographics and related characteristics

Participant	Demographic Identifiers	University Description
1	Black, Male, Assistant Professor with a College Student Affairs specialty	R3 school with approximately 5,000-15,000 students, approximately 30% URM staff and 25% URM students.
2	White, Female, Full Professor with a Mental Health specialty	R2 school with approximately 15,000 or more students with approximately 30% URM staff and 25% URM students
3	Black, Male, Clinical Professor with a Mental Health specialty	R1 school with approximately 15,000 or more students with approximately 43% URM staff and 45% URM students
4	Black, Female, Assistant Professor with a Mental Health specialty	R2 school with approximately 5,000-15,000 students with approximately 25% URM staff and 30% URM students
5	Black, Female, Assistant Professor with a Mental Health specialty	R3 school with approximately 5,000 or fewer students with approximately 15% URM staff and 40% URM students
6	Latinx, Male, Assistant Professor with a Mental Health specialty	R1 school with approximately 15,000 or more students with approximately 22% URM staff and 25% URM students
7	White, Female, Clinical Professor with a School Counseling specialty	R1 school with approximately 15,000 or more students with approximately 14% URM staff and 30% URM students
8	White, Male, Associate	R3 school with approximately 15,000 or more students

	Professor with specialties in Mental Health, School and College Student Affairs	with approximately 30% URM staff and 25% URM students

*****URM = Underrepresented Minority

Data Collection

We used a semi-structured interview, recommended and appropriate for phenomenological studies, (Moustakas, 1994) as the primary means of data collection. The research interviews included open-ended questions concerning the instruction of SDOH in counseling education courses, including: (1) "Please describe which specific SDOH indicators you typically include in the counselor education curriculum?," and (2) "Describe the experience of teaching counseling students about SDOH." The first, second, third, and fifth authors of this paper conducted the interviews, which lasted between 45 and 86 minutes, via video conferencing software. An online transcription service was then used to transcribe the audio recordings and later examined for accuracy in audio-to-text transcription.

Research Team and Trustworthiness

As a whole, our research team is large and diverse, representing graduate students and a professor. The analysis team included four researchers who are all doctoral students in counselor education and supervision. Each team member contributed to all steps of the research. We took several steps to enhance trustworthiness throughout the data analysis process. Following the Braun and Clarke (2006) process of TA, we engaged in triangulating investigators (Nowell et al., 2017) and reflexive journaling (Lincoln & Guba, 1985). Additionally, we bracketed our assumptions about this topic to enhance trustworthiness through journaling and group discussion with acknowledgment of the fact that assumptions cannot be fully bracketed when conducting

qualitative research (Tufford & Newman, 2010). We all believe that integrating education about SDOH in the counseling curriculum is important and will help produce counselors who view their work through a multicultural and social justice lens. These assumptions were bracketed during the data analysis to improve the trustworthiness of our interpretations of the data. We took steps to ensure that the research process was logical, traceable, and clearly documented (Tobin & Begley, 2004). We also reached out to our participants for member checking purposes. The participants were emailed a copy of their respective transcripts to check for accuracy, clarity, and to provide a chance to make any changes; none of the participants responded.

Data Analysis

To explore the motivating factors for counselor educators teaching about SDOH in counseling programs, we utilized TA, a "method for identifying, analyzing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). Within TA, qualitative data is organized into themes which "[capture] something important about the data in relation to the research question, and [represent] some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 10). TA was a fitting analysis method for this phenomenological study, as it allowed for identifying common themes across participants' experiences to discover their essences. TA is also a recommended analytical approach with many qualitative approaches, including phenomenology (Braun & Clarke, 2006).

Following the six-phase approach to TA described by Braun and Clarke (2006), we began Phase One by familiarizing ourselves with the data. Each researcher actively, analytically, and critically reviewed each interview transcript several times to gain a deep and intimate understanding of the participants' experiences. We met virtually and engaged in consistent

communication regarding the data via email and Google messaging. Phase Two involved systematically and intentionally generating the initial codes we believed accurately reflected the participants' experiences and meanings. Phase Three included organizing the coded data into potential themes. In Phase Four, we critically examined the themes to determine if they were in line with the research question or if they should be discarded. In Phase Five, with greater than 75% agreement between the coders, the codebook was defined and maintained and themes were named (Joffe, 2012). Each retained theme was determined to be a unique and accurate representation of the participants' experiences. Finally, Phase 6 involved producing this report.

Findings

Our exploration of counselor educators' experiences incorporating SDOH in the counseling curriculum yielded three themes: Educator Identity, Motivations, and Challenges. These themes were developed after critically examining the data according to our research question. Each theme retained was determined to be an accurate reflection of the participants' experiences, and all participants are represented in each theme. Each theme is explained below with thick, rich descriptions.

Theme 1: Educator Identity

Educator Identity describes the participants' stances on why they incorporate equity, access, and SDOH topics into their counseling curriculum, and is representative of 88% of participants. Their identity included descriptions of personal histories, theoretical beliefs, perspectives from experience, and their convictions related to the topic. At the intersection of personal history and theoretical beliefs, Participant 1 noted:

> You’re going to deal with clients who are coming to you. First of all, they're not going to trust you because you don't have their experiences and you look culturally different than they do. Second of all, they come from an environment where they've been abused, marginalized, stigmatized, and you gotta work through all of that and build it up so they can trust you. And so, I bring those experiences that I've had, not only as a consumer of services but as a provider of services into the classroom.

Similar to the incorporation of self that Participant 1 included, other participants highlighted the self’s role in the natural incorporation of SDOH-related content in their counseling courses. Very generally, Participant 2 stated, “it's a part of who I am” and went further to say:

> ...because I feel like it is so important for a person to be taking care of themselves and to look at the whole self in order to be a good professional counselor. And so for me, I believe it just comes out in how I teach as I hit on different aspects of what I'm teaching. If it applies to their overall wellbeing, then I will mention that.

While many participants highlighted their personal history and convictions, others’ identities hinged on a theoretical perspective for incorporating equity, access, and SDOH topics, namely social justice. Participant 3 noted, “I would definitely say that it is a social justice issue...social justice has to be incorporated into one's counseling because part of it is about being an advocate for your clients as well.” Several participants echoed this theoretical identity. Moreover, Participant 4 stated:

> I think it is social justice because again, there's a lot of room for inequality and I also think it's ...an ethical issue because, if we're talking about being the leaders of wellness

and prevention there's no way that we can ignore these other areas and not address them and expect for clients to get better.

Theme 2: Motivations

Theme two, Motivations, is defined as the participants' reasoning for including content in their counselor education classes related to SDOH and is representative of 100% of the participants. Several participants expressed their desire to integrate SDOH into their classes to expand the scope of the content covered when discussing multicultural competence and social justice. Participant 5 stated, "...we need to push further than just thinking that social justice is about race and ethnicity… The conversation stops once you get into social justice and people think, 'okay social justice you're talking about black and white." Along with increasing the scope of the class discussion, other participants believed that teaching about SDOH produces higher quality and more competent counselors. Participant 7, a school counselor educator, stated:

> We are preparing folks to work primarily in K-12 schools and in higher ed settings. Schools carry a heavy load and a heavy burden of blame sometimes for what's happening… I think talking about all of the different avenues or aspects allows our students to have choices. Start with anyone. Start with poverty, start with the racial divide, start with the language barriers for some kids.

Other participants believed that teaching about SDOH was an ethical obligation for counselor educators. Participant 4 noted:

> I think it is a social justice issue because there's a lot of room for inequality and I also think it's an ethical issue. If we are talking about being the leaders of wellness and

> prevention, there's no way that we can ignore these other areas [SDOH factors] and not address them and expect for clients to get better.

Theme 3: Challenges

Theme three, Challenges, describes the reported barriers and difficulties participants face when incorporating SDOH content in the counseling curriculum and is representative of 88% of the participants. Multiple participants described difficulty incorporating SDOH into the existing curriculum. For example, Participant 6 discussed the difficulties balancing standards that have to be taught because of accreditation and adding in any additional content, "...the curriculum and just making sure that we cover everything in the curriculum. They need proof and evidence that we are covering all of these different aspects that they want us to throughout the program." While some were able to seamlessly include SDOH others were struggling to find the space in their courses and the curriculum overall. Furthermore, participants described how they perceived that their colleagues' perceptions and knowledge serve as barriers to teaching about SDOH. Participant 8 described how they perceived that lack of knowledge and awareness serve as a barrier by stating:

> I think the biggest thing is probably just, well one, it's probably the professors not even knowing. I think we have a lot of professors who, they're probably fifth or sixth generation PhDs and so they've never been through any kind of struggle really when it comes to stuff like that.

Moreover, Participant 4 expressed a similar sentiment: "I think some educators may not have experience...or, they don't realize how deep the detriments can be or they don't think it's in their role." The lack of experience is related to the last challenge that many participants noted: the

perception of potential backlash from colleagues. A statement from Participant 6 summarizes much of what was reflected by others in terms of barriers: “resistance of other faculty members and feelings of fear about having conversations surrounding SDOH.”

Discussion

This exploration of counselor educators' lived experiences incorporating SDOH content in their curriculum yielded three themes. These themes, educator identity, motivations, and challenges, told the story of counselor educators who are driven to incorporate concrete equity and access content because of their personal and professional experiences, identities, and their beliefs in its necessity. The participant experiences also highlighted barriers that arise when incorporating new content (i.e., SDOH) that is not as directly connected to things like the CACREP standards or skill-based competencies.

The first theme, educator identity, describes a construct instrumental in participants’ motivation to teach about SDOH. This finding aligns with extant research which identifies interpersonal factors as important in the decision making and the perceived ability of educators to teach about multicultural and social justice issues in the classroom (Engebretson, 2018; Ortiz et al., 2018). Specifically in counselor education, researchers have explored educator identities and experiences teaching multicultural counseling (Brady-Amoon, 2011; Merlin-Knoblich et al., 2019; Mitcham et al., 2013; Reynolds, 2011). However, the current study adds to the extant knowledge base by exploring a specific multicultural social justice equity issue: SDOH. As a reminder, the World Health Organization (2008) lists SDOH as a key driver of inequitable and adverse health outcomes amongst the world population. Discussing SDOH during helping and health care professionals’ graduate programs is key in producing professionals who are prepared

and ready to address complex healthcare challenges in practice (Mangold et al., 2019; Meili et al., 2011; Schoenthaler et al., 2019; Sharma et al., 2018; Siegel et al., 2018). The current findings related to counselor educators' motivations to teach about SDOH is an important contribution to the counselor education literature, given that such motivations include SDOH content in the counseling curricula as an important part of the responsibility of counselor educators who are committed to equity, access, and social justice (Pieterse, 2009; Ratts et al., 2016). Additionally, the extant literature highlights the fact that counselor educators' personal experiences and identities contribute to the variability of education in multicultural social justice training (MSJT) CITs receive (Flores et al., 2014; Magnuson et al., 2006; Motulsky et al., 2014).

The second theme, motivations, describes participants' reflections on why they included SDOH content in their instruction of counseling students. The participants' reported motivations included broadening perceptions of multicultural and social justice education beyond race and ethnicity and the belief that SDOH education produces more competent counselors. These findings, while new in the counselor education literature, are in line with research in medical health professions which found that awareness of SDOH does lead to more competent providers, specifically related to the provision of higher quality of care (Page-Reeves et al., 2016; Schroeder et al., 2019), stronger rapport building with clients (Schoenthaler et al., 2019), and increased provider self-awareness leading to culturally competent care (Klein & Vaughn, 2010; Meurer et al., 2011).

Lastly, counselor educators motivated to expand their students' understanding of multiculturalism, related specifically to topics such as power, privilege, and socioeconomic status, were able to address these topics through SDOH-related curriculum. In the literature on

teaching about SDOH, a best practice approach is moving from the abstract adjacent SDOH topics, in which multicultural competence can be considered, to the more concrete SDOH topics (Chokshi, 2010); therefore, counselor educators' motivation is also aligned with best practice approaches in educating healthcare professionals about SDOH (Gard et al. 2019).

The third theme, challenges, describes the common barriers and difficulties participants face when teaching about SDOH. Reported challenges were related to other professors' perceived knowledge and experiences, curriculum, time constraints, and feelings such as fear. Participants reported having already full schedules and teaching responsibilities, making the incorporation of SDOH-information in the curriculum difficult, alongside the notion that their fellow faculty members are ill-equipped or resistant to do so. Resistance or lack of support from fellow faculty members to incorporate SDOH in the counseling curriculum may create emotional or time burdens for other faculty members, perhaps discouraging the new inclusion of such information. These findings are unsurprising in light of the higher education literature on faculty workload and satisfaction (O'Meara et al., 2017; O'Meara et al., 2019). For example, O'Meara et al. (2019) found that faculty in departments perceived as more equitable reported higher satisfaction. The researchers highlighted the influences of faculty perception of their own workload and contribution as important.

In this study, participants shared their perceptions of faculty workload as already full and unaccommodating of new information, like SDOH. However, although the challenges to integrating SDOH content into the curricula were shared by all participants, many were able to overcome some of these barriers and challenges due to their possession of strong educator identities inclusive of motivations relating to social justice. Additionally, there is currently a

dearth of information in the counseling literature on SDOH, despite the need for counselors to be prepared to address social justice and equity-related issues (Author et al., *in press*; Author & Author, 2021; Ratts et al., 2016) and the general call for increased education on health equity (Mogford et al., 2011). Lastly, these findings align with medical and allied health professional literature that discusses similar challenges related to barriers to incorporating SDOH in coursework and curriculum (Mogford et al., 2011; O'Meara et al., 2017; 2019).

Implications

Considering our findings, there are steps counselor educators may take to better address SDOH material in the counseling classroom, thereby preparing counselors in training to address their clients' SDOH-related challenges in practice. For one, counselor educators should engage in reflexive practices, contemplating their own personal and professional experiences, privileges, and biases. This sort of reflexive practice may promote learning, increases in reflexive thinking, and integration of new material for counselor educators (McAuliffe, 2011). This work may also strengthen educators' social justice identities, thereby influencing their teaching, supervision and advocacy practices. Counselor educators may also consider their understanding of social justice, how their conceptualizations do or do not include SDOH, and how such beliefs affect their work. This is highlighted as a best practice approach for integrating and teaching multicultural and social justice topics in counselor education (Ratts et al., 2016). Counselor educators can be intentional with incorporating SDOH into their curriculum through assignments, readings, and class discussions. They may also incorporate a SDOH statement in their syllabi that addresses student needs related to SDOH such as community housing shelters, local food banks, affordable health clinic information, etc.

Additionally, counselor educators may work to further incorporate SDOH-related content in the counseling curriculum through in-class discussions and activities, service learning, and readings as well as assessing for SDOH related content and discussions in students field practices. Others might consider advocating for the inclusion of SDOH content in their particular program and/or at the national level with accrediting bodies. To address challenges related to already packed curriculums, counselor educators might consider performing an audit of their programs, removing unnecessary repetition in the curriculum which might make space for new content related to SDOH. Counselor educators may also consider the ways in which they can use SDOH to highlight concrete challenges in society (Choski, 2010) which improves student learning and grasp of abstract concepts.

Limitations and Future Research Directions

Researchers should interpret this study's current findings and implications in light of its limitations. The study is purposed to capture the themes of participant experiences and report trustworthy findings for contemplation and transferability to other settings (Merriam & Tisdell, 2016; Creswell, 2013); thus, true generalizability is impossible. Additionally, as researchers, we maintain belief in the importance of teaching and learning about SDOH in the counseling profession, though bracketed our experiences and assumptions to minimize and mitigate the potential threat to trustworthiness. Lastly, we recruited participants from CACREP accredited universities, making the results potentially less generalizable to non-CACREP accredited programs. This study offers several directions for future research. Considering our findings on participants' difficulty integrating SDOH-related material in already full curriculums, future researchers may explore how and under what circumstances counselor educators seek to change

the curricula in their programs. Researchers may replicate the present study with a larger, more diverse sample, and perhaps with counselor educators from other ACES regions not presently included.

Conclusion

SDOH are an often-overlooked component of social justice in the counseling curriculum. To better understand the inclusion and barriers to the inclusion of SDOH in the counseling curriculum, we conducted a phenomenological exploration of counselor educators' experiences teaching about SDOH, which yielded findings related to various challenges, motivating factors, and the influences of educators' identities. Participants highlighted the influences of not only their own identities, but also within systems and in relation to the perceived beliefs and competencies of their colleagues. This research makes a significant contribution to counselor education as it highlights both the importance of and the barriers to enhancing counselor education programs through education on SDOH. Thus, we implore researchers and educators in the field of counseling to consider how barriers to incorporating SDOH in the counseling curriculum may be removed. We also suggest that counselor educators examine how such efforts may be supported by individuals, counseling departments, and professional organizations alike.

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