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Aspiring Counselors' Mental Health: Recognizing Students' Wellbeing as an Impactor on Development

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Abstract

Aspiring Counselors (AC) are learning to navigate professional knowledge and skills while engaging in developmentally necessary self-reflection. Wellness, as a professional cornerstone, has been an emphasis in the instruction and development of AC. AC's development can have barriers of professional and personal disposition, such as un-met or underattended mental health concerns which may require remediation. AC may also have higher prevalence of adverse childhood and trauma experiences. Exploring the current literature on AC's development, wellness, and adverse childhood experiences and trauma provides insights in how counselor educators can structure programs in a more proactive rather than responsive way. The purpose of this manuscript is to explore AC's development, wellness, gatekeeping and remediation, and adverse childhood experiences or trauma.

Keywords

Counselor Education, Trauma, Wellness

Author's Notes

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Aspiring Counselors (AC) enter a world of work where mental health services are significantly needed. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2021) highlights that 30% of adults with a mental health concern did not receive services to fully address their needs. The COVID-19 pandemic further amplified stress for many, with some needing professional support to regulate their emotions (Rajkumar, 2020). With mental health occupations projected to be in growing demand through the decade (Bureau of Labor Statistics, 2020), counselor educators (CE) are tasked with helping AC develop reflective practices (2.F.1k) and "self-care strategies" (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015, 2.F.1.l) so that AC are prepared for navigating their personal and professional needs in a way that does not impede their practice. AC need this professional development support no matter their life experience but for some the need may be more acute.

Aspiring Counselors (AC) come to training programs with diverse experiences in all areas of life (Arañez Litam. 2020; Degges-White & Stoltz, 2015; Sue et al., 2019). Around 50% of AC sought counseling before entering or during their training program (Harris et al., 2013; Merryman et al., 2015). Engagement in counseling services does not indicate all had clinically significant or chronic mental health concerns; however, AC's practice may be impacted by mental health needs whereas resilience and coping may increase longevity (Arañez Litam et al., 2021). Thus, encouraging AC's awareness of their own wellness needs and how to support these is a consideration for CE.

Wellness sits at the crossroads between student wellbeing and counselor professional development. Myers et al. (2000) defined 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 more

fully within the human and natural community." (p. 252). Wellness, ultimately, holds a special role in professional development as installation of wellness in the client or student requires an aspect of wellness in the counselor (Lawson & Myers, 2011; Lawson et al., 2007; Myers et al., 2016), similar to how client installation of hope requires some genuine hope from the counselor. The implementation of wellness and coping skills is associated with mitigating stress and reinforcing the therapeutic alliance (Gnilka et al., 2012; Norcross & VandenBos, 2018), supporting self-efficacy (Liao et al., 2021), and strengthening perception of professional work (Aafjes-Van Doorn et al., 2021; Lawson, 2007). As training programs support AC installation of wellness, they also support AC engagement in personal practices that produce higher wellbeing. The purpose of this paper is to explore the impact of trauma history and current mental health concerns on the development of AC and how wellness exists as a potential safeguard. Connecting these ideas will help inform CE practice in supporting AC.

Installation of Wellness

Wellness is recognized as a foundational aspect of the counseling profession (Myers, 1991) which distinguishes it from the pedagogical approaches of other mental health professions and unites its specialty areas (Kaplan & Gladding, 2011). Self-care, a specific intervention used to rebalance unattended areas, and self-compassion, a mindset of grace despite internal messages of deficiency, work in tandem to support wellness (Coaston & Lawrence, 2019). While the concept of wellness is not inaccessible to other professions, counseling has recognized it as a core kernel to the diverse counseling practices that make up the profession and have chosen to keep it as a cornerstone to conceptualizing the work of counselors.

It is paramount that counselors learn to integrate personal wellness practices to mitigate the risk of burnout and other professional risk factors (Blount et al., 2020; Roach & Young, 2007).

The ACA's code of ethics (2014, C.2.g) reinforces the responsibility to not practice while being impacted by significant psychological or physiological issue and to self-screen for issues that may impact practice. Psychological reactions that interrupt the therapeutic process may include countertransference, inability to regulate emotional reaction in a way that promotes processing, or inability to maintain focus on client's or student's goals (Wolf et al., 2014). Wellness practices counteract impairment from personal psychological issues (Roach & Young, 2007; Whitmer & Young 1996). Supporting AC to develop wellness practices into their lives is important to provide a foundation for their professional practice (Can & Watson, 2019). Wellness is often integrated into programs through passive mechanisms of program atmosphere and CE modeling, as well as active mechanisms of practice opportunities and supervision.

Atmosphere and Modeling

Atmosphere and modeling are strong passive forces where Aspiring Counselors (AC) initially experience wellness as a concept and lifestyle. The atmosphere of a program is formed through the guided co-construction between CE and AC. Implementation of a strong, overarching wellness atmosphere involves integration by all CE and program leaders (Lenz et al., 2017; Puig et al., 2012). An atmosphere of wellness is not a mechanism that can be completed by a singular programmatic event (Burck et al., 2014). Rather, CE's creation of a comprehensive supportive environment, such as through being available to AC and willingness to support their needs, is a significant indirect wellness support (Thompson et al., 2011). CE have a role in setting the tone for a wellness atmosphere, specifically in the way they conduct themselves.

An atmosphere of wellness is strongly enabled by the way that CE carry themselves in class, the hallways, and in other encounters with AC. Whether or not CE self-describe as having balance within their own wellbeing, AC will view them as wellness experts (Lenz et al., 2017).

The modeling of personal wellness is important to AC's development (Burck et al., 2014) as it exemplifies the ability to set personal boundaries while still being passionate about the work (Thompson et al., 2011). Myers et al. (2016) theorized that CE model wellness for AC who then model it for students and clients. This is reinforced by Blount et al. (2020) who identified the tension in holding on to wellness while also preparing AC to work in a medical model system; however, Blount et al. noted the infusion of wellness has to come from the top down. AC observe CE's behaviors whether it is a model of self-neglect or one of wellness with transparency and vulnerability being important over trying to project flawless implementation (Gleason & Hays, 2019). While these passive elements may be important (Merryman et al., 2015), a wellness atmosphere must also be constructed through the active engagement, discussion, and enactment of wellness for AC.

Opportunities for Practice and Supervision

Opportunities to practice wellness provide the most concrete support in implementing self-care and self-compassion processes in a way that can be made part of an AC's lifestyle. The implementation of opportunities cannot be limited to brief one-time or short interventions (Ohrt et al., 2015); rather, AC need integration that forms a comprehensive wellness atmosphere with engaging concrete examples (Thompson et al., 2011) and action-oriented plans (Blount et al., 2020). Further, encouraging self-monitoring through formal and informal assessments (Burck et al., 2014; Blount et al., 2020; Puig et al., 2012) can help AC reflect on wellness in their lives and encourage realistic expectations (Merryman et al., 2015). CE should find a balance of purposeful implementation that is not prescriptive or punitive in design but instead an encouraging, enabling, and engaging opportunity (Gleason & Hays, 2019). This similar balance should be considered in supervision.

Supervision provides such a place to encourage wellness practices as supervision is the most structured ongoing process that many AC will experience in their training program. Supervision serves as the integration of professional knowledge and skills with time to provide more individualized feedback (Bernard & Goodyear, 2019), meaning it is also a key place for wellness to be supported. While wellness practices in supervision may have a slower progressive impact versus immediate result (Lenz et al., 2017), it is still an important aspect to infuse. The significance of an intentional implementation of wellness into supervision is evident as Lenz et al. noted in their 2017 meta-analysis that AC who received it "rated themselves nearly two thirds of a standard deviation more well… than same-institution peers who received supervision as usual" (p. 353). Supervision is both well positioned for as well as an impactful space for wellness practices.

The installation of wellness, though, may look different for AC who have had or are currently managing significant problems that are impacting their overall wellbeing. Negative wellbeing and coping patterns, often connected to mental health symptomology, seem to be related to professional struggles and doubt (Aafjes-Van Doorn et al., 2021). The general programmatic encouragement of wellness practices may be inadequate to meet the needs for ACs' managing symptoms of mental health issues.

Aspiring Counselors (AC)'s Mental Health

The draw to become a counselor may stem from a variety of considerations (Barnett, 2007; Degges-White & Stoltz, 2015). While a desire to help and have a social impact may be a-common element (National Center for O*NET Development, 2020), the diverse personalities and backgrounds even across specialty areas seems to suggest divergent motivations for entering the counseling profession (Degges-White & Stoltz, 2015). AC often develop their own understanding

of what counseling is during their training program, starting with parroting textbook definitions and moving towards more personalized understandings (Gibson et al., 2010). Thus, many AC are applying their current understanding of counseling while still grappling with it in their field experiences rather than applying with a full understanding of the unique qualities required of the counseling profession. The individual factors that bring an AC into a training program also may impact their experience in the program, especially as it relates to mental health concerns.

AC bring a variety of personal experiences into a program. Approximately 56-67% of AC surveyed reported they had engaged in counseling to address a personal issue in the past (Byrne & Ost, 2016; Merryman et al., 2015; Smith et al., 2007) with most identifying as being self-referred for services (Merryman et al., 2015). This is higher in some specialty areas, with 78% of surveyed aspiring clinical mental health counselors sharing they had engaged in counseling services, over 20% higher than their school counseling peers (Byrne & Ost, 2016). Similarly, surveyed clinical mental health counselors also were more likely than counselor educators to endorse identifying as a wounded healer indicating they previously faced significant personal difficulty (Degges-White & Stoltz, 2015). While engagement in supportive activities like therapy is important for all counselors, it is vital when personal issues may become a barrier to the work of a counselor (Cummins et al., 2007). AC's struggling with wellness issues risk not only low potency of their work but potential harm to clients.

How AC Mental Health can Impact Practice

Paralleling Myers et al.'s (2016) theory that wellness is needed to propagate wellness is that mental health issues can serve as barriers to professional practice. CE often look at impairment from the perspective of Aspiring Counselors (AC)'s practice, psychological wellbeing, or ethical behavior (Brown-Rice, 2012). These domains are laid out by the ACA's (2014) *Code of Ethics*

throughout section F in the ethical responsibility of CE and supervisors. It is also echoed by the CACREP (2015) standards of AC gatekeeping. Li et al. (2008) noted that interviewed CE identified the top reasons that AC were going through remediation or dismissal were the AC "had deficient interpersonal skills, has difficulty receiving supervision, had inappropriate boundaries, lied… refused to consider personal counseling… and had a personality disorder" (p. 6). To varying degrees, each of these reasons can be associated with some mental health related concerns. While some may be as simple as lack of awareness or reflection, others may be related to more deep-seated issues such as complex trauma or personality disorders. While not a reflection of cases, Henderson and Dufrene (2012) noted that the second largest reference to behaviors of AC that required remediation was symptoms of mental health issues. This seems to be similar to the findings of Evans et al. (2012), where emotional problems and concerns were the second highest problematic behaviors AC self-identified.

Identification of mental health concerns, whether by self or CE, is not immediately concerning and may instead be developmental or related to the rigor of graduate school (Eisenberg et al., 2018). What is concerning is that AC may face internalized stigma about seeking therapy (Sullivan & Mancillas, 2015) allowing issues to go unaddressed. Proactivity by CE is necessary in screening for concerns as AC may try to conceal impressions of clients or students, countertransference or attraction, or personal issues because of concerns of how they would be seen, fear or shame, or other relational concerns (Cook et al., 2018). This may contribute to problems in AC's ability to move from self-focused awareness to awareness of others (Stoltenberg & McNeill, 2010), in countertransference (Copeland et al., 2019), and in doing harm. When mental health concerns are acute, pervasive, or link to trauma response, they may negatively impact AC's development and the welfare of their clients and students.

Trauma Responses and Impact on Helping Professionals

Traumatic experiences can cause cross-categorical symptoms that may impact the efficacy of wellness practices and have long-term effects on mental wellbeing. Trauma responses can be so jarring that they cause ripples in life experiences moving forward. These ripples may contribute to symptoms of anxiety, depression, and other mood related responses whether or not they rise to a clinical threshold (Foa et al., 2006). Increased understanding of traumatic responses have resulted in recognizing the breadth of experiences that can cause a traumatic response (Herman, 1992), the maladaptive changes in brain chemistry and physiology (Van der Kolk, 2014), and the generalization of the trauma creating triggering experiences (Foa et al., 2006). Risk of a triggering experience serves as a barrier to quality care.

How traumatic experiences may be a risk for Aspiring Counselor (AC)'s practice can be understood through Foa et al.'s (2006) emotional processing theory (EPT) of trauma. EPT acknowledges that a fear response within itself is not dysfunctional but when these responses are generalized to experiences not commonly considered threatening, they become dysfunctional. Based on EPT, the impact of a traumatic experience is in part connected to the level of avoidance mentally and contextually of an associated stimulus related to the traumatic experience that reinforces anxiety (Foa et al., 2006). Support allows some individuals to be able to continue interacting with the stimulus with mild enough reactions avoid dysfunction. Individuals in other circumstances, because of the severity of the experience, lack of support, or other contextual factors, may utilize avoidance as a necessary coping mechanism (Foa et al., 2006). These two approaches to managing traumatic experiences in part suggest how some are able to recover without therapeutic intervention and others may develop symptomology that may require clinical intervention. For AC, the forced exposure of a triggering stimulus in the counseling room could

produce an undesired response or AC may act to avoid the stimulus and not attend to the needs of clients or students (Cummins et al. 2007). While traumatic responses can come from a host of areas across the lifespan, multiple early traumatic experiences or severe traumatic experiences seem to be associated with risk of revictimization and continued symptomology into adulthood (Pratchett & Yehuda, 2011). Because of the relationship between early stress experiences and impact later in life, the concept ACE was developed.

Adverse Childhood Experiences and Associated Risks

ACE are stressful or abusive experiences in childhood connected to events that can be traumatic, though not all meet current diagnostic criteria, or have long term health effects (Felitti et al., 1998). Traumatic exposures are measured under current diagnostic standards by an event that is observed or experienced in which actual or perceived risk of death, serious physical injury, or sexual violence occurs (American Psychiatric Association [APA], 2022). ACE is defined as a disruption in childhood such as abuse, neglect, or instability in the home (Felitti et al., 1998) but has been expanded to include the experience of adversity in the community (Pachter et al., 2017) to capture a more diverse experience.

ACE scales highlight stressful experiences including verbal, physical, sexual, and emotional abuse as well as neglect, exposure to domestic violence, and disturbance in family systems related to separation from parents by divorce or incarceration and mental illness and substance use in the home (Feletti et al., 1998) as well as bullying, discrimination, safety in community, and foster care (Pachter et al., 2017). High ACE scores reflect high levels of exposure to stressful incidents but do not inherently track the response or whether the experiences were traumatic. Traumatic symptomology development may be mitigated because of the threshold for experiences that qualify as trauma, the level of support in an environment, temperament, and

genetic resilience (APA, 2022). Symptomatology is exemplified in how Brockie et al. (2015) noted that Native American in late adolescence to early adulthood who endorsed any ACE were more likely to experience symptoms that met the threshold for PTSD, noting further that identifying with three or more on the ACE scale saw three-fold more likely to experience PTSD in this population based on the DSM IV's diagnostic criteria. This aligns with research that disaggregates demographic information and highlights higher ACE endorsing among a variety of marginalized groups (Giano et al., 2020; Gilbert et al., 2015; Merrick et al., 2018). The results suggest that a trauma response related to ACE may be more likely for some people than for others.

Higher scores on ACE scales predict a variety of health risks later in life (Felitti et al., 1998; Gilbert et al., 2015; Merrick et al., 2018). In Felitti et al.'s (1998) initial exploration they found "…a significant ($p < .05$) dose-response relationship between the number of childhood exposures and the following disease conditions: ischemic heart disease, cancer, chronic bronchitis or emphysema, history of hepatitis or jaundice, skeletal fractures, and poor self-rated health" (p. 250). These findings were similarly echoed by Gilbert et al. (2015), who noted how increasing ranges of ACE doses were associated with more significant responses or risks.

Further, Hughes et al. (2017) found in their metanalysis that ACE of four or more were related to several behavioral health concerns: three and a half times more likely to have anxiety, four times more likely to be pregnant as a teenager, four times more likely to be depressed, five and a half times more likely to have problematic drinking, seven and a half times more likely to be a victim of violence, eight times more likely to be a perpetrator of violence, ten times more likely to have problematic drug use, and thirty times more likely to have attempted suicide. Understanding this risk highlights the need for CE to be aware of the level of risk to AC and whether certain programmatic supports are needed.

Trauma Responses and ACE in AC

Helping professions are notable by the relational and empathic nature of the work. Jung observed a relationship between history of personal struggles and a desire to help others so he suggested that a personality archetype may be the wounded healer (Degges-White & Stoltz, 2015). Mental health practitioners have to manage their own exhaustion (Newcomb et al., 2019) and wellness (Foreman, 2018) to be able to be engaged and present with their students and clients. To best understand how to support AC and ensure the safety of the clients and students that AC may work with, several studies have been conducted to explore ACE in aspiring helping professionals. The importance of exploring these experiences with AC is highlighted by Copeland et al. (2019), who noted that unresolved issues may cause countertransference with clients, or students. or may cause diminished ability to effectively intervene because of internal focus. Some evidence also exists on how ACE can be associated with experiences that impact clinician efficacy (e.g., compassion fatigue, burn out, vicarious trauma) (Mott & Martin, 2019; Williams et al., 2012). Concerns about trauma and ACE experience prevalence is not unique though to AC.

ACE have been reported by professional helpers and aspiring professional helpers across multiple professions. Compared to the general population, where 57.8% report one or more ACE, 14.1% report four or more ACE, and 3.8% report six or more ACE, professional helpers appear to have high ACE levels (Felitti et al., 1998; Giano et al., 2020; Gilbert et al., 2015). In a graduate social work program, Thomas (2016) noted 79.8% of students endorsed one or more ACE, 41.8% endorsed four or more ACE, and 24.1% endorsed six or more. With nursing students 72% reported one or more ACE, 23% reported four or more ACE, and 6% reported six or more ACE (McKee-Lopez et al., 2019). Staff members in day treatment and residential programs for individuals who have intellectual and developmental disabilities endorsed ACE as a similar rate: more than one,

75.6%; more than four, 29.7%; and more than six, 15.5% (Keesler, 2018). Utilizing a similar scale to ACE, Nikčević et al. (2007) noted that junior psychology students interested in pursuing clinical career paths endorsed significantly higher scores overall as well on sexual abuse and neglect subscales when compared to junior psychology students pursuing non-clinical career paths and junior business students. In a clinical practice sample of master's and doctoral level practitioners 82.5% endorsed one or more ACE with 45.8% endorsing three or more (Mott & Martin, 2019). While the draw to a helping profession may not be causal by ACE, the association across multiple professions provides the concern that AC may similarly have elevated ACE scores.

Evident is the need for understanding that traumatic experiences, while not a disqualifier for entering a counseling training program, may impact AC's wellbeing and ability to fully engage in learning experiences. For those who experience a significant and or plethora of traumatic experiences that are not supported, the risk of pervasive impact is significant (Foa et al., 2006; Van der Kolk, 2014). Because of the avoidance of triggers, the traumatic response may not be evident. However, working with students and clients often involves discussing emotional and difficult topics for the counselors working with them. CE often provide formal and informal education (Lenz et al., 2017; Puig et al., 2012) on wellness to support the AC's development and ability to be effective in the counseling room (Lawson & Myers, 2011; Lawson et al., 2007; Myers et al., 2016). Wellness practices may be supportive AC managing traumatic responses but may not be sufficient to fulfill AC's development needs.

Implications for Counselor Educators

Program coordinators and faculty need to reflect on how the program structure monitors for and intervenes early when signs of mental health distress present, knowing that it is not *if* mental health concerns arise for AC in their program but *when*. Programs may consider how to

incorporate a trauma-informed approach to programmatic structure. This can be achieved through supporting connections within the program and intentionally using program structure to support reflection and wellness practices.

CE should reflect on how to create a program culture that maintains the rigor in meeting professional standards but also encourages connection to CE as supportive of AC's wellbeing. Creating approachability may involve different challenges based on program format, size of program, and personalities; however, this can be done in innumerable ways just as professional counselors utilize their context and personality to build the therapeutic alliance. Outside of direct faculty support, there may be benefits from a peer-mentor program. By utilizing peers such as through honors society mentoring, senior, established, and academically performing peers can be provided with community resources. Peer mentors do not need to be charged with an evaluative function but could assist as an extra connection in the program that assists AC navigate programmatic expectations and resources.

In programs with a cohort or structured course order, there may be some organic planned opportunities to encourage personal reflection (e.g., group processing experience, skills practices). Reminding students of community resources during these experiences also may be helpful to provide access to resources without AC having to directly elicit them from CE. Programs with a less structured format may need to rely more on advisors tracking student progress and triangulating reports from across courses. Either way, intentional discussions and programming on wellness may be beneficial even if not fully adequate to support AC's wellbeing.

Responding to Individual AC Needs

CE nuanced understanding of the different types of individuals who seek to enter the counseling profession will assist in proactively supporting students. The beginning of supporting

AC's development stems from the admissions process. When students apply to the counseling program assessing the AC using the same metrics that will be used during their progression within the program (e.g., professional dispositions, wellness measures) helps faculty to conceptualize potential students by whether there is a foundation upon which to build. Wellness measures may even have the added benefit of helping students recognize their own growth throughout the program and showing it as a programmatic priority from the beginning. Programs could determine whether to use a wellness scale and ask for participants results or conversely could use it as a reflective activity and assessment where AC are asked to complete the scale and reflect on the results. Pre-admission screening is not about only admitting AC who are already wellness experts, but screening for AC who are closed off or not willing or able to seek the wellness supports needed to help them thrive in a program and eventually in practice.

While annual reviews (CACREP, 2015) may be a stopgap to ensure AC progress is being monitored, ideally, programs are being proactive in evaluating dispositional progress and setbacks. This may be done informally outside of annual reviews with regular advisor meetings as well as incorporated in more process-oriented spaces such as practicum and internship. Discussions of AC's wellbeing should be programmatically integrated as to create a supportive atmosphere where help feels not only available but offered.

Evaluation of AC's ability to progress programmatically because of unmet or under met mental health needs may require discussions of pacing. CE may need to explore a slower pace of coursework that allows the AC time to address mental health needs and show signs of dispositional progress that reflects an ability to progress with program and field placements. Gatekeeping may be required when dispositional progress is not being actively sought or when the mental health distress appears to be chronic in nature as to not allow for regular ethical practice.

Future Research

While many indications suggest a prevalence of AC who have experienced high stress or traumatic experiences, there needs to be additional exploration directly into what percentage of AC have experienced past trauma. Having more data that clearly shows these numbers will support CE ability to be proactive. Additionally, understanding if any relationship exists between AC who have experienced past trauma and AC's professional development or potential efficacy as a counselor would inform whether need for programmatic changes is needed. If a relationship does exist, could growth after the traumatic experience mitigate changes in professional development? While quantitative studies may support the understanding of prevalence and impact of prevalence, additional studies may improve the understanding of lived experiences, especially for AC who have marginalized identities that may not be able to be disaggregated in a quantitative analysis.

Increased knowledge around whether any relationship exists between ACE and wellness development would further highlight the need for additional programmatic measures. If a relationship exists, then understanding this relationship can support wellness interventions development and design. Additionally, programmatic wellness experiences may be at low risk for any negative impact but assessing the efficacy of programmatic wellness initiatives is important to understanding how programs can support the installation of wellness.

In a different avenue, further research is needed exploring how counselor wellness impacts client wellness. For example, collecting information on counselor and client wellness may be explored through assessing counselor wellness and client's simultaneous experience of wellness support. There is a foundation of literature on wellness and even how it intersects with counselors; however, further refining our knowledge can support intentional practice.

Conclusion

AC enter programs in different states of wellbeing and with different life experiences. But research highlights some of the trends that CE can expect to see in applicants and AC. By being aware of the higher prevalence of traumatic experiences in aspiring counselors, CE can explore within their program how to most effectively encourage wellness and encourage AC growth. The potential benefits of a preventative and early intervening approach ripple beyond the AC, the CE who would another remediation meeting, and both the public and the profession.

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