National Organization for Human Services

The National Organization for Human Services (NOHS) was founded in 1975 as an outgrowth of a perceived need by professional care providers and legislators for improved methods of human service delivery. With the support of the National Institute of Mental Health and the Southern Regional Education Board, NOHS focused its energies on developing and strengthening human service education programs at the associate, bachelor‘s, master‘s, and doctoral levels.

The current mission of NOHS is to strengthen the community of human services by: (a) expanding professional development opportunities, (b) promoting professional and organizational identity through certification, (c) enhancing internal and external communications, (d) advocating and implementing a social policy and agenda, and (e) nurturing the financial sustainability and growth of the organization.

Members of NOHS are drawn from diverse educational and professional backgrounds that include corrections, mental health, child care, social services, human resource management, gerontology, developmental disabilities, addictions, recreation, and education. Membership is open to human service educators, students, fieldwork supervisors, direct care professionals, and administrators. Benefits of membership include subscriptions to Human Service Education and to the Link (the quarterly newsletter), access to exclusive online resources, and the availability of professional development workshops, professional development and research grants, and an annual conference.

Six regional organizations are affiliated with NOHS and provide additional benefits to their members. They are the New England Organization for Human Service, Mid-Atlantic Consortium for Human Services, Southern Organization for Human Services, Midwest Organization for Human Services, Northwest Human Services Association, and Western Region of Human Service Professionals.

NOHS is closely allied with the Council for Standards in Human Service Education (CSHSE). CSHSE, founded in 1979, has developed a highly respected set of standards for professional human service education programs and also provides technical assistance to programs seeking Council accreditation.

Membership information can be found on the organization‘s website by clicking “Join Now”’ at: www.nationalhumanservices.org. Correspondence about membership can be found at http://www.nationalhumanservices.org/membership.

Table of Contents

Research Articles

Conceptual Articles

Training Culturally Competent Practitioners: Student Reflections on the Process

Shuntay Z. Tarver, *Old Dominion University* and Melvin Herring, *Johnson C. Smith University*

Abstract

A major aspect of cultural competence is developing critical self-reflection skills. Critical self-reflection is a culturally competent practice that positions practitioners with the ability to recognize and respond to the influence of power, privilege, and oppression within client interactions. Contributing to the existing literature on cultural competence, this article posits that teaching critical self-reflection is an essential aspect of training culturally competent practitioners. To investigate this connection, researchers qualitatively examined the retrospective accounts of 15 human services students who critically reflected on an assignment: exploring how they were personally impacted by issues of power, privilege, and oppression. Findings unveiled students' perceptions of developing culturally competent critical self-reflection to be characterized by working through resistance, exploring personal biases, and developing empathy. Implications suggest that instructors seeking to train culturally competent human services practitioners should strategically integrate opportunities for students to work through resistance, explore their existing biases, and develop empathy.

Keywords: cultural competence, self-reflection, human services education

Introduction

According to the ethical standards of the National Organization for Human Services (NOHS), practitioners have a professional responsibility to clients, to self, to students, and to the public to engage in culturally competent practices (2015). For example, NOHS standard 7 states that, "human services professionals ensure that their values or biases are not imposed upon their clients" (p. 2). Similarly, standard 34 requires that "human services professionals are aware of their own cultural backgrounds, beliefs, values and biases [and] recognize the potential impact of their backgrounds on their relationships with others…to provide culturally competent service to all of their clients" (p. 4). These guidelines emphasize that adherence to the NOHS professional standards is only possible through the engagement in culturally competent practice. Although multiple empirical definitions exist that highlight the importance of cultural competence (e.g., Azzopardi & McNeill 2016; Neukrug, 2017), limited attention has been attributed to understanding how vital developing critical self-reflection is to the process of training culturally competent practitioners (Brinson & Denby, 2008; Neukrug & Milliken, 2008). In addition, less is known about how students experience the process of developing critical self-reflection skills. To address this gap, the authors utilized an innovative approach of investigating students' retrospective accounts of an assignment utilizing critical self-reflection to illustrate the importance of teaching critical self-reflection as a vital component of training culturally competent practitioners. The primary purposes of this study were to assert that critical self-reflection is an essential aspect of cultural competence and to illustrate how educators should create classroom environments that enhance students' ability to engage in critical self-reflection in order to effectively engage in culturally competent practice.

Understanding Cultural Competence

The concept of cultural competence has been well defined within existing literature by disciplines such as social work and human services, and multiple definitions of this concept have

been presented empirically (Abrams & Moio, 2009; Neukrug, 2017). Within the field of human services, cultural competence is conceptualized as "gaining the necessary attitudes, skills, and knowledge to be able to work with a wide variety of ethnically and culturally diverse clients" (Neukrug, 2017, p. 340). NOHS embeds this definition into standards that require such acquisition to be translated into practice through the adherence of professional standards. This professional expectation underscores the urgency of human services professionals (HSPs) to develop culturally competent practices (Foronda, Baptiste, Reinholdt, & Ousman, 2016). Such development requires a deeper understanding of various aspects of cultural competence skills. The following deconstructs essential aspects of cultural competence that HSPs need to engage in effective practice.

Cultural Competence

Cultural Competence is rooted in an understanding and consideration of the concepts of power, privilege, and oppression (Collins, 2014; Johnson, 2006; Neukrug, 2017; Ore, 2014; Schmidt, 2006). These elements impact the interactions between client and practitioners across multiple diversity factors such as race, gender, socioeconomic status, age, ability status, and sexual orientation. As a result, practitioners need to be aware of the attitudes, skills, and knowledge required for engaging in culturally competent practice (Neukrug, 2017). Although each encounter will vary, every successful interaction is predicated upon practitioners' ability to recognize and respond to the inevitable influence of various elements of diversity. A thorough understanding of how these dynamics interact to impact client-practitioner relationships is critical to engaging in culturally competent practice. In addition, cultural competence also requires continual acknowledgement and response to the influences of power, privilege, and oppression within professional interactions.

Power, Privilege, and Oppression

It is imperative that HSPs are capable of recognizing and critically examining the presence and influence of power in perpetuating privilege and oppression even when it is not explicitly obvious (Kishimoto, 2018). Practitioners need to have the ability to influence, control, and access resources within their respective roles, as well situate themselves as power brokers within society, regardless of their awareness that such power dynamics are embedded within their professional roles (Johnson, 2006; Neukrug, 2017). Power is then executed through the granting or denial of opportunities that enhance or restrict clients' quality of life (Boyd & Noblit, 2015). When these decisions are based on group membership, privilege is corroborated or restricted from individuals who belong to perceived groups, regardless of intentionality. When people are denied privilege, they experience oppression (Ore, 2014). Thus, HSPs have the power to exacerbate or minimize oppression that clients experience as a result of their race, gender, socioeconomic status, sexual orientation, age, and/or ability status irrespective of their acknowledgement of the existence of such power. If HSPs are unaware of the areas in which they and their clients experience privilege and oppression, their ability to provide culturally competent services will be greatly impaired. It is essential that emerging practitioners be taught to recognize and understand these dynamics in ways that will result in culturally competent practice (Neukrug & Milliken, 2008). Understanding the presence and influence of power, privilege, and oppression within professional interactions is inextricably connected to the ability to engage in critical self-reflection of individual assumptions and socialization (Azzopardi & Mcneill, 2016; Heron, 2005; Larrivee, 2000). Consequently, the development of critical self-reflection is an essential aspect of engaging in culturally competent practice.

Critical Self-Reflection

Critical self-reflection is "a deep examination of personal values and beliefs, embodied in the assumptions [practitioners] make and the expectations they have for their [clients]" (Larrivee, 2000, p. 294). It is a critical component of cultural competence that requires a keen awareness of the influence of power, privilege and oppression on personal perspectives, and how these factors impact the dynamics of a helping relationship. Through critical self-reflection, students become aware of their personally held beliefs and biases that often go unnoticed (Bender, Negi, & Fowler, 2010; Boyd & Noblit, 2015). This results in questioning the beliefs transmitted through socialization and weighing them against reality and the experiences of others (Larrivee, 2000; Heron, 2005). Through examination of their personal beliefs, students are better able to identify and critique their personal biases (Foronda et al., 2016; Rosen, Mccall, & Goodkind, 2017). This awareness enhances their professional ability to become culturally competent practitioners by allowing them to "act with integrity, openness, and commitment, rather than defensiveness or fear" (Larrivee, 2000, p. 295). Thus, critical self-reflection is a vital component of cultural competence that educators should be strategically invested in developing.

Collectively, culturally competent practices include the ability to recognize and respond within diverse interactions. Such diverse interactions include an awareness of differential positionality between clients and practitioners regarding race, ethnicity, gender, age, ability status, socioeconomic status, and sexual orientation. Nevertheless, culturally competent practice also requires practitioners to be flexible and responsive to the unique needs of clients while assessing the presence and influence of dynamics such as power, privilege, and oppression that inevitably influence client-practitioner interactions. To investigate the development of such skills, investigators examined students' perceptions of their development of critical self-reflection. Such an investigation unveils the significance of developing critical self-reflection skills as an aspect of training culturally competent practitioners.

Method

This study utilized secondary data analyses of de-identified qualitative data to ascertain students' perceptions of their experiences developing critical self-reflection skills. Students were originally invited to write a short reflection of their experience with a theoretically based assignment designed to enhance their cultural competence as emerging HSPs. The assignment incorporated critical self-reflection into their process of becoming culturally competent HSPs. Their reflections specifically explored their experiences with and reactions to (a) what they did for their assignment; (b) what their initial reactions to the assignment were; (c) what they learned from the assignment; and (d) what they learned from hearing their peers present the assignment. The reflections of the actual assignment are beyond the scope of this paper and the current investigation was conducted two years after the students' information was submitted and de-identified for data analyses. For the purposes of this study, permission to use the de-identified information for secondary research purposes was obtained from the first author's university Institutional Review Board (IRB). Upon IRB approval, the de-identified data was theoretically examined and thematically analyzed from a cultural competence lens to understand students' perception of developing critical self-reflection skills as emerging HSPs.

Sample

The de-identified information prevented expanded descriptions of characteristics from the study's sample. As a result, only self-disclosed and general institutional descriptions were

available. Study participants attended a southeastern, minority-serving public university. All participants were enrolled in an upper level undergraduate course called *Diversity in Human Services*. The course was composed of twenty-five students from various majors, with most identifying as human services majors. All participants were offered an opportunity to write a reflection paper on their experience engaging in an integrative writing assignment designed to enhance their cultural competence as emerging human services practitioners. Participants' reflections captured their experiences with the required assignment, in which they were challenged to consider how they were personally socialized and influenced by issues of power, privilege, and oppression. These reflections also described how they felt about, and what they learned from the required assignment. Of the 25 students in the course, 15 decided to write reflection papers on their experience. Only the voluntary submissions of the reflection papers were theoretically and thematically analyzed for this study. Within the context of their papers, 10 of the 15 participants identified as Black and 5 identified as White. All participants were undergraduate and classified as either a traditional student (i.e. emerging adult matriculating through college post high school) or non-traditional student (i.e. returning students with previous careers and/or military experience). These racial and generational status demographics reflected the larger university demographics.

Thematic Analysis

This study utilized a theoretical thematic analysis, as defined by Braun and Clarke (2006), to engage in secondary data analyses. This methodology is "driven by the researcher's theoretical interest…[and] tends to provide a less rich description of the data overall, and a more detailed analysis of some aspect of the data" (p. 84). Cultural competence, as defined above, was employed as a theoretical framework to examine student reflections in an effort to understand their perceptions on developing critical self-reflection skills. This theoretical lens guided the six steps of thematic analysis utilized for this study.

Thematic Analysis. According to Braun and Clarke (2006), thematic analysis is a specific qualitative methodology composed of six steps. The first step requires researchers to immerse themselves in the data by reading and re-reading transcribed information. The initial reading of students' reflections was conducted as the first author's review of students' experience with a theoretically based assignment. Two years after the submission of the students' reflections, the first author de-identified the data, and re-engaged in the first step by re-reading the reflections from a theoretical perspective. These subsequent readings of students' reflections began to unveil a nuanced description of how students experienced the development of critical self-reflection skills. Consequently, the first author entered the second phase of thematic analysis by developing preliminary codes. Doing so required a re-read of all reflections both individually, and collectively (as an entire group). Thus, as codes emerged, all individual reflections had to be re-read to search for the emerging code. This required several iterations of reading through the reflections to ensure that all reflections were coded as codes were identified. These preliminary codes included commonalities and contradictions regarding how students described their experiences. The third stage of thematic analysis is "searching for themes" (p. 87). During this stage the authors incorporated thematic narrative analysis as outlined by Spector-Mersel (2011), by reading through the data at least six additional times for identified themes that captured the thematic narratives of participants. During this stage the authors identified three major themes in the data: resistance, exploring biases, and developing empathy.

During the fourth stage of thematic analysis researchers reviewed the identified themes to ensure that the identified themes adequately represented the data. This was done by re-reading the reflections and coding specifically for how resistance, bias, and empathy were characterized by participants within the data. The fifth stage required researchers to name and define the themes based on the ways in which participants described the themes in the data. Consequently, the identified themes were re-named as working through resistance, exploring biases, and developing empathy. The sixth and final stage is producing the report. During this stage the first author identified specific excerpts from the data to illustrate the themes. The second author verified that the identified themes made empirical sense. This also required both researchers to situate the data within the larger context in an effort to "tell the story" interpreted from within the data (Braun & Clark, 2006). Thus, both researchers utilized the theoretical framework to reflect how students developed critical self-reflection through the cultural competence concepts of process, power, privilege and oppression. This report is presented in the results section of this paper. However, before presenting this information it is critical that qualitative researchers address issues of trustworthiness in order to substantiate the researchers' ability to authentically engage in thematic analysis. Braun and Clarke posit that, "the keyness of a theme is not necessarily dependent on quantifiable measures- but rather on whether it captures something important in relation to the overall research question" (p. 82). The following trustworthiness section articulates the researchers' positionality in and expertise for being able to capture the key themes within the data. It also describes the theoretical and empirical triangulation of the data that supports the themes identified in the results section.

Trustworthiness

Trustworthiness is the process(s) of addressing validity within qualitative studies (Glesne, 2006). Referring to this construct as "validation strategies," Creswell (2013) identified eight existing methods of addressing trustworthiness (p. 250). Throughout the conceptualization and implementation of this study the authors address trustworthiness through two of Creswell's identified methods, triangulation and clarification of researcher bias. Each of these strategies strengthen the study's validity despite the existing limitations later described.

Triangulation of Data

The authors addressed trustworthiness by engaging in theoretical and empirical data triangulation. According to Creswell (2013), triangulation is defined as "corroborating evidence from different sources to shed light on a theme or perspective" (p. 251). The authors utilized cultural competence theory to theoretically triangulate the data by creating codes that captured the process of engaging in critical self-reflection. Thus, the authors highlighted all implicit and explicit references to issues of power, privilege, and oppression. This allowed researchers to theoretically identify student perceptions of their culturally competent critical self-reflections. Empirically, researchers situated the findings within the current and emerging understandings of critical self-reflection and its connection to becoming culturally competent.

Clarifying Researchers' Bias

According to Creswell (2013), "clarifying researchers' bias" is another method of attending to issues of trustworthiness within qualitative research (p. 251). This strategy is characterized by researchers acknowledging their subjectivity, including previous experiences, research decisions and orientations that influence the research process. This approach qualitatively deconstructs researchers' partiality as opposed to assuming that biases can be

bracketed in ways that will completely alleviate the empirical influence of researchers' worldviews. This is also consistent with the theoretical orientation of cultural competence through critical self-reflection that posits the necessity of acknowledging biases in an effort to work through them as opposed to adopting a post-racial ideology that assumes being politically correct could eradicate biased perceptions (Kishimoto, 2018 & Ricks, 2014). Thus, the following reflects the identification and naming of the researchers' subjectivity that influenced their empirical lens.

The research team engaging in this study were educators who have extensive experience training various practitioners (e.g. teachers, professors, law enforcement personnel, human services professionals, and social workers) to engage in the process of becoming culturally competent. They utilized an interdisciplinary model of cultural competence that coincides with the process orientation of becoming culturally competent. The first author was an African American woman from a mid-western state and the second author was an African American man from a southeastern state. Both authors have master's degrees in Social Work and doctoral degrees in Human Development and Family Studies. The first author was a faculty member in a Human Services Program within a south eastern public university. She directly facilitated the diversity course taken by study participants and maintained the reflection papers after the completion of the course. For the purpose of this study, she de-identified the reflection papers two years after the course ended in response to the emergence of social issues within the larger societal context. The first author perceived that current societal issues, including the racially charged 2016 presidential elections, numerous police shootings of unarmed Black men, and heightened campus and community incidents, underscored the need for critical self-reflection. The second author was a program director within a Social Work Program in a southeastern private university. He had no direct contact with the sample and only engaged the de-identified data through secondary data analysis. He was essential in triangulating the theoretical analyses, assessing thematic findings, and validating pedagogical implications. Collectively, each author was instrumental in ensuring the theoretical and empirical validity of the overall study.

Results

Results indicated that participants' development of cultural competence included their engagement in critical self-reflection skills that were characterized by three unique themes: working through resistance, exploring their biases, and developing empathy. Findings revealed that students most readily described their process of working through resistance as a salient influence on their critical self-reflection. Participants highlighted their awareness of power dynamics as a part of their development of critical self-reflection very few times. They most readily addressed understanding issues of privilege and oppression as they discussed their development of empathy. Collectively, the following results reflect that students perceived their development of critical self-reflection to be characterized by working through resistance, safely exploring biases, and developing greater empathy.

Working through Resistance

Consistent with existing research, students described initial feelings of resistance to the course content related to issues of power, privilege, and oppression (Cooper & Gause, 2008; Kishimoto, 2018). Such resistance was defined by various emotions that presented barriers to engaging in critical self-reflection and subsequent personal assessments that allowed them to work through resistance. Participants identified various emotions such as fear, anger, and discomfort as barriers to engaging in critical self-reflection. For example, one participant said, at

first, I was "highly annoyed" with the assignment. Another student said, "it was kind of emotional for me to pick apart those experiences and visit the past again." Another student explained that the content made her feel exasperated. While another stated, "I struggled and even dreaded [engaging in the course] because I thought it would be too hard."

Despite existing resistance, students asserted their ability to work through their resistance by engaging in personal assessments. For instance, one student described their assessment by saying, "I still am struggling with identity issues. I am still kind of uncomfortable talking about racial identity because of my own experiences with privilege and marginalization within my own race." Similarly, other students described privilege and or marginalization when explaining the personal assessments, they engaged in as strategies to work through their resistance to the course content. These personal assessments were defined as a need to engage in deeper evaluation of themselves, or a re-evaluation of others. One student described their experience with privilege as follows:

> I never really thought about my capabilities because I have never been physically disabled or known anyone to be disabled so I had nothing to compare it to. I have never experienced any situation where diversity and differences in diversity has slapped me in the face. Basically, what I am trying to say is that I have never really thought about my diversity and everything that plays into diversity (marginalization, privilege, etc.) until this assignment. This assignment really opened my eyes to the world and the people around me.

In this instance, the student acknowledged that never having to think about realities outside of their own was a privilege they experienced. However, the resistance they experienced was only evident through a personal assessment of their privileged existence. Alternatively, another student highlighted their personal assessment of oppression and how their emotions were initially barriers to engaging in critical self-reflection. They reported:

> Initially I wasn't excited to do this project because it can be kind of emotional to speak about the social locations because they are sensitive issues. I didn't want to be judged by the class. I just felt uncomfortable. This assignment, has made me aware of the areas of oppression that I had never thought about. Although, this project was really hard for me.

Collectively, students reported that working through resistance was challenging emotionally, but only possible through their engagement in personal assessments through critical self-reflection. As illustrated above, such personal assessments include students' ability to consider 'social locations' or diversity factors for both themselves and their future clients. Those who described engaging in personal assessments also characterized their experiences as life changing. For example, one student explained:

> I struggled with this assignment and even dreaded it because I thought it would be hard to talk about myself. In my entire years of education, I've never had the opportunity to write about myself, my experiences and how that's shaped my self-concept until this assignment.

Thus, engaging in critical self-reflection allowed students the opportunity to understand their own diversity and how their respective positionality may interact with others. As illustrated, several students found that such exploration occurred infrequently, yet perceived it to be life changing. Students also identified the classroom climate as an influence on their ability to work through their resistance and explore their existing biases.

Safely Exploring Biases

Several students described that the assignment and class context provided them safety to explore their personal biases. They defined biases as personally held judgments of others that were dismantled during their experiences within the course. For example, one student stated, "I formed opinions about certain others and categorized them as arrogant. But after the project I understood that they have experienced marginalization before and it made me connect to them more." Another student explained, "I had an idea of what some of my classmates would do or say, but I was actually surprised." Collectively students who described their ability to explore their personal biases acknowledged existing biased beliefs that were evident through their critical self-reflection. For example, one student described that the course was her first time being honest about her biases in class. Another student stated, "man I did still have some biases but hearing the story of others really challenged me." Students' reflections collectively illustrate that a safe context to explore their personal biases allows them to engage in critical self-reflection. In addition, students also describe their ability to understand the influence of power in their interactions. For instance, one student reported that, "I learned [through exploring their biases] to appreciate who I am, where I come from, and how to interact with other[s]." Such realization coincides with an understanding that power dynamics influence interactions between HSPs and their clients (Johnson, 2006; Ore, 2014).

Developing Greater Empathy

The majority of the participants reported that they developed a greater level of empathy from listening to the presentations of their peers. They described that such experiences expanded their perspectives through exposure and insight into the realities of others. For example, one student reported:

> I consider it a blessing to get to sit through all the presentations that were given and see all the many different aspects of diversity through my peer's work…to just get a little taste of their perspective on their life and their diversity was amazing and really eye-opening. I gained more respect for my classmates.

Similarly, several students reported that they had a cross-cultural experience when hearing from and empathizing with their peers. One student described that the assignment was "an opportunity to see how others viewed themselves in the world. As opposed to how I may view them." These students also described their experience of developing empathy as allowing them to become more aware of how privilege and oppression operated. For example, one student stated, "some of my colleague's presentations almost had me in tears because of their presentations. They were powerful, meaningful, and I know that some of the presentations were probably hard to give because [of the oppression they experienced]." Similarly, another student articulated, "I left the classroom with some knowledge of how someone else views the world. I learned that one person's privilege is someone else's marginalization." Collectively students who described their development of critical self-reflection skills to include developing empathy reported that the most salient aspect of their experience was being challenged to see things from a different perspective than they previously had. Student perceptions revealed that such a shift required students who were most often privileged, to challenge themselves by finding ways they identified with experiences of marginalization. In addition, it also challenged students who most readily understood aspects of their marginalized identity to explore areas where they also experienced privilege. This challenge is consistent with Collins (2014) theoretical assertion that individuals simultaneously occupy privileged and marginalized identities. In this way critical self-reflection enhanced students' ability to engage in cultural competence by recognizing the

influence of power, privilege and oppression within interactions. Such an understanding will strengthen their ability to recognize these dynamics within future client-practitioner interactions. Collectively these findings reveal that students' cultural competence through critical self-reflections included their development of empathy through interactions with their peers.

Discussion

The thematic analyses unveiled that students' development of cultural competence through critical self-reflection was characterized by their experiences working through resistance, exploring their personal biases, and developing greater empathy. Students' perceived experiences from engaging in critical self-reflection helped deconstruct the attitudes, skills, and knowledge necessary for training culturally competent practitioners (Neukrug, 2017). Moreover, findings suggest that critical self-reflection allowed the students to gain introspective insight of their personal biases, beliefs, and assumptions through the juxtaposition of their positions of privilege and marginalization with those of their fellow classmates. This heightened awareness of difference in standpoint as it relates to others may further suggest improved culturally competent practices, given that the students demonstrated a greater ability to recognize and empathize with the social realities of others. This critical aspect of cultural competence is vital to pedagogical practices within the classroom (Neukrug & Milliken, 2008). As a result, human services educators should be strategic about making sure that they specifically address the development of critical self-reflection skills when seeking to train culturally competent practitioners. It is also important that human services educators help students make the connection between their discomfort in being transparent in class with how clients may experience discomfort within a helping relationship (Kishimoto, 2018; Ricks, 2014). This experience has the potential to deepen students' ability to work through their resistance, explore their biases, and develop empathy. Overall, the findings of this study highlight the important role and responsibility of human services educators to create a safe and strategic classroom context for students to engage in critical self-reflection in order to become culturally competent practitioners. When human services educators train culturally competent practitioners by creating a context that is conducive for engaging in critical self-reflection, students are able to develop culturally competent skills by working through resistance, safely exploring personal biases, and developing deeper empathy of others' experiences.

Limitations

Despite the design of this investigation and the future implications that it yields, there are a number of existing limitations within this study. The first limitation is that the study employed a secondary data analysis. Thus, the data utilized was not originally collected for the purposes of the study. Consequently, strengthening the study by checking with participants post analysis was unable to be performed. Another limitation of this study is the inability to generalize the findings to larger populations. Although such limitations may be seen as a characteristic of qualitative research, it is a limitation because the de-identified nature of the study prevented specific descriptions of the actual sample in ways that would unveil how the findings may have pertained to specific populations. Understanding participants' backgrounds may have added insight for understanding if different aspects of the process of developing critical self-reflection skills were more or less prevalent among specific populations such as traditional versus non-traditional students. The implementation of only two (triangulation and clarification of biases) out of eight existing methods of addressing trustworthiness was another limitation of this study. Because the study was designed post-hoc, the incorporation of additional methods for qualitative validation

were unable to be utilized. Future studies can address this limitation by designing a more intentional research that recruits students specifically for the purposes of fully understanding students' perceptions of their development of critical self-reflection skills. Doing so would allow additional methods of addressing trustworthiness, a more detailed description of study participants, and analyses that were designed for the data collected. Despite these limitations, there are a number of future implications that may be drawn from the current study.

Future Implications

This study emphasizes the importance of educators who seek to train culturally competent practitioners to strategically develop students' critical self-reflection as an essential aspect of cultural competence. Findings suggest that cultural competence through critical self-reflection has the potential to mitigate the visceral reactions involved with understanding power, privilege, and oppression. For example, research indicates that when educators teach controversial content related to issues of power, privilege, and oppression there is often resistance from students who are exposed to this information for the first time (Bonilla-Silva, 2018; Giroux, 2003). Such resistance manifests in various forms, such as hostile student reflection papers, unwarranted student complaints to upper level administration, and at times disrespectful or threatening e-mails (Cooper & Gause, 2007). These reactions impede the learning process and create barriers for training emerging practitioners to engage in cultural competence by self-reflecting on the influence of power, privilege, and oppression within future client-practitioner interactions. Within this study, participants reported visceral feelings of anger, fear, and discomfort were a barrier to engaging in critical self-reflection. Such findings highlight how essential it is to normalize the visceral reactions that often emerge when teaching culturally competent content specifically related to issues of power, privilege, and oppression (Kishimoto, 2018). Furthermore, findings also suggest that creating a context for students to explore their personal biases and develop empathy are also important aspects of the developing culturally competent critical self-reflection skills. Such skills are vital in training emerging human services practitioners to consider the influence of power, privilege, and oppression within professional-client relationships. Consequently, it is essential that human services educators create a context where students are safe to work through emergent resistance, explore personal biases, and develop empathy. Such training is essential for equipping emerging practitioners to professionally engage in culturally competent practice.

References

Abrams, L. S., & Moio, J. A. (2009). Critical race theory and the cultural competence dilemma in social work education. *Journal of Social Work, 45*, 245-261. doi:10.5175/JSWE.2009.200700109

Azzopardi, C. & McNeill, T. (2016). From cultural competence to cultural consciousness: Transitioning to a critical approach to working across differences in social work. *Journal of Ethnic & Cultural Diversity in Social Work, 25*, 282-299. doi:10.1080/15313204.2016.1206494

Bender, K., Negi, N., & Fowler, D. N. (2010). Exploring the relationship between self-awareness and student commitment and understanding of culturally responsive social work practice. *Journal of Ethnic & Cultural Diversity in Social Work, 19*, 34-53. doi:10.1080/15313200903531990

Bonilla-Silva, E. (2018). *Racism without racist: Color-blind racism and persistence of racial inequality in the United States* (5th ed.) New York, NY: Rowman & Littlefield.

Boyd, A. S., & Noblit, G. W. (2015). Engaging students in autobiographical critique as a social justice tool: Narratives of deconstructing and reconstructing meritocracy and privilege with preservice teachers. *Educational Studies, 51*, 441-459. doi:10.1080/00131946.2015.1098644

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

Brinson, J., & Denby, R. (2008). Cultural competency coursework, personal counseling or both: What influences students' ability to work effectively with culturally diverse clients? *Human Services Education, 28*, 44-68. Retrieved from https://www.nationalhumanservices.org/assets/Journal/2008.pdf

Collins, P. H. (2014). Toward a new vision: Race, class, and gender as categories of analysis and connection. In T. E. Ore (Ed.), *Social construction of difference and inequality: Race, class, gender, and sexuality* (6th ed.) New York, NY: McGraw-Hill.

Cooper, C. W., & Gause, C. P. (2008). Who's afraid of the big bad wolf? Facing identity politics and resistance when teaching for social justice. In D. Carlson & C. P. Gause (Eds.), *Keeping the promise: Essays on leadership democracy, and education* (pp. 197-216). New York, NY: Peter Lang.

Creswell, J. W. (2013). *Qualitative inquiry and research design choosing among five approaches*. (3rd ed.) Los Angeles, CA: SAGE Publishing.

Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing, 27*, 210-217. doi:10.1177/1043659615592677

Giroux, H. A., (2003). Public pedagogy and the politics of resistance: Notes on a critical theory of educational struggle. *Educational Philosophy and Theory, 35*, 5-16. doi:10.1111/1469-5812.00002

Glesne, C. (2005). *Becoming qualitative researchers: An introduction* (3rd ed.). New York, NY: Longman.

Heron, B., (2005). Self-reflection in critical social work practice: subjectivity and the possibilities of resistance. *Reflective Practice: International and Multidisciplinary Perspectives*, *6*, 341-351. doi:10.1080/14623940500220095

Johnson, A. G. (2006). *Privilege, power, and difference* (2nd ed.). New York, NY: McGraw-Hill.

Kishimoto, K. (2018). Anti-racist pedagogy: From faculty's self-reflection to organizing within and beyond the classroom. *Race Ethnicity and Education, 21*, 540-554. doi:10.1080/13613324.2016.1248824

Larrivee, B. (2000). Transforming teaching practice: Becoming the critically reflective teacher. *Reflective Practice, 1*, 293-307. doi:10.1080/14623940020025561

National Organization for Human Services [NOHS]. (2015). Ethical standards for human services professionals. Retrieved from http://www.nationalhumanservices.org/ethical-standards

Neukrug, E. S. (2017). *Theory, practice, and trends in human services* (6th ed.). Boston, MA: Cengage Learning.

Neukrug, E., & Milliken, T. F. (2008). Activities to enhance the cultural competence of human services students. *Human Services Education, 28*, 17-28.

Ore, T. E. (2014). *Social construction of difference and inequality: Race, class, gender, and sexuality* (6th ed.) New York, NY: McGraw-Hill.

Ricks, S. (2014). Teaching and learning in "post-racial" America: Implications for human services professionals. *Journal of Human Services, 34*, 163-168.

Rosen, D., McCall, J., & Goodkind, S. (2017). Teaching critical self-reflection through the lens of cultural humility: An assignment in a social work diversity course. *Social Work Education, 36*, 289-298. doi:10.1080/02615479.2017.1287260

Schmidt, J. J. (2006). *Social and cultural foundations of counseling and human services: Multiple influences on self-concept development*. Boston, MA: Allyn & Bacon.

Spector-Mersel, G. (2011). Mechanisms of selection in claiming narrative identities: A model for interpreting narratives. *Qualitative Inquiry, 17*, 172-185. doi:10.1177/1077800410393885

Examining Differences of Human Service Utilization among Latino Men Living with HIV and Varied Racial Identifications

Paul A. Datti, *University of Scranton* and Liza M. Conyers, *Pennsylvania State University*

Abstract

Data from the National Working Positive Coalition - Vocational Development and Employment Needs Survey was used to describe demographic and human service use characteristics of a sample of 227 Latino male respondents living with HIV with focus on racial identification comparisons. Findings make several contributions to understanding how racial identification varies within this population including how it may relate to factors such as affectional/sexual orientation, key outcomes (e.g., employment, homelessness), and to potential incentives and barriers to human service use. Statistically significant results include that those who racially identified as Black were more likely to be unemployed and to have experienced homelessness, and those who racially identified as "Latino" were more likely to have received substance abuse services. Implications for human service professionals, study limitations, and suggestions for future research are also discussed.

Keywords: Latino, race, HIV, AIDS, human services

Introduction

Latino Americans continue to be the nation's largest ethnic minority group, comprising approximately 18% (about 57.5 million) of the United States population (U.S. Census Bureau, 2018). This group remains disproportionally affected by the Human Immunodeficiency Virus (HIV), accounting for 21% of all people living with HIV (PLWH) in the country and an alarming 24% of all new HIV infections (Centers for Disease Control and Prevention [CDC], 2017). Latino men constitute 87% of all Latinos living with HIV, and the majority of these individuals are men who have sex with men (MSM; CDC, 2017), making them one of the groups most affected by HIV.

Latino culture in the United States is diverse, including several ethnic subgroups and individuals with varied racial identifications (Garcia, Sanchez, Sanchez-Youngman, Vargas, & Ybarra, 2015; Zea, Reisen, & Díaz, 2003). The largest Latino ethnic subgroups in the United States are Mexican, Puerto Rican, and Cuban Americans, making up approximately 63.2%, 9.5%, and 3.9% of the Latino American population respectively (U.S. Census Bureau, 2018). While it is important to investigate and understand the nuances between the ethnic subgroups in the Latino population, racial identification is important to consider as well, since Latinos identify with a range of different racial groups and race is often associated with use of human services (Lieb et al., 2011; Stokes-Brown, 2012; U.S. Census Bureau, 2017; Wilson, 2005).

Racial identification of Latinos is infrequently addressed in human services research (Datti, Conyers, & Boomer, 2013; Sanchez, 2013; Stokes-Brown, 2012), even though scholars and the U.S. Census Bureau recommend collecting both race and ethnic-specific data for Latinos (Zambrana & Carter-Pokras, 2001). As noted by Newby and Dowling (2007), U.S. immigrants encounter a racial system that consists of "Whites, Hispanics…and African Americans" (p. 351), thus suggesting that Latinos are often compared to White, Black, and other racial groups without sufficient examination of the racial diversity within the Latino population. Lopez (2013) cautions against considering Latinos' race and ethnicity as one construct, noting that it may lead to missed opportunities to better understand the varied experiences among individuals from different racial

backgrounds within the very broad Latino categorization. Without more information about the potential effects of racial identification for Latino men, including those living with HIV, human service professionals may not understand or neglect many important variations and characteristics of the different groups.

Examining differences in racial identity is particularly important in HIV-related research since, in contrast to census data, a much higher proportion of respondents' self-report a Black racial identification, which is also associated with poorer outcomes (Oramasionwu et al., 2009). According to national surveys, more Latinos identify as White as opposed to Black (Frank, Akresh, & Lu, 2010; Golash-Boza & Darity, 2008), and, as of the most recent census, only two and a half percent of Latinos identified as Black while 53% identified as White (U.S. Census Bureau, 2011). Research describing racial identification of Latino men living with HIV in New York who completed the National Working Positive Coalition - Vocational Development and Employment Needs Survey (NWPC-VDENS), however, found that a similar number of respondents identified as Black (46%) as White (41%), while about 13% identified as "Other" (Datti & Conyers, 2010). The higher number of Black-identified individuals is likely due in part to New York having a large number of Black-identified Latinos (Datti, 2009; Logan 2003). In their national study using the NWPC-VDENS data, researchers found that over half (56%) of Latino men living with HIV racially identified as White, while 27% identified as Black, 10% identified as Multiracial, and seven percent identified as Latino in terms of race (Datti et al., 2013). The latter identifier is important to consider as many Latinos avoid race questions or report some form of *Latino* as their race (Lopez, 2013; Stokes-Brown, 2012), thus indicating that many Latino individuals racially identify as *Latino* even though it is widely accepted as an ethnically-related as opposed to a racially-related descriptor (Gonzalez-Barrera & Lopez, 2015).

As noted by Stokes-Brown (2012), Latino racial identity is associated with factors related to socioeconomic status (SES). Highly educated Latinos and those with higher incomes, for example, tend to identify as White (Stokes-Brown, 2012), while Latinos who identify as Black tend to have higher unemployment and poverty rates and lower education rates (Frank et al., 2010; Logan, 2003). Furthermore, several studies indicate that Black-identified men tend to experience homelessness more than men of other racial identifications (e.g., Horvitz-Lennon, et al., 2009; Linton et al., 2017). As such, SES, and variables related to it (e.g., education levels, employment, poverty) are important to consider when studying potential effects of racial identification of Latino men. As a factor that affects several men living with HIV, homelessness is particularly important to consider as well.

With regard to affectional/sexual orientation, several studies indicate heightened stigma associated with non-heterosexuality within Latino and Black male cultures and that such identifications can affect use of human services (e.g., Henny, Nanin, Gaul, Murray, & Sutton, 2018; Zea, Reisen, Poppen, Bianchi, & Echeverry, 2005). However, studies tend to not address the racial identification of the Latinos. Henny et al.'s study on gay identity of Black and Latino MSM, for example, noted that 10% of the sample identified as both Black and Latino; however, no comparisons were made with regard to this group and others on gay identity. The phenomenon of not differentiating the racial identification of Latinos, but rather using groupings such as White, Black, or Latino, is consistent across HIV and other scholarly literature. Given the dearth of literature focusing on racial identification of Latino men and its potential effect on affectional/sexual orientation identification, this is also an important variable to consider, particularly since HIV affects Latino MSM at such high rates.

Several studies also suggest that racial identification is correlated with service utilization, often indicating that individuals who identify as Black tend to be underserved in the human

services field as compared to those who identify as White. This includes mental health counseling (Hood, Golembiewski, Benbow, Sow, & Vetta, 2017), substance abuse counseling (Wilson, et al., 2014), case management (Horvitz-Lennon, et al., 2009), and state-federal vocational rehabilitation (VR) services (Wilson, 2005). Once more, however, very few studies examine racial identification of Latinos and the differences between them, as they tend to focus on differences among Whites, Blacks, and Latinos (and other groups).

To date, research has not fully examined racial differences among Latino men living with HIV and its relation to various factors. As such, this study, using a sample of Latino men living with HIV from the NWPC-VDENS, aimed to address racial identification and how it may relate to affectional/sexual orientation and key outcomes including employment, education, poverty, homelessness, and human services use (i.e., case management, mental health counseling, state-federal VR services, and substance abuse counseling). Variables were selected given available research on human services use by Latinos and PLWH as well as health and human services research examining the impact of racial identification. Hypotheses included that respondents who racially identify as Black would report lower levels of non-heterosexual identification, employment, education, and use of human services compared to those who identify with other race categories; and that respondents who identify as Black would report higher levels of poverty and homelessness compared to those who identify with other race categories.

Method

Participants

Data consisted of responses from a sample of Latino male participants who volunteered to complete the NWPC-VDENS, a national survey of 2506 PLWH that assessed vocational development, employment, and other needs (For a detailed description of the NWPC-VDENS, see Datti, 2009). Responses from participants ($N = 227$), each of whom reported being a U.S. citizen or permanent resident, being at least 18 years old, male, Latino, and having HIV or advanced HIV (Acquired Immunodeficiency Syndrome) were included.

Procedures

Survey research methods were used for this study, which was approved by a university Institutional Review Board. Data collection took place at 33 HIV service provider agencies as well as via the Internet by national HIV organizations and internet portals to recruit participants from as many areas of the country as possible. Participants were provided with an informed consent form letting them know the purpose of the study and that their participation was voluntary and had no effect on service delivery. Some participants received a small stipend for completing the survey depending upon agency polices and resources. Items from the NWPC-VDENS instrument were used to measure the variables for this study. Table 1 includes all variable descriptions. Descriptive statistics were used to delineate demographic characteristics of the Latino male respondents in the sample with regard to variables in Table 1. Bivariate (Pearson Chi Square) analyses were used to assess if there were significant statistical differences between participants with regard to these variables based on racial identifications.

Table 1
Variable Definitions and Measures

Racial Identification	Categorical. Whether participants self-identified as White, Black, Multiracial, or "Latino." Measured by an item listing several racial identifications as well as an option to choose Other and fill in blank (those who filled in "Latino" or any Latino subgroup (e.g., Puerto Rican, Mexican, Cuban) were counted as "Latino."
Affectional/Sexual Orient.	Categorical. Whether participants self-identified as heterosexual, gay, or bisexual. Measured via an item listing several affectional/sexual orientation options.
Education	Categorical. Level of education completed. Measured by an item listing several educational levels.
Employment	Dichotomous. Whether participants reported being employed or not.
Poverty	Dichotomous. Defined by U.S. Department of Health and Human Services (USDHH, 2011) standards of yearly income of $10,890 for single person, and increasing $3,820 per additional family member. Measured via items assessing yearly household income level and number of people in the (shared income) household at the time data was analyzed.
Homelessness	Dichotomous. Whether participants reported experiencing homelessness or not.
Receive CM Services	Dichotomous. Whether participants received case management services or not. Measured by an item listing several types of human services received currently, in past, or never.
Receive VR Services	Dichotomous. Whether participants received vocational rehabilitation services or not. Measured by an item listing several types of human services received currently, in past, or never.
Received MH Counseling	Dichotomous. Whether participants received mental health counseling services or not. Measured by an item listing several types of human services received currently, in past, or never.
Receive SA Counseling	Dichotomous. Whether participants received substance abuse counseling services or not. Measured by an item listing several types of human services received currently, in past, or never.

Note. CM = Case Management, MH = Mental Health, Orient = Orientation, SA = Substance Abuse, VR = Vocational Rehabilitation.

Results

Descriptive Statistics

The mean age of participants was 44.6 years with a range from 20 to 67 years (*SD* = 3.66). Almost two thirds of participants racially identified as White (*n* = 141; 62.1%), while 18.1% (*n* = 41) identified as Black, 11.9% (*n* = 27) as Multiracial, and 7.9% (*n* = 18) as *Latino*. About one third of the participants identified as Puerto Rican (*n* = 71; 31.3%), while 15.4% (*n* = 35) identified as Mexican, and the remainder (*n* = 121; 53.3%) identified as belonging to some

other Latino ethnicity. Over half of participants identified as gay (n = 128; 58.7%), while 31.2% (n = 68) identified as straight, and 10.1% (n = 22) as bisexual. Almost three quarters were not working (n = 163; 72.1%). Over half (n = 123; 56.4%) reported having more than a high school education, while 23.9% (n = 52) reported high school/GED attainment, and 19.7% (n = 43) reported having completed less than high school. Almost half reported being in poverty (n = 94; 43.5%) and having experienced homelessness (n = 83; 49.4%). The vast majority of participants reported receiving case management services (n = 176; 83.4%), and 30% (n = 59) reported receiving VR services. Almost 80% (n = 166) reported receiving mental health counseling, and about half (n = 94; 46.1%) reported receiving substance abuse treatment at some point as well. Most (n = 211, 93.4%) reported having health insurance and receiving medical care (n = 200, 94.3%). Table 2 lists the descriptive findings for all demographics and variables.

Bivariate Statistics

Pearson Chi Square analyses were run to compare groups of each identified race (White, Black, Multiracial, and *Latino*) on each of the variables noted in Table 1. The assumptions for Chi Square analyses were met, including independence of observations and adequate cell sizes. This included ensuring that there was only one observation per subject that was not paired in any way, and expected cell frequencies were at least five for the majority (80%) of each case (Leong & Austin, 2006; McHugh, 2013). Statistically significant differences were found with regard to employment (X^2 = 10.36, Cramer's V = .214, p < .05; i.e., those who identified as Black were more likely than other groups to be unemployed), education (X^2 = 18.84, Cramer's V = .191, p = .05; i.e., those who identified as Multiracial were more likely to have more than a high school/GED education than other groups), and homelessness (X^2 = 8.51, Cramer's V = .225, p < .05; i.e., those who identified as Black were more likely than other groups to have experienced homelessness). In terms of human services use, significant results were found with substance abuse services (X^2 = 13.09, Cramer's V = .253, p < .01; i.e., those who racially identified as *Latino* were more likely than other groups to have received these services). Analyses comparing racial identification with poverty, mental health counseling, and state-federal VR services were nonsignificant, and data limitations did not allow for accurate bivariate analysis with regards to affectional/sexual orientation or case management services. Table 2 also lists significant Chi Square findings for the data set.

Table 2
Statistics for Variables

	n	%	%	%	%	Total%
Racial Identification						
Black	41	18.1				
White	141	62.1				
Multiracial	27	11.9				
"Latino"	18	7.9				
		Black	White	Multi	Latino	
Affectional/Sexual Orientation						
Heterosexual	68	7.3	17.4	1.4	5.0	31.2
Gay	128	7.8	39.4	8.7	2.8	58.7
Bisexual	22	2.8	5.0	2.3	0.0	10.1
Education*						
Less than High School	43	4.6	11.5	0.9	2.8	19.7
High School Graduate/GED	52	5.5	13.3	1.8	3.2	23.9
More than High School	123	6.9	37.6	9.6	2.3	56.4
Employed*						
Yes	63	2.7	18.1	5.8	1.3	27.9
No	163	15.5	43.8	6.2	6.6	72.1
Poverty						
Yes	94	8.3	25.9	4.2	5.1	43.5
No	122	9.3	35.6	8.3	3.2	56.5
Homelessness*						
Yes	83	12.5	24.4	7.1	5.4	49.4
No	85	6.0	35.7	4.8	4.2	50.6
Receive CM						
Yes	176	15.2	51.2	8.5	8.5	83.4
No	35	1.4	11.4	3.8	0.0	16.6
Receive VR Services						
Yes	59	5.6	17.8	5.1	1.5	30.0
No	138	9.1	46.7	8.1	6.1	70.0
Receive MH Counseling						
Yes	166	13.0	48.6	11.5	6.7	79.8
No	42	2.9	15.4	1.4	0.5	20.2
Receive SA Counseling**						
Yes	94	9.3	26.0	4.4	6.4	46.1
No	110	6.4	37.7	8.3	1.5	53.9

Note. CM = Case Management, MH = Mental Health, Multi = Multiracial, SA = Substance Abuse, VR = Vocational Rehabilitation. Significant association reported as * (Chi Square test $p < .05$) or ** (Chi Square test $p < .01$).

Discussion

This study addressed racial identifications of a sample of Latino men living with HIV and how these identifications may relate to affectional/sexual orientation and key outcomes including employment, education, poverty, homelessness, and human service utilization. Findings make several contributions to understanding the population and how racial identification and other factors may play roles in their lives. In particular, this study highlights (a) how respondents who identify as Black face particular challenges with employment, education, and homelessness as compared to other racial groups; (b) how affectional/sexual orientation varied with regard to racial identification; (c) and differences in human services utilization among racial groups within the sample. These and other factors are discussed below along with implications for human services professionals, study limitations, and the need for future research.

One of the main points that this study illustrates is the significant unemployment experienced by Latino men living with HIV, particularly those who identify as Black. While almost three quarters of all respondents were not working, over 85% of those who identified as Black were unemployed, which supported our hypothesis that self-identified Black respondents would have higher rates of unemployment. This is not surprising, as research indicates that Black individuals consistently have the highest unemployment rates (Austin, 2012). While there is some literature indicating that Latinos who identify as Black have higher unemployment rates than Latinos who identify as White (e.g., Bell, Marquardt, & Berry, 2014; Logan, 2003), very few studies adequately address racial identity of Latino men and its potential effects on employment (Dickerson vonLockette & Johnson, 2010), particularly those living with HIV.

Additionally, almost half of the sample had high school education or less; however, those who identified as White and Multiracial reported higher levels of education than those who identified as Black and *Latino*, thus supporting the initial hypothesis and indicating that those who identify as White and Multiracial tend to be more educationally advantaged. This too is not surprising, as Black and Latino individuals tend to have lower education levels than White, Non-Latino individuals (Ryan et al., 2005). Ryan et al., in fact, studied neuropsychological impairments of racial and ethnic minority individuals living with HIV and found that not only did Black and Latino individuals have lower education levels than non-Latino Whites, they also were more likely to have discrepant reading and education levels as compared to others. That is, in contrast to others with equal educational attainments, they scored lower on neuropsychological tests. The researchers noted that inequities in education for racial/ethnic minorities, acculturation levels, and HIV-related cognitive impairment can be factors; however, these findings, along with the current study outcomes, underscore the need to address educational disadvantages of Black and Latino individuals, particularly those with HIV.

Furthermore, this study revealed that Black-identified Latino men living with HIV were more likely than other groups to have experienced homelessness; thus supporting the initial hypothesis as well. These results are reflective of other studies examining homelessness, as several indicate that Black men tend to experience homelessness more than men of other racial identifications (e.g., Horvitz-Lennon et al., 2009; Linton et al., 2017). It is important to consider that the Black-identified individuals in this study were not only more likely to have experienced homelessness, they were also more likely to be unemployed. While employment disadvantages may be associated with homelessness and other issues (Richardson et al., 2014), each of these may pose significant challenges for PLWH, as access to necessary medical care and HIV medications may be reduced. Interestingly, most participants in this study reported having health insurance and receiving medical care. These results may be particularly important, as they conflict with studies suggesting that Black-identified individuals have less frequent use of and

access to services. Factors that may partially explain these results are the relative low level of poverty among the sample as well as the increased likelihood of access to insurance and medical care, since most participants were recruited from HIV Service Organizations and were likely connected to Medicaid, other insurances, and medical care by the organizations.

Along these lines, this study also highlights that racial identification of Latino men living with HIV may have effects on utilization of some human services. For example, although data limitations did not allow for significance testing, it was noted that, while the vast majority of respondents received case management services, every respondent who racially identified as *Latino* received the services. These results are reminiscent of Horvitz-Lennon et al.'s (2009) study that investigated service disparities among adults with severe mental illnesses, in which they found that Latinos were more likely to utilize these services; however, the Latino participants' racial identification was not differentiated in the Horvitz-Lennon study, where Latino respondents were compared to others who identified as either White or Black. With regard to substance abuse services, while almost half of the overall sample had received these services, more than 80% of those who racially identified as *Latino* reported receiving the services, which was far higher than the other groups. Indeed, research indicates that Latino men tend to be at high risk for alcohol and drug abuse (Anonymous, 2014; Gonzalez et al., 2009), and according to the HIV Cost and Services Utilization Study, only 50% of those living with HIV reported being drug free (Gonzalez et al., 2009). In the current study, however, the men identified racially with an ethnicity identifier and, therefore, it is difficult to draw conclusions with regards to racial differences. Nonetheless, there is a dearth of Latino representation in substance abuse counseling research (Gonzalez et al., 2009), particularly research that addresses racial identification and an HIV diagnosis. While the current study did attempt to address racial identification and its potential effects on mental health counseling and state-federal VR services, neither was statistically significant. These results may be related to the Latino community having limited information about mental health and mental health counseling (National Alliance on Mental Illness, 2019) as well as limited knowledge of VR services, including those living with HIV (Datti et al., 2013), regardless of racial identification.

A factor that may impact human services use among other things is affectional/sexual orientation. Several studies note that stress related to the coming out process and potential fears of harassment or discrimination can be barriers to human service use for non-heterosexual individuals (Currin et al., 2018; Whitehead, Shaver, & Stephenson, 2016). These are also concerns for many PLWH (Geter, Sutten, & Hubbard-McCree, 2018; Johnson, Polansky, Matosky, & Teti, 2010), and these and other factors can increase due to dual marginalized identities (Hays & Erford, 2018). Several studies indicate stigma associated with non-heterosexuality within Latino and Black male cultures tends to be high (e.g., Henny et al., 2018; Zea et al., 2005). Indeed, studies show that Black and Latino MSM are less likely to identify as gay and are less likely to disclose same-sex behaviors (Sandfort & Dodge, 2008). Although data limitations did not allow for significance testing in the current study, it was noted that, even though almost 70% of participants identified as gay or bisexual, higher percentages of both those who identified as Black (41%) and Latino (64.7%) identified as heterosexual as compared to those who identified as White (28.1%) or Multiracial (11.1%). While concerns about non-heterosexual identification may have been a factor in these results, it is important to consider that affectional orientation and sexual behaviors may not be related to many of the respondents' HIV diagnosis as they may have acquired HIV via intravenous drug use or other ways. This study, however, is one of few that measured racial identity of Latino men living with HIV and its

potential relationship to affectional/sexual orientation, which is important given the differing views and perceptions of non-heterosexual identities among various racial and ethnic groups.

Despite the benefits of examining racial identification differences among Latino men living with HIV, capturing this data can be challenging as many Latinos avoid race questions, answer with an ethnicity (e.g., *Latino*), or simply respond "some other race" if given the option (Lopez, 2013; Stokes-Brown, 2012). This phenomenon is noted in U.S. census data as well as major research studies (Gonzalez-Barrera & Lopez, 2015). Nonetheless, considering the racial identification of Latino men and making more deliberate attempts to measure it accurately are important factors with regard to their use of human services, particularly for PLWH, a group with a high need for such services as compared to the general population.

Implications for Human Service Professionals

There are various reasons for human services utilization among Latino men living with HIV. These can be related to potential psychosocial and mental and physical health issues that tend to affect them, such as depression, anxiety, and substance abuse, as well as need for housing, medical, vocational, and finance assistance (Chiu, Conyers, & Boomer, 2018; Conyers, Richardson, Datti, Koch, & Misrok, 2017). This study described issues that many Latino men living with HIV encounter including poverty, lower education levels, unemployment, and homelessness, each of which, in addition to a diagnosis of HIV, may further create a need for human service utilization. While the need exists, barriers may come into play concerning use of services for the population. These may include limited access to services, racism, ethnocentrism, language barriers, HIV stigma, and discrimination based on affectional/sexual orientation (Chiu et al., 2018; Datti et al., 2013; Senices, 2005). It is imperative that practitioners be aware of these potential barriers and work to eradicate them, as well as be knowledgeable and competent with regard to racial diversity and potential implications of racial differences within the group. This can include being aware of and addressing several forms of bias and discrimination given the possibility of multiple marginalized identities. As a potential method to address these issues on an agency level, for example, practitioners can be provided consistent training on the National Organization for Human Services (NOHS) Ethical Standards (2015) and how they relate to this (and other) specific population(s). Several standards (e.g., Standards 10, 11, 26, and 34) delineate the need for best practices with culturally diverse clientele, and that practitioners are to be knowledgeable of their own cultures, and others,' as well as be aware of their values and biases in efforts to provide culturally competent services. Trainings aimed at maintaining and increasing knowledge, awareness, and skills in these areas can help to increase frequency and quality of human services provision to Latino men living with HIV.

In that vein, training in human services education programs is important to promote appropriate service provision to this population, as it is unlikely that coursework on the specific population of Latino men living with HIV is provided. While the main accrediting body that provides oversite to human services education programs, the Council for Standards of Human Service Education (CSHSE, 2018) has requirements in their standards for education about people with disabilities, in which this group sometimes falls, it is possible that this population may not be addressed much or at all in curriculums. Therefore, it is important for human services educators to make deliberate attempts to infuse information about the population into courses at both the undergraduate and graduate levels. While many programs have at least one course devoted to cultural diversity, they may only touch on Latino ethnicity, gender identity, affectional/sexual orientation, and chronic illnesses such as HIV. Thus, creation of specific courses geared toward these topics can be helpful with increasing trainees' knowledge and

competence with the issues. Programs without such courses can contact those that do and request information on how to infuse their curricula with this information. Many colleges, for example, offer specific courses on affectional/sexual orientation and gender identity (College Choice, 2019), and can be contacted for further information. In addition to initial college-level training, it is important that practitioners pursue further post-graduate professional development opportunities and continuing education that provides programming about the population in efforts to obtain more knowledge and increase competence. For example, NOHS (n.d.), the American Counseling Association (ACA, 2019), and the U.S. Conference on AIDS (USCA, 2019), among others, each offer continuing education sessions at annual conferences that are geared towards affectional/sexual orientation, gender identity, cultural competence (including race and ethnicity specific information), and several topics related to PLWH.

Advocating for this marginalized population is also imperative, and it would be helpful for practitioners to consistently do so in practice and community venues. For example, advocating for specific services (e.g., free HIV testing, creation of Latino- and HIV-related support or therapy groups) inside agencies, practices, and communities would be helpful. In addition, it would be helpful to have specialized resources geared not only toward PLWH, but also specific to Latino men. An excellent source to find PLWH-specific resources is the Lesbian, Gay, Bisexual, and Transgender (LGBT) National Help Center (www.glnh.org), which has resources including peer support, a national hotline, and a large database called *GLBT Near Me* that identifies many HIV-related and other resources within a given radius of an entered zip code (LGBT National Help Center, n.d.). In some areas, there are specialized resources and programs for those with intersecting identities, such as Latino, PLWH, and LGBT, which can be significant assets to Latino men, and others, living with HIV.

Limitations

This study has limitations that should be considered when interpreting results and utilizing them for practice, education, or future research. First, the survey data involved only self-report from participants. Self-reporting can be influenced by social valuation, as participants may have wanted to appear in a desirable way or to comply with any given standard when answering some questions. Also, some participants were paid for participation, which may have caused bias if they completed the survey solely for the incentive. While the survey instrument was consistent across participants, administration did vary (i.e., electronic and pencil and paper form), thus leaving potential for outcomes to be affected by the differing methods. Also, differences in language between English and Spanish as well as dialects and word meanings may have had potential for misinterpretation of some items. Another limitation is the use of only categorical level variables. While participants were free to choose from a number of options in most cases (e.g., racial identifications, ethnicities, affectional/sexual orientations, etc.), some may not have identified with any given category (or more than one of them); therefore, grouping the individuals into fixed categories may have reduce ability to fully evaluate the variables and their potential impact. In that vein, more specific information with regards to income can be considered a limitation, as mean, median, and standard deviation for this variable were not available nor taken into account; therefore, it is difficult to understand the nuances, for example, between those who are in poverty and have incomes at the higher end of the income range of this category as opposed to those with incomes at the lower end. Finally, while the archived data used in this study yielded important information, it would be helpful to gather new data that includes more in-depth exploration of racial identity to better understand the ways in which it can impact factors including human service use.

Recommendations for Future Research

Additional research is needed to further examine the meaning and impact of racial identity among Latino men living with HIV and how it may affect the broader range of human service delivery. This may include taking further steps to consider within group differences among the diverse racial identities in the Latino male population. For example, in this study, participants who identified racially as *Latino* were significant more likely to have used substance abuse services. Further studies examining racial identity of Latino men and its potential effect on accessing these services may shed more light on some of the factors that may be related to it. In addition, further studies about the identities of Latino men who identify as Multiracial and its effects on human service use may be helpful. Multiracial individuals, for example, may have preference toward one or more racial identification, which may have effects on service use.

Further studies to explore processes behind the relationships of racial identification of Latino men living with HIV and other identifiers would be helpful as well. For example, in this study, White and Multiracial Latino men more frequently identified as gay. Qualitative studies (e.g., in-depth interviews, focus groups) to help illuminate potential relationships of this may be helpful. The same can be done to examine themes that may relate to access and frequency of use of human services. Finally, there is a need for studies that include those who have not used human services in order to identify and address barriers to service utilization. For example, 70% of participants in this study had not used VR services yet may benefit from them. While there is some research related to this (e.g., Datti & Conyers, 2010; Datti et al., 2013), further studies examining factors related to limited use of VR and other human services can help stakeholders to identify potential barriers and incentives for service use among Latino men with HIV, and other groups, and to improve service provision frequency and quality.

References

American Counseling Association [ACA]. (2019). *Past conferences.* Retrieved from https://www.counseling.org/conference/past-conferences

Anonymous. (2014). Addressing the specific behavioral health needs of men. *Journal of Drug Addiction, Education, and Eradication, 10*(1/2), 1-197. doi:10.1080/1533256x.2014.902254

Austin, A. (2012). *For African-Americans, 50 years of high unemployment*. Retrieved from https://www.epi.org/publication/african-americans-50-years-high-unemployment-2/

Bell, M. P., Marquardt, D., & Berry, D. P. (2014). "Diversity," immigration, and the new American multi-racial hierarchy. *Journal of Managerial Psychology, 29*(3), 285-303. doi:10.1108/jmp-08-2012-0242

Centers for Disease Control and Prevention [CDC]. (2017). *HIV among Hispanics/Latinos.* Retrieved from https://www.cdc.gov/hiv/group/racialethnic/hispaniclatinos/index.html

College Choice. (2019). *Best LGBTQ schools.* Retrieved from https://www.collegechoice.net/rankings/best-lgbt-friendly-colleges-and-universities/

Chiu, Y., Boomer, K. B., & Conyers, L M. (2018). The impact of psychosocial factors on health and retention outcomes for people living with HIV: implications for rehabilitation counselors and educators. *Rehabilitation Counseling Bulletin, 61*(3), 1-14. doi:10.1177/0034355218755304

Conyers, L. M., Richardson, L., Datti, P. A., Koch, L., & Misrok, M. (2017). Benefits of employment for people with HIV: Health, social, and prevention outcomes. *AIDS Education & Prevention, 29*(5), 476-491. doi:10.1521/aeap.2017.29.5.475

Council for Standards of Human Service Education [CSHSE]. (2018). Overview of the CSHSE national standards. Retrieved from https://cshse.org/membership-resources/standards/

Currin, J. M., Hubach, R. D., Crethar, H. C., Hammer, T. R., Hang-Shim, L., & Larson, M. (2018). Barriers to accessing mental healthcare for gay and bisexual men living in Oklahoma. *Sexuality Research & Social Policy, 15*(4), 483-496. doi:10.1007/s13178-018-0321-5

Datti, P. A. (2009). *Latino men with HIV:* Factors influencing use of vocational rehabilitation services (Doctoral dissertation). Retreived from Proquest/UMI Dissertation Database.

Datti, P. A., & Conyers, L. M. (2010). Application of the behavioral model of service utilization to predicting factors associated with VR use among a sample of Latino men with HIV/AIDS in New York State. *Journal of Vocational Rehabilitation, 33*, 1-11.

Datti, P. A., Conyers, L. M., & Boomer, K. B. (2013). Factors affecting VR use among Latino men with HIV/AIDS: A national perspective. *Journal of Applied Rehabilitation Counseling, 44*(3), 42-50.

Dickerson vonLockette, N. T., & Johnson, J. (2010). Latino employment and residential segregation in metropolitan labor markets. *Du Bois Review, 7*(1), 151-184. doi:10.1017/s1742058x10000147

Frank, R., Akresh, I. R., & Lu, B. (2010). Latino immigrants and the U.S. racial order: How and where do they fit in? *American Sociological Review, 75*(3), 378-401. doi:10.1177/0003122410372216

Garcia, J. A., Sanchez, G. R., Sanchez-Youngman, S., Vargas, E. D., & Ybarra, V. D. (2015). Race as lived experience. *Du Bois Review, 12*(2), 349-373. doi:10.1017/s1742058x15000120

Geter, A., Sutton, M. Y., & Hubbard McCree, D. (2018). Social and structural determinants of HIV treatment and care among black women living with HIV infection: A systematic review: 2005-2016. *AIDS Care, 30*(4), 409-416. doi:10.1080/09540121.2018.1426827

Golash-Boza, T., & Darity, W. (2008). Latino racial choices: the effects of skin color and discrimination on Latinos' and Latinas' racial self-identifications. *Ethnic and Racial Studies, 31*(5), 899. doi:10.1080/01419870701568858

Gonzalez, J. S., Hendriksen, E. S., Collins, E. M., Durán, R. E., & Safren, S. A. (2009). Latinos and HIV/AIDS: Examining factors related to disparity and identifying opportunities for psychosocial intervention research. *AIDS and Behavior, 13*(3), 582-602. doi:10.1007/s10461-008-9402-4

Gonzalez-Barrera, A. & Lopez, M. H. (2015). *Is being Hispanic a matter of race, ethnicity, or both?* Retrieved from http://www.pewresearch.org/fact-tank/2015/06/15/is-being-hispanic-a-matter-of-race-ethnicity-or-both/

Hays, D.G., & Erford, B.T. (2018). *Developing multicultural counseling competence: A systems approach* (3rd ed.). Upper Saddle River, NJ: Pearson.

Henny, K. D., Nanin, J., Gaul, Z., Murray, A., & Sutton, M. (2018). Gay identity and HIV risk for Black and Latino men who have sex with men. *Sexuality & Culture, 22*(1), 258-270. doi:10.1007/s12119-017-9465-3

Hood, S., Golembiewski, E., Benbow, K., Sow, H., & Vetta, S. T. (2017). Who can I turn to? Emotional support availability in African American social networks. *Social Sciences, 6*(3), 104. doi:10.3390/socsci6030104

Horvitz-Lennon, M., Frank, R., Thompson, W., Baik, S., M.S., Alegría, M., Rosenheck, R. A., & Normand, S. T. (2009). Investigation of racial and ethnic disparities in service utilization among homeless adults with severe mental illnesses. *Psychiatric Services, 60*(8), 1032-8.

doi:10.1176/ps.2009.60.8.1032
Johnson, D., Polansky, M., Matosky, M., & Teti, M. (2010). Psychosocial factors associated with successful transition into HIV case management for those without primary care in an urban area. *AIDS and Behavior, 14*(2), 459-68. doi:10.1007/s10461-009-9628-9
Leong, F. T., & Austin, J. T. (Eds.). (2006). *The psychology research handbook* (2nd ed.). Thousand Oaks, CA: SAGE Publishing.
LGBT National Help Center. (n.d.). *LGBT National Help Center.* Retrieved from www.glnh.org
Lieb, S., Prejean, J., Thompson, D. R., Fallon, S. J., Cooper, H., Gates, G. J.,…Malow, R. M. (2011). HIV prevalence rates among men who have sex with men in the southern United States: Population-based estimates by race/ethnicity. *AIDS and Behavior, 15*(3), 596-606. doi:10.1007/s10461-010-9820-y
Linton, S. L., Cooper, H. L. F., Kelley, M. E., Karnes, C. C., Ross, Z., Wolfe, M. E., & Paz-Bailey, G. (2017). Cross-sectional association between ZIP code-level gentrification and homelessness among a large community-based sample of people who inject drugs in 19 US cities. *BMJ Open, 7*(6), 1-9. doi:10.1136/bmjopen-2016-013823
Logan, J. R. (2003). *How race counts for Hispanic Americans*. Albany, NY: University at Albany, Lewis Mumford Center for Comparative Urban and Regional Research.
Lopez, N, (2013). Killing two birds with one stone? Why we need two separate questions on race and ethnicity in the 2020 census and beyond. *Latino Studies 11*(3), 428–438. doi:10.1057/lst.2013.25
McHugh, M. L. (2013). The chi-square test of independence. *Biochemia Medica*, *23*(2), 143–149. doi:10.11613/BM.2013.018
National Alliance on Mental Health [NAMH]. (2019). *Latino mental health*. Retrieved from https://www.nami.org/find-support/diverse-communities/latino-mental-health
National Organization for Human Services [NOHS]. (n.d.). *Conference proceedings.* Retrieved from https://www.nationalhumanservices.org/conference-proceedings
National Organization for Human Services [NOHS]. (2015). Ethical standards for human service professionals. Retrieved from https://www.nationalhumanservices.org/ethical-standardsfor-hs-professionals
Newby, C. A., & Dowling, J. A. (2007). Black and Hispanic: The racial identification of Afro-Cuban immigrants in the southwest. *Sociological Perspectives, 50*(3), 343-366. doi:10.1525/sop.2007.50.3.343
Oramasionwu, C. U., Hunter, J. M., Skinner, J., Ryan, L., Lawson, K. A., Brown, C. M.,…Frei, C. R. (2009). Black race as a predictor of poor health outcomes among a national cohort of HIV/AIDS patients admitted to US hospitals: a cohort study. *BMC Infectious Diseases*, *9*, 127-139. doi:10.1186/1471-2334-9-127
Ryan, E. L., Baird, R., Mindt, M. R., Byrd, D., Monzones, J., & Morgello, S. (2005). Neuropsychological impairment in racial/ethnic minorities with HIV infection and low literacy levels: Effects of education and reading level in participant characterization. *Journal of the International Neuropsychological Society, 11*(7), 889-98. doi:10.1017/s1355617705051040
Richardson, L. A., Milloy, M. S., Kerr, T. H., Parashar, S., Montaner, J. G., & Wood, E. (2014). Employment predicts decreased mortality among HIV-seropositive illicit drug users in a setting of universal HIV care. *Journal of Epidemiology and Community Health, 68*, 93-96. doi:10.1136/jech-2013-202918
Sanchez, D. (2013). Racial identity attitudes and ego identity statuses in Dominican and Puerto

Rican college students. *Journal of College Student Development, 54*(5), 497-510. doi:10.1353/csd.2013.0077

Sandfort, T. G., & Dodge, B. (2008). "And then there was the down low:" Introduction to Black and Latino male bisexualities. *Archives of Sexual Behavior, 37*(5), 675-82. doi:10.1007/s10508-008-9359-4

Senices, J. (2005). The complexity behind the Hispanic identity. *Journal of Applied Rehabilitation Counseling, 36*(2), 20-24.

Stokes-Brown, A. (2012). America's shifting color line? Reexamining determinants of Latino racial self-identification. *Social Science Quarterly*, *93*(2), 309-332. doi:10.1111/j.1540-6237.2012.00852.x.

U.S. Census Bureau. (2011). *Overview of race and Hispanic origin: 2010*. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf.

U.S. Census Bureau. (2017). *U.S. Census Bureau guidance on presentation and comparison of race and Hispanic origin data.* Retrieved from http://www.census.gov/topics/population/hispanic-origin/about/comparing-race-and-hispanicorigin.html#par_textimage_1

U.S. Census Bureau. (2018). *Facts for features: Hispanic heritage month 2017*. Retrieved from https://www.census.gov/newsroom/facts-for-features/2017/hispanic-heritage.html

U.S. Conference on AIDS [USCA]. (2019). 2019 USCA / Sept 5-8. Retrieved from http://2019usca.org/

Whitehead, J., Shaver, J., & Stephenson, R. (2016). Outness, stigma, and primary health care utilization among rural LGBT populations. *PLOS ONE 11*(1): e0146139. doi:10.1371/journal.pone.0146139

Wilson, K. B. (2005). Vocational rehabilitation closure statuses in the United States: Generalizing to the Hispanic/Latino ethnicity. *Journal of Applied Rehabilitation Counseling, 36*, 4-11.

Wilson, P. A., Nanin, J., Amesty, S., Wallace, S., Cherenack, E. M., & Fullilove, R. (2014). Using syndemic theory to understand vulnerability to HIV infection among Black and Latino men in New York City. *Journal of Urban Health, 91*(5), 983-98. doi:10.1007/s11524-014-9895-2

Zambrana, R. E., & Carter-Pokras, O. (2001). Health data issues for Hispanics: Implications for public health research. *Journal of Health Care for the Poor and Underserved, 12*, 20-34. doi:10.1353/hpu.2010.0547

Zea, M. C., Reisen, C. A., & Díaz, R. M. (2003). Methodological issues in research on sexual behavior with Latino gay and bisexual men. *American Journal of Community Psychology*, *31*, 281-290. doi:10.1023/a:1023962805064

Zea, M. C., Reisen, C. A., Poppen, P. J., Bianchi, F. T., & Echeverry, J. J. (2005). Disclosure of HIV status and psychological well-being among Latino gay and bisexual men. *AIDS and Behavior, 9*, 15-26. doi:10.1007/s10461-005-1678-z

Clarifying the Identity of Human Services through a Content Analysis of Programmatic Accreditation

Nicola A. Meade, Shuntay Z. Tarver, and Mark C. Rehfuss, *Old Dominion University*

Abstract

Throughout the United States, accrediting bodies serve as voluntary self-regulating entities designed to ensure accountability and quality assurance at the institutions that seek accreditation. To examine the impact of accreditation on the field of human services, a mixed-method content analysis was utilized. The 50 human services programs accredited by the Council for Standards on Human Services Education (CSHSE) as of July of 2018 were examined. Researchers also employed a triangulated approach to understand these programs through an analysis of Carnegie Classifications, regional accreditation agencies, and institutions' programmatic websites. Results offer insight into how the CSHSE influences the professional identity of human services thorough: (1) variations in the length of time programs have been accredited; (2) regional distinctions between accredited programs; (3) and the titles of programs accredited by the CSHSE.

Keywords: CSHSE, programmatic accreditation, content analysis, human services identity

Introduction

Throughout the United States, accrediting bodies serve as voluntary self-regulating entities designed to ensure accountability and quality assurance at the institutions that seek accreditation (Kincaid & Andresen, 2010). Regionally, accrediting bodies are appointed to ensure educational quality and institutional adherence to national standards of higher education (U.S. Department of Education, 2018). In addition, accrediting bodies such as the Council for Standards on Human Services Education (CSHSE) serve the role of granting accreditation to programs that adhere to professional standards within specific disciplinary fields. For example, the accreditation guidelines set by the CSHSE (n.d.c) requires accredited human services degree programs to be "committed to improving the quality, consistency, and relevance of human service education programs and assuring best practices in human service education through evidence-based standards and a peer-review accreditation process" (para. 1). Although accreditation is a self-regulated voluntary process, each institution that seeks accreditation chooses to demonstrate its successful adherence to and alignment with the standards articulated by the accrediting body. Therefore, achieving accreditation affirms the institution's integrity, quality, and adherence to identified educational standards (Kincaid & Andresen, 2010; U.S. Department of Education, 2018). The importance and role of accrediting bodies have been well documented in ways that emphasize the importance of institutions to be accredited (Adams, 1998; Berry & Hammer, 2018; Longenecker, 2012; Murphy, 2016; Olivi, 2013; Pavlakis & Kelley, 2016). However, limited attention has been focused on understanding the extent to which accrediting bodies influence their respective disciplines. To fill this gap, a content analysis was conducted to examine the programmatic, regional, and national influence of the CSHSE on the identity of the human services field.

Previous research investigating CSHSE programmatic accreditation has been limited. Existing literature has focused on how professional standards address diversity and social justice issues (Kincaid, 2008; Neukrug & Milliken, 2008), the CSHSE's contribution to the discourse on

the term *human services* (Kincaid, 2009) the translation of the CSHSE's educational standards into classroom pedagogy (Herzberg, 2010), and the CSHSE's requirement for a programmatic self-study (Kincaid & Andresen, 2010). Although such investigations suggest that the CSHSE has significant influence on the field of human services, less is known about the programs accredited by the CSHSE.

The College Board (2018) reports that 487 schools currently offer a major in the field of human services, yet only 50 programs were listed on the CSHSE website as being programmatically accredited as of July 11, 2018 (see Appendix; CSHSE, n.d.a). This delineates that as of July 2018, only 10% of human services programs were accredited by the CSHSE. This trend questions the extent to which the CSHSE, as the programmatic accrediting body for the field of human services, influences the overall discipline of human services. To gain insight into this issue, a content analysis of the programs that have been granted CSHSE accreditation was employed. Although presently CSHSE accredited programs represent a minority of human services programs, an examination of these programs can aid in learning more about how the CSHSE influences the field of human services. This investigation is timely, considering the CSHSE's 40th anniversary and the relevance for increasing the field's knowledge regarding professional identity at a time when programmatic accreditation is becoming increasingly vital (CSHSE, n.d.d; Jackson, Davis, & Jackson, 2010). Additionally, this study could offer an opportunity to strengthen Sparkman-Key's and Neukrug's (2016) assertion that the U.S. Department of Labor website does not presently represent the full human services field. For instance, the U.S. Department of Labor (2018) states, regarding education in the field of human services, that what is needed for employment is a "certificate or an associate's degree in a subject such as human services" (para. 3). However, the CSHSE's accredited programs offer far more than certificates and associate's degrees. To gain insight into this issue, a content analysis of the programs that have been granted CSHSE accreditation was employed. The study examined (1) variations in the length of time programs have been accredited by the CSHSE; (2) regional distinctions between the CSHSE's accredited programs; and (3) the titles of programs accredited by the CSHSE. This study aimed therefore to capture and present a fuller picture of the accredited human services programs and thereby provide more clarity to the identity of the field.

Accreditation

There are two primary types of accreditation: regional and programmatic (U.S. Department of Education, 2018). Regional accreditation, also referred to as national accreditation, is required for institutions of higher education to have the authority to receive federal funding from the U.S. Department of Education. Programmatic accreditation is discipline specific and offers affirmation of specific professional standards, skills, and knowledge within a specific field of study (U.S. Department of Education, 2018). Although both regional and programmatic accreditation are important to institutions of higher education, not every field of study within an institution of higher learning has an external accrediting body which can therefore give more weight to such credentialing overall (Jackson et al., 2010). Within the field of human services, programs have the opportunity to be both regionally and programmatically accredited. The following briefly describes the regional and programmatic accreditation of institutions that are accredited by the CSHSE.

Regional Accreditation

According to the U.S. Department of Education (2018), regional accrediting bodies exist to "assess the quality of academic programs, create cultures of improvement and raising standards, engage staff and faculty in evaluation and planning, and set criteria for certification and licensure" (Some important functions of accreditation, para. 3). Within the United States, institutions of higher education seek regional accreditation from one of six accrediting bodies that report to liaisons in the U.S. Department of Education (2018). The region of accreditation is tied to the geographical location of the school and/or its headquarters (Jackson et al., 2010). The regional bodies are the Higher Learning Commission (HLC), the Middle States Commission on Higher Education (MSCHE), the New England Association of Schools and Colleges (NEASC), the Northwest Commission on Colleges and Universities (NWCCU), the Southern Association of Colleges and Schools, Commission on Colleges (SACSCOC), and the Western Association of Schools and Colleges (WASC). Regional accreditation is necessary for federal funding eligibility, enhancing national reputation, establishing credibility, attracting quality students and fostering employability of graduates (U.S. Department of Education, 2018).

Programmatic Accreditation

Agencies that grant programmatic accreditation, like regional accrediting bodies, engage in formalized activities for evaluating the quality, rigor, and adherence to specific guidelines. Within institutions of higher education programmatic accreditation affirms the (a) validity of a program within the institution in relation to other similar higher education programs, (b) its alignment with national professional standards within the program curriculum, and (c) its continuity of programmatic policies and procedures regarding curriculum delivery and consistency in relation to other similar programs, as well as continuous improvement (Kincaid & Andresen, 2010; US Department of Education, 2018). Additionally, programmatic accreditation elevates the profession, which adds value to students, clients, and administrators who matriculate from such programs (Olivi, 2013). While programmatic accreditation is not mandatory for operation and degree issuance, it is perceived to indicate a higher standard of academic and professional rigor that translates into the honing of professional knowledge and skills within a specific discipline (U.S. Department of Education, 2018).

Council for Standards for Human Services Education (CSHSE) Accreditation

Within the field of human services, the CSHSE is the definitive programmatic accrediting body. Emergence of the CSHSE began in 1976 when the Southern Regional Education Board, a parent organization of the Southern Association of Colleges and Schools, conducted a survey of over 300 human services training programs throughout the United States (CSHSE, n.a.b). The survey revealed a strong convergence in many areas including field experiences, skills, faculty characteristics, and program policies (CSHSE, n.a.b). These similarities were formalized resulting in the formation of the CSHSE in 1979. Their work came to guide the educational delivery of programs designed to train human services professionals, and the CSHSE has been evaluating, improving, and enhancing the professional standards of accredited human services programs since its founding (CSHSE, n.d.b). To explore how this programmatic accrediting body has influenced the professional identity of the human services discipline, a mixed-method content analysis of the programs accredited by the CSHSE were investigated.

Method

To provide a thorough investigation, this study followed Krippendorf's (2013) widely cited approach to content analysis that utilizes a mixed methods approach. The authors utilized quantitative research questions that also indicate the hypotheses for the current study (Krippendorf, 2013). This methodology also employs a qualitative approach by addressing issues of reliability through the triangulation of data from various contexts (i.e., programmatic, regional, national). For example, our study includes analyses from various perspectives such as accredited human services programs, regional accrediting bodies, and national Carnegie Classifications. The authors also utilized qualitative methods such as acknowledging and discussing the subjective influences of the various content analyzed and the subjectivity and trustworthiness of the authors. The following sections integrate these approaches in a holistic way.

Following Krippendorf's (2013) content analysis framework requires integration of five components:

> (1) a body of text, the data that a content analysis has available to begin an analytical effort; (2) a research question that the analyst seeks to answer by examining the body of text; (3) inferences that are intended to answer the research question, which constitute the basic accomplishment of the content analysis; (4) a context of the analyst's choice within which to make sense of the body of the text; and (5) validating evidence, which is the ultimate justification of the content analysis. (p. 35)

Each of these components are included within this analysis as it relates to our specific study. It is important to note that while this framework is often detailed as a linear and dichotomous process, a more recursive and integrative approach has been used here. Thus, our inferences were guided by our research questions, and inferences are discussed collectively as opposed to two distinct steps.

The Bodies of Text

Within this study the primary body of text is taken from the CSHSE's official website. Attention was focused on the list of the accredited schools presented on the CSHSE website as of July 11, 2018 (n.d.a; see Appendix). From this data set, the name of the institution, the state in which the institution was located, the years accredited, and the accredited program's website link were gathered. Additionally, the program link for each of the 50 schools was followed to identify the name of the program. To situate this information into a national context, each institution's name was identified within the Carnegie Classification of Institutions of Higher Learning institution search engine. The institutions' sizes and types were also identified.

Research Questions and Inferences

Three primary research questions guided this study and led to investigative inferences related to each as required within the methodology of content analysis (Krippendorf, 2013). RQ1: What variations exist among CSHSE accredited programs in relation to institutional size and time accredited? Neukrug (2017) explained that the origins of the human services field were to meet an increased need for community based human services that were general in scope as compared to more established fields such as social work and psychology. Thus, the authors inferred that the oldest accredited human services programs would be situated within two-year institutions. Also, the authors inferred that two-year programs would represent between 70-75% of the total institutions with CSHSE accreditation, given the generalist focus of human services

programs, coupled with the U.S. Department of Labor's assertions that human services careers needed only a certificate or associates degree. Thus, researchers predicted that programs accredited in four-year institutions would represent the programs most recently accredited by the CSHSE and be between 25-30% of the total institutions with CSHSE accreditation.

RQ2: What are the regional distinctions between CSHSE's accredited programs? Given the previously discussed history of the CSHSE that originated from a survey spearheaded by the SACSCOC regional accrediting body, the authors hypothesized that this region would account for the majority of CSHSE accredited programs.

RQ3: What do the titles of the programs accredited by CSHSE reveal about the field of Human Services' identity? The authors inferred that the growth of the field of human services would result in distinctions between how the programs with accreditation presented themselves. Thus, examining the program names was anticipated to reveal important information regarding the identity of human services and how identity may vary by the institutional Carnegie Classifications.

The Context of Choice and Validating Evidence

The multiple texts examined were the CSHSE website, institutional websites of accredited CSHSE programs, geographical delimitations of regional accreditations, and the Carnegie Classifications of Institutions of Higher Education's website. Using different sources of textual information fits within the quantitative framework of content analysis that requires adherence to explicit methodological steps (Krippendorf, 2013). This also provided a context for this study and allowed for multiple sources to provide information regarding the CSHSE's influence on the field of human services. The following describes the data collected from the Carnegie Classifications of Institutions of Higher Education's website, information on regional accreditation, and CSHSE accredited institutional websites.

Carnegie classifications. Carnegie Classifications for Institutions of Higher Education provides a national framework for "recognizing and describing institutional diversity within United States Higher Education" (Carnegie Classifications, 2017a, para 5). They categorize and classify institutions in ways that measure their comparability with other institutions on several indices such as institutional size, degree type, and involvement in institutional research (Carnegie Classifications, 2017b). Consequently, Carnegie Classifications are ideal for providing an external context for comparison and understanding of the institutions that offer human services programs across the nation. The data included in this analysis consisted of the institutional degree level (e.g. two-year or four-year) combined with institutional size (e.g., very large, large, medium, small, very small), and institutional type (e.g., Associates, Baccalaureate, Masters, Doctoral).

Regional accreditations. As aforementioned, there are six regional accrediting bodies within the United States. It stands to reason that each region housing CSHSE's accredited programs offers different influences on the field of human services. Therefore, data were grouped by regional affiliation.

Institutional websites. The CSHSE's accreditation standards require all accredited programs to have a link to their respective Human Services programs (CSHSE, n.d.a). These institutional links were used to identify departments that offered degrees in human services. The identified names of human services programs were linked to the program identity.

The Context and Organization of Data Analysis

According to Krippendorf (2013), researchers utilizing content analysis must articulate the context in which the data is being understood and organized. Such decisions are important for making sense of how data are organized and analyzed. Within this study the data was organized and situated within the larger context in various ways. Two primary decisions that guided this study included how to define the time frames examined and utilizing Carnegie Classifications to specify the institutional size and type. Researchers calculated the length of time a program had been accredited by the CSHSE by subtracting the year of accreditation from 2018, the year the data was analyzed. The programs were divided into four categories according to the length of time that were accredited. These equidistant time frames were defined as: 30-39 years, 20-29 years, 10-19 years, and 0-9 years. Carnegie Size Classifications were applied to accredited human services programs by degrees offered (i.e., two-year and four-year degrees) and by institutional size (i.e., very small, small, medium, large). Utilization of the Carnegie Classifications allowed researchers to align the CSHSE's accredited programs with nationally defined institutional descriptions as a method for comparing programs.

Reliability and Trustworthiness

Within qualitative content analysis, various aspects of trustworthiness include transferability, creditability, triangulation, audit checking, and dependability (Graneheim & Lundman, 2004; Hill et al., 2005; Krippendorf, 2013). Each of these concepts reveal the subjectivity of the researchers in relation to how suitable they are to engage in the methodology and data interpretation. The research team consisted of three members: one White female doctoral student, one African American female assistant professor, and one White male associate professor. All three have extensive experience conducting qualitative research and have been involved in programmatic accreditation processes at the bachelors, masters and doctoral levels. In addition, one author has experience with regional accreditation processes. All three have been enrolled and matriculated from accredited universities found within the Carnegie classifications and each have completed between three to four degrees. The data was read and scored by each researcher. Then the perspectives on the findings were discussed and clarified using a triangulation of perspectives to clarify and refine the findings. Each of these factors speak to the trustworthiness of the researchers to engage in the current study.

Results

Results from this investigation are organized by the research questions guiding this study and unveil various aspects of the field of human services identity. They present trends related to length of accreditation and Carnegie Size Classifications, regional accreditation distribution, and program titles and Carnegie Type Classifications.

Length of CSHSE Accreditation in Telation to Carnegie Size Classifications

Noteworthy variations appeared among CSHSE accredited programs in relation to institutional size and time accredited. When considering all CSHSE accredited institutions, it was found that 24% (n = 12) were accredited for 30-39 years, 10% (n = 5) were accredited for 20-29 years, 24% (n = 12) were accredited for 10-19 years, and 42% (n = 21) were accredited for 9-0 years. When these results were segregated along institution size most institutions were two-year, large at 22% (n = 11), two-year, medium at 20% (n = 10), and four-year, large at 18% (n = 9). Since the 0-9 years' time frame constituted such a large percentage of accredited programs

(42%), it was divided in half to examine a similar comparison regarding the quantity of schools in each time frame. With this adjusted time frame, 18% (n = 9) were accredited for 5-9 years, and 24% (n = 12) were accredited for 0-4 years. Overall, 66% of CSHSE accredited schools were listed as a two-year while 34% were listed as a four-year (see Table 1).

Table 1
Carnegie Size Classifications Based on Time Frames with 0-9 Separated

	0-4 years	5-9 years	10-19 years	20-29 years	30-39 years
Four-year, small	1	1	-	-	-
Four-year, medium	1	1	2	-	2
Four-year, large	2	1	2	2	2
Two-year, small	3	1	1	-	-
Two-year, medium	2	2	2	1	3
Two-year, large	3	2	2	2	2
Two-year, very large	-	1	3	-	3

Length of CSHSE Accreditation in relation to Regional Accreditation Location

Next, the length of CSHSE accreditation and geographical location grouped by the six regional accrediting bodies were explored. Out of the 50 institutions accredited by CSHSE, 34% (n = 17) were from the Higher Learning Commission (HLC) region, 30% (n = 15) were from the Middle States Commission on Higher Education (MSCHE) region, and 24% (n = 12) were from the Southern Association of Colleges and Schools, Commission on Colleges (SACSCOC) region. A very small portion of schools (n = 6; 12%) were from the other three regions combined, three from the New England Association of Schools and Colleges (NEASC) region, two from the Northwest Commission on Colleges and Universities (NWCCU) region and one from Western Association of Schools and Colleges (WASC) region. Therefore, when considering all CSHSE accredited programs, 88% (n = 44) are from three regions (HLC, MSCHE, and SACSOC), while only 12% (n = 6) are within the other three regions (NEASC, NWCCU, and WASC). In addition, the states with the greatest number of CSHSE accredited programs were Pennsylvania (n = 5; 10%), Maryland (n = 4; 8%), Delaware (n = 4; 8%), North Carolina (n = 4; 8%), and Ohio (n = 4; 8%).

When the length of program accreditation time and regional accreditations were evaluated, the HLC region had the most programs with accreditation of 20 years or greater (47%; n = 8), followed by SACSCOC and MSCHE (18%, n = 3). NEASC had two programs accredited for greater than 30 years, and WASC had one program that had been accredited for more than 30 years. Within the 10-19 year time frame, MSCHE had the most accredited programs (66%; n = 8). However, SACSCOC had the most accredited programs (38%; n = 8) within the 0-9 years' time frame, followed closely by HLC (33%; n = 7). When looking at the 20-year mark as a divider, all regions had more accredited programs within the last 20 years than in the first 20

years, except for WASC that had only one accredited program, in the 30-39 year timeframe (see Table 2).

Table 2
Regional Accreditation Based on Time Frames Based on Time Frames 0-40 years

	0-9 years	10-19 years	20-29 years	30-39 years
MSCHE region	4 – Pennsylvania (3); New Jersey (1)	8 - Maryland (2); Delaware (4); Pennsylvania (2)	1 - New York	2 – both Maryland
NEASC region	1- Massachusetts	-	-	2 – both Massachusetts
SACSCOC region	8 – Georgia (2); North Carolina (3); South Carolina; Tennessee; Texas	1- South Carolina	-	3 – Florida; North Carolina; South Carolina
HLC region	7- Arkansas; Michigan; Missouri; Nebraska; Illinois; Ohio (2)	2- Indiana and Nebraska	4 – Colorado; Nebraska; Ohio; Wisconsin	4 – Colorado; Illinois; Ohio; Wisconsin
WASC region	-	-	-	1-California
NWCCU region	1- Nevada	1- Alaska	-	-

These findings highlight the low number of total accredited programs (n = 6) in the NWCCU, WASC, and NEASC regions and that the three states with the greatest numbers of programs, Pennsylvania, Maryland, and Delaware, come from the same region (MSCHE). These regional and geographical concentrations stand in stark contrast to WASC region and California, which have only one accredited institution. Additionally, the programs accredited for greater than 20 years were most frequent in the HLC region (n = 8), whereas the greatest quantity of programs accredited for nine years or less were the SACSCOC (n = 8) and HLC (n = 7) regions.

Human Services Program Names in Relation to Carnegie Type Classification

Of all programs, institutions represented in the category of Associate's were 66% (n = 33), Baccalaureate/Associate's Colleges were 6% (n = 3), Baccalaureate Colleges were 2% (n = 1), Master's Colleges and Universities were 18% (n = 9) and Doctoral Universities were 8% (n = 4). Three institutions within the last category were listed in the subcategory of Moderate Research Activity, none were listed in the subcategory of Higher Research Activity, and one was listed in the subcategory Highest Research Activity. In addition, it was found that despite claims by CSHSE of accrediting associate's, baccalaureate, and master's programs, no master's programs were declared as having accreditation (see Table 3).

The titles of the programs accredited by the CSHSE were categorized by the Carnegie Type Classifications (see Table 3). Programs within Associates Colleges were most commonly titled *human services* (n = 14) and an additional 11 programs had the term human services in the title (i.e., *Human Services Technology* or *Health and Human Services*), however, 24% (n = 8) did not use the term human services. The least number of accredited types were Baccalaureate/Associates Colleges and Baccalaureate College with a total of only four institutions; three titled *human services*, and one without the term human services in the title. Master's Colleges and Universities along with Doctoral Universities constituted the remaining 26% of institutions with most (n = 10) having the term human services in their title, and a few (n = 3) without the term human services. Overall, from all 50 institutions accredited, 76% (n = 38) had the term human services in their name, and 24% (n = 12) had no reference to the term human services in their name.

Table 3
Department/Program Names Categorized by Carnegie Classification of Institution Type

Associate's Colleges	Humanities and Social Sciences; Counseling and Human Services; Department of Human Services; Psychology and Human Services; Health and Human Services; Public and Social Services; Public Services and Safety; Allied Health; Education and Human Services; Community, Family and Child Studies; Behavioral and Social Sciences; Division of Allied Health; Social and Human Services; Community and Human Services; Health Sciences; Human Services Generalist; three named Human Services Technology; 14 named Human Services
Baccalaureate/ Associate's Colleges	College of Social Services; two named Human Services
Baccalaureate College	Human Services
Master's Colleges and Universities	Behavioral Sciences Department; Human Services; Education and Human Services; College of Health and Human Services; Department of Human Services; Sociology and Human Services; Counseling; two named Counseling and Human Services.
Doctoral Universities	Human Development and Family Services; Department of Human Services; Department of Counseling and Human Services; Department of Social Work and Human Services

Discussion

Length of CSHSE Accreditation in Relation to Carnegie Size Classification

The project began with the prediction that the schools with the longest accreditation would be two-year schools, of varying size, and that the four-year schools would have received accreditation more recently. The primary reason articulated for this perspective was based on the researchers' belief that human services programs were primarily developed in two-year schools

and that four-year schools formed programs afterwards. However, in the oldest time frame of 30-39 years (n = 12), four programs were in four-year institutions (33%), and in the next oldest time frame of 20-29 years (n = 5), two programs were in four-year institutions (40%). As such, human services programs within four-year institutions have always been a part of the CSHSE accreditation. Therefore, the researchers' inference was shown incorrect and offers some evidence contrary to assertions that associates level degrees emerged in response to community needs for training and paraprofessionals (U.S. Department of Labor, 2018).

It was also predicted that two-year schools would constitute 70-75% of all accredited programs. However, only 66% (n = 33) of human services programs were degreed within two-year schools. A substantial portion of accredited human services programs are classified within four-year institutions. These findings illustrate that although there are more CSHSE accredited programs within institutions classified as two-year institutions (66%), there is a considerable percentage of programs that are found within four-year schools (34%), and this percentage is consistent across each time frame of the CSHSE's lifespan. These results offer substantial evidence to challenge the U.S. Department of Labor's (2018) description of the human services field as inaccurate. Alternatively, this finding supports the position of the National Organization of Human Services (NOHS) that asserts the human services is a field that offers far more than certificate and associate degrees (Sparkman-Key & Neukrug, 2016).

Length of CSHSE Accreditation in Relation to Regional Accreditation Location

Exploration of the length of CSHSE accreditation and by location of regional accreditation unveiled existing regional distinctions. The inference that the Southern Regional Education Board (1976) survey would result in the greatest number of programs in a region was inaccurate. Instead, only 26% (n = 13) of the 50 institutions were within the SACSCOC region, and the greatest number of accredited institutions were located within the HLC region (34%, n = 17) followed by the MSCHE region (30%; n = 15). In addition to disproving the original hypothesis, these percentages make it clear that programs are not equally distributed across the United States. The Southeast, Mid-East, and Central areas collectively made up 88% of all the institutions with CSHSE accreditation and only 12% were situated within the other three regions. These were far greater variations than inferred and indicate that large geographical areas of the United States may not be included in the development of human services identity.

It is also noted that for the three regions with the greatest number of accredited programs, those programs were accredited across the time frames. The SACSCOC, for instance, had three programs with accreditations for more than 30 years, two for 10-19 years, three for 5-9 years, and five for 0-5 years. A similar phenomenon can be seen with MSCHSE, which had at least one accreditation within each time frame. On the other hand, HLC had four or five institutions accredited for every time frame except 10-19 and 5-9, where both had only two institutions. This seems to imply that programmatic accreditation in these regions continued to be pursued throughout the lifespan of the CSHSE. The finding that Maryland, Delaware, and Pennsylvania account for the greatest quantity of accredited programs appears to highlight an unexplored regional pursuit of CSHSE accreditation, while a lack of the same in WASC, NWCCU, and NEASC regions might highlight a similar but negative relationship.

Human Services Program Names in Relation to Carnegie Type Classification

The finding that the Carnegie Type Classification described 66% of the institutions as Associate's Colleges was slightly lower than the estimated 70%-75%. It fit our expectations that there would be few Baccalaureate/Associate's Colleges (6%; n = 3) and Baccalaureate Colleges

(2%; *n* = 1). What was unexpected was the large number of Master's Colleges and Universities (18%; *n* = 9), as well as Doctoral Universities (8%; *n* = 4). These higher rates may reflect the pressures of the public wanting more accountability in higher education and the increased role of programmatic accreditation in ensuring quality. If so, then even human services programs in Doctoral Universities are experiencing that pressure and are using the CSHSE to demonstrate their program's ability to meet high academic standards. In addition, the absence of any CSHSE accredited master's programs in human services was a surprise, since the CSHSE indicated that it does accredit at this level and has forms available for such a process. This nonexistence supports the idea that non-graduate programs are more representative of the field.

The inference that the names of human services programs would vary between the Carnegie Type Classifications was shown to exist. The department naming as identified through web pages seemed to follow certain patterns according to the type of institution. For instance, Associates Colleges most often included the title *human services* in the program's name. However, Doctoral Universities ascribed to naming systems such as *Department of* and then *human services* often coupled with *social work* or *counseling*. One exception to this trend was a *Behavioral Science Department*. There are multiple possible explanations for these differences including the internal structuring of Associate's Colleges versus Doctoral Universities, possible differences in beliefs about branding, or financial explanations to naming conventions.

In addition, though the human services field is described by the NOHS (n.d.) to be "broadly defined, uniquely approaching the objective of meeting human needs through an interdisciplinary knowledge base" (para. 1), there is some danger that departments that are combined with other disciplines will reflect a greater interdisciplinary identity versus a unique human services identity. The fact that most programs titled *human services* are found in Associate's Colleges creates an interesting construction of professional identity, since historically a field's research comes primarily from Doctoral Universities. Finally, what was completely unexpected was that 24% of accredited institutions had no reference to the term *human services* in their name. This lack of professional identification connected to the field of human services, while holding the CSHSE accreditation, is concerning in relation to the field's national identity development. This trend underscores the field's struggle to create an identity distinct from other social services and helping fields. Together, these findings highlight the disparities in identity that presently exist within the institutions accredited by the CSHSE.

Limitations

Though this study offers valuable insight into understanding the CSHSE's accredited programs and its impact on the field of human services, there are several limitations to this investigation. First, there is a lack of existing historical data. As such, the current exploration represents only a single moment in time. It was impossible to determine if the current 50 programs are an exhaustive list of all programs the programs ever accredited by the CSHSE, because the CSHSE website does not offer any information on institutions that were previously accredited and may no longer be accredited. In addition, finding variation in programs' names suggests that current CSHSE accreditation requirements necessitating the term human services in the program's name (CSHSE, n.d.e) may have been added or changed without record on the website of such updates. Another limitation is that there is an overrepresentation of data from the perspective of the CSHSE as two of the three data points were obtained from the CSHSE website. Only CSHSE data were examined and therefore perspectives of the accredited and non-accredited programs were not included. Although such limitations are important to note, the method of content analysis is designed to focus primarily on the documented materials. In the future, combining

content analysis with additional forms of data collection, such as interviews, could offer a more holistic perspective. The final limitation is that the CSHSE only represents about 10% of total human services programs in the United States (College Board, 2018). By design then, this study captured a minority of human services programs nationally. However, the growth of CSHSE accredited programs in the last 10 years suggests that its role as a programmatic accreditor within the field could continue to expand and therefore it could represent a larger percentage of the whole over time.

Implications and Future Considerations

The purpose of this study was to examine what the programs accredited by the CSHSE reveal about the field of human services' identity and capture a snapshot of the field as it currently stands. The clear part of the picture is the presence of four-year universities within the history of CSHSE accreditation going back to its conception. As four-year schools are usually engaged in the research that defines and informs a field, their history with CSHSE may provide a great resource for understanding their role and its implications more fully. Despite the academic tradition of Doctoral Universities leading the research of a field, for the field of human services, many of the institutions accredited by the CSHSE are Associate's Colleges (66%). This percentage suggests that gaining a deeper insight into the field and its identity would be assisted by examining the role that associates level colleges play in shaping the field.

The finding that 42% of all accredited programs had their accreditation for nine years or less also appears to support the assertion that accrediting bodies' impact has taken on a greater significance in recent years (Jackson et al., 2010). This trend reflects the public's continued push for assurances in the value of their education and highlights that the CSHSE has an opportunity to increasingly influence the field of human services in ways that support contributions of the entire field. This also indicates a growing opportunity for the CSHSE to expand, clarify, and articulate the identity of the human services field to a larger audience and ensure the training of a high-quality worker.

In other fields, the history of programmatic accreditation demonstrates that different industries have been able to create accountability and a higher public confidence in their roles by creating strong links between accreditation standards, education, and work in the field (Pavlakis & Kelley, 2016). This highlights the vital role that accrediting bodies can play in the process of helping a profession develop a recognizable public identity. However, it is something currently missing from 90% of human services programs (The College Board, 2018). This finding is also important when considering that most accredited programs (88%) are located in only three of six regions in this country. If the field of human services is to create consistently high standards for all programs and follow the example of other related fields, accreditation must be expanded to more programs. Future research should explore and clarify the barriers preventing programs from pursuing the accreditation process, as well as its benefits and its connection to professionals' performance and preparation in the workforce.

This content analysis was one way to examine the field's identity as it relates to accreditation. Future research should consider pursuing more in-depth studies such as talking with employees of the CSHSE, especially any that have been active since its inception, and discussing with them how they see the field changing over time from the perspective of accreditation and what they expect to see in the future. Further investigation is necessary for understanding why no master's programs were listed as having the CSHSE accreditation at the time of this investigation, despite the CSHSE articulation that it offers accreditation at the

graduate level (n.d.d.). In addition, further examination of master's level accreditation standards may also shed light on the lack of accreditation for human services doctoral programs. Other areas of examination could be comparing these findings with human services programs that no longer have accreditation or have never sought accreditation, which may offer the field a more nuanced view. Conducting interviews with the faculty within the various types of programs (CSHSE accredited, formally CSHSE accredited, and never CSHSE accredited) might also assist the field in better understanding where accreditation fits within the human services' identity.

As noted previously, NOHS (n.d.) describes the field of human services as being broad and drawing upon a multidisciplinary approach to appropriately improve the lives of the populations in the field. According to this content analysis, such diversity is reflected in the program titles of human services programs accredited by the CSHSE. However, these findings also point to a lack of a singular identity which may be worrisome as it hints at a need for the field, including NOHS and CSHSE, to create unified professional identity that resonates with educational institutions, the profession, and the public. It is hoped that future explorations will continue to clarify the scope and practice of human services education while delineating the continued development of human services and its importance to both individuals and organizations in the field.

References

Adams, L. (1998). *An analysis of radiation therapy program directors' attitudes toward specialized accreditation* (Doctoral dissertation). ProQuest (UMI number 9906225).

Berry, A., & Hammer, E. (2018). The relationship of accreditation and student engagement in a college of business: An internal, multi-year comparison of high impact practices. *International Journal of Management Education, 16*(1), 43-51. doi:10.1016/j.ijme.2017.12.005

Carnegie Classification of Institutions of Higher Education. (2017). *Size & setting classification description.* Retrieved from http://carnegieclassifications.iu.edu/classification_descriptions/size_setting.php

Council for Standards in Human Service Education [CSHSE]. (n.d.a). *CSHSE accredited programs.* Retrieved from https://cshse.org/members-and-accredited-programs/cshse-accredited-programs/

Council for Standards in Human Service Education [CSHSE]. (n.d.b). *Our history.* Retrieved from https://cshse.org/about-us/our-history/

Council for Standards in Human Service Education [CSHSE]. (n.d.c). *Our mission.* Retrieved from https://cshse.org/our-mission/

Council for Standards in Human Service Education [CSHSE]. (n.d.d). *Overview of the CSHSE National Standards.* Retrieved from https://cshse.org/membership-resources/standards/

Council for Standards in Human Service Education [CSHSE]. (n.d.e). *Reasons for accreditation.* Retrieved from https://cshse.org/reasons-for-accreditation/

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*, 105-112.

Herzberg, J. (2010). *Perceptions of human services students about social change education* (Doctoral dissertation). ProQuest (UMI number 3432050).

Hill, C. E., Knox, S. Thompson, B. J., Williams, E. N. Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*(2) 196–205.

Jackson, R. S., Davis, J. H., & Jackson, F. R. (2010). Redesigning regional accreditation: The impact on institutional planning. *Planning for Higher Education, 38*(4), 9-19.

Kincaid, S. O. (2008). Diversity and social justice dynamics: An analysis of the National Standards for Human Services Education. *Human Services Today*, *5*(1), 1-8.

Kincaid, S. O. (2009). Defining Human Services: A discourse analysis. *Human Service Education*, *29*(1), 14-24.

Kincaid, S. O., & Andresen, S. A. (2010). Higher education accountability and the CSHSE accreditation process. *Journal of Human Services, 30*(1), 8-17.

Krippendorf, K. (2013). *Content Analysis: An introduction to its methodology* (3rd ed.). Los Angeles, CA: SAGE Publishing.

Longenecker, P. (2012). *Institutional assessment in colleges with multiple programmatic accreditations: A multiple case research study.* (Doctoral dissertation). ProQuest (UMI number 3505961).

Murphy, W. (2016). *An empirical study of outcomes and quality indicators between accredited and non-accredited clinical mental health counseling programs* (Doctoral dissertation). ProQuest (UMI number 10119220).

National Organization of Human Services [NOHS]. (n.d.) *What is Human Services?* Retrieved from https://www.nationalhumanservices.org/what-is-human-services

Neukrug, E. S. (2017). *Theory, practice, and trends in human services* (6th ed.). Boston, MA: Cengage Learning.

Neukrug, E., & Milliken, T. F. (2008). Activities to enhance the cultural competence of human services students. *Human Service Education*, *28*, 17-28.

Olivi, P. (2013). Institutional vs programmatic accreditation. *Radiologic Technology*, *84*(5), 542-543.

Pavlakis, A., & Kelley, C. (2016). Accreditation in the professions: Implications for educational leadership preparation programs. *Journal of Research on Leadership Education, 11*(1), 68-90. doi:10.1177/1942775116641663

Sparkman-Key, N., & Neukrug, E. (2016). Inclusion of human service professionals in the Standard Classification Occupation System. *Journal of Human Services, 36*(1), 69-72.

The College Board. (2018*). Big future - college search - find colleges by major, location, type, and more.* Retrieved from https://bigfuturcollegeboard.org/college-search

United States Department of Education. (2018). *Accreditation in the United States.* Retrieved from https://www2.ed.gov/admins/finaid/accred/accreditation_pg2.html.

United States Department of Labor. (2018). *How to become a social and human services assistant*. Retrieved from https://www.bls.gov/ooh/community-and-social-service/social-and-human-service-assistants.htm#tab-4

If it Exists, It Can Be Measured: Piloting a Major Field Test for Human Services Academic Programs

Bill R. Garris, Kwangman Ko, Bethany A. Novotny, and Bethany A. Novotny, *East Tennessee State University*

Abstract

This study reviewed the current state of major field tests among social science programs and explored the need for an end-of-program assessment for academic human services programs. A review of the literature found a paucity of research on major field tests and no such assessments for human services. The researchers offered a 60-item test for baccalaureate human services programs, based upon the 10 CSHSE Curriculum Standards for this level. This test positively correlated with years of human services education and age. A critique of the proposed instrument suggested attainable improvements to the assessment, directions for future research, and proposed further collaboration and development, with significant benefits for the profession.

Keywords: major field tests, end-of-program assessments, human services instrument development

Introduction

Academic institutions have sought to assess the quality of learning since the medieval university was created (Wilbrink, 1997). Efforts to measure learning and cultivate accountability in post-secondary educational contexts have become particularly rigorous since the 1980's (Van Vught & Westerheijden, 1994). The expectation to assess has only intensified in the past twenty-five years as citizens and state governments pressure learning institutions to provide evidence of the value they claim to provide (Banta, Rudolph, Van Dyke, & Fisher, 1996; Brown & Knight, 2012). This paper reviews the literature on major field tests (MFT), explores the need for such an instrument for human services programs, and describes a pilot instrument of human services competencies based upon the 2018 Council for Standards in Human Service Education (CSHSE) standards for bachelor's programs.

Review of Literature

The Emergence of MFT

In the second half of the twentieth century, institutions of higher learning could no longer depend upon the public implicitly trusting the received wisdom: that universities advanced social capital. Furthermore, shrinking state and federal expenditures for education required policy makers to carefully manage resources and make evidence-based decisions about resource allocation and program development. Advances in applied statistics, computers, and maturation in the fields of social sciences and public administration provided the tools (Borden, 2018). Out of this matrix, institutional effectiveness and MFT arose.

Now, it is common for institutions of higher learning to provide evidence to external accreditors and internal program reviews in order to demonstrate effectiveness. This evidence is often in the form of an end-of-program assessment. MFTs were initially developed by Educational Testing Service (ETS) in 1989 to address these emerging needs (ETS, 2002). ETS modeled their MFT design after the development of the Graduate Record Examinations except that there is no intent for them to function as a predictor of graduate school success. Instead, the focus is competence and content validity. As of 2019, ETS provided 14 MFTs for undergraduate

majors (ETS, 2019). Although the company established tests for social science fields such as criminal justice and psychology, notably, ETS has not created a measure for human services.

MFTs support academic programming. Not only do they address the quality concerns of external accreditors, they are also used internally to (a) guide program development; (b) target areas for improvement; (c) track progress; (d) and signal to prospective students the program characteristics and strengths (Bush, Duncan, Sexton, & West, 2008; Dolinsky & Kelley, 2010). MFTs have become an indispensable part of the higher education terrain.

Relevant Research on MFT

Despite the significance placed upon MFTs by institutions, relatively little scholarship on their use, correlates, and predictive value has been published. The researchers conducted a systematic literature review to explore scholarship on the topic of MFTs and their development. They reviewed three databases for the phrase "major field test" through the years 1999 - 2019. The review yielded 44 articles (PsycInfo $N = 37$; JSTOR $N = 4$; Web of Science $N = 3$). After removing duplicates, the researchers retained 40 articles from the search. The majority of articles addressed MFTs in business programs, while only four described MFTs in the social sciences (all in psychology). This review did not locate any scholarship on MFTs within human services.

The research on MFTs within psychology, a near proxy for human services, found that the tests have modest criterion-related validity. Frazier and Edmonds (2002) administered the MFT in Psychology test (MFTP-II) to their students and explored correlations between grades in core courses with MFTP-II scores. They identified only one course that correlated significantly with MFTP-II: research methods. A second similar study (Van der Horst, 2014) noted that Brain, Behavior, and Cognition positively correlated with the psychology MFT. Other studies have found that the ETS tests strongly correlated with previous ACT or SAT scores or overall GPA, but correlated only weakly or not at all with the number of psychology courses or GPA within the psychology major (Dolinksy & Kelley, 2010; Stoloff & Feeney, 2002; Van der Horst, 2014). Dolinksy and Kelley explained that the MFT, GPA, and psychology credits were all "unique measures" of student learning (2010, p. 254). On the other hand, Pinter, Matchock, Charles, and Balch (2013) found that the MFT could distinguish between psychology seniors, first year psychology majors, and high achieving non-major students enrolled in an introductory psychology class.

Stoloff, Good, Smith, and Brewster (2015) suggested that high impact educational practices (Kuh, 2008; Kuh, 2009; Kuh & O'Donnell, 2013) significantly and positively correlated with MFT scores. High impact practices describe a set of educational experiences believed to enrich learning. These experiences include living in learning communities, writing-intensive courses, service-learning, and internships, among others (Kuh, 2008). Stoloff et al. (2015) surveyed 278 psychology department chairs and found specific high impact practices, such as leading campus organization and engaging in research with faculty, were associated with higher psychology MFT scores.

Our literature review also located a precedence for scholars creating MFTs. Peter, Leichner, Mayer, and Krampen (2015) created a test for basic knowledge in psychology and described their process. They proposed that their brief, 21-item instrument provided a useful, valid, yet simpler, measurement of psychology knowledge when compared with the 140 item ETS test (ETS, 2019a) and the 200 item Graduate Record Exam Subject Test Psychology (ETS, 2019b). Peter et al. (2015) reported administering the test to students at different levels of study (e.g., first year, advanced, and doctoral) and seeing averages for the different groups increase commensurate with more study.

For various social and economic reasons, MFTs have grown in importance for academic institutions. Yet despite their role in guiding and monitoring higher education, relatively little research has been published on their criterion validity, particularly in the social sciences. What research does exist suggests a relationship between high impact practices and psychology MFT scores. However, the literature has been neither robust enough, nor correlations strong enough, to state that the psychology MFT measures competence in an undergraduate psychology program. Moreover, our literature review located no sources exploring MFTs and the academic field of human services.

The Need for MFTs

MFTs can support the professionalization of a major. In recent decades, the field of human services emerged as a distinct academic discipline, developing practitioners who help others in a range of roles and capacities. The profession functions as an umbrella for diverse academic programs that address poverty, disability, substance abuse, and marginalized communities, among other human needs (Neukrug, 2017). Although this broad grouping reflects the diverse ways in which practitioners serve their communities, this breadth has also created challenges in terms of identity. For example, curricula are not standardized. An archived directory from 2013 lists approximately 600 human service programs (www.dcrdata.com). However, fewer than 10% of programs are accredited by CSHSE (CSHSE, 2019a), suggesting that most are not obligated to abide by a set curriculum nor standards. Even programs that are accredited by CSHSE are granted latitude with how to achieve mastery of standards. As a result, the human services field contends with an absence of a formalized canon of content, and issues of identity and professionalization. Implementing an MFT would contribute to solidifying the human services canon.

Indeed, other social science programs have MFTs. ETS provides a test for psychology, a discipline with 2,002 undergraduate academic programs (Norcross et al., 2016). Less common majors also have MFTs. Sloan and Buchwalter (2017), in their review of undergraduate criminal justice programs, identified 670 post-secondary schools that offered bachelor's degrees in criminal justice, roughly commensurate with the number of human services programs (www.dcrdata.com). The criminal justice field has a 150 item MFT, as well (ETS, 2019c). Currently, no MFT designed for human services programs exists.

The assessment nearest to a program test is the Human Services Board Certified Practitioner Exam (HS-BCPE). In 2008, CSHSE collaborated with the Center for Credentialing and Education to develop the test as a professional credentialing exam, normed on human services practitioners actively working in the field (Hinkle & O'Brien, 2010). Despite its intended application for credentialing practicing professionals, academic programs sometimes use the HS-BCPE for academic program assessment.

A true MFT in human services would offer many benefits and resolve a few outstanding issues. Jones et al. (2013), from their work in academics more generally, suggested that the lack of a major field test contributed to a diffused professional identity within the field. This possibly weakened the argument for the profession's inclusion in the government's Standard Occupational Classification (SOC) system, which resulted in significant vocational costs to members of the profession (Sparkman-Key & Neukrug, 2016). At an imminently practical level, the 600 academic human services programs lack a means for assessing program effectiveness, as often required by their institutions and by external stakeholders, such as accreditors. As the field of human services continues to grow, the need for a standardized assessment, grounded in the CSHSE standards and normed on human services students, grows with it.

Method

Instrument Development

In July of 2018 the CSHSE released revised standards for baccalaureate degree programs. (2019b). These standards consisted of ten general competencies, which were subdivided further into three to ten smaller elements and skills. For example, Standard 15 addressed program planning and evaluation. This standard was further delineated to include the following (a) program design and planning; (b) implementation; (c) evaluation; and (d) the requisite knowledge and skills to conduct a needs assessment.

That same month a research team convened. The team (Garris, Novotny, and Langenbrunner) taught in a human services program and earned doctorates in human development and family studies, counselor education, and human ecology, respectively. This workgroup created 10-17 questions that addressed each standard, for a total of 162 questions. Ko, also human services faculty with a doctorate in human development and family science, joined the group in September to assist with statistical analysis. The initial team of three reviewed an update to Bloom's taxonomy (Krathwohl, 2002) as part of an ad hoc interrater reliability norming process. Following this, the group discussed each question and rated it on a continuum between 1 and 3. Questions rated 1 could be answered with memorized content. A score of 3 was reserved for questions involving middle levels of Bloom's taxonomy, notably application to work and clinical situations. This was an acknowledgement of the groundwork laid by the HS-BCPE, which consisted mostly of questions based on case studies and application, and also the applied nature of the human services field. The group deselected lower ranking questions in a first review of the instrument. This reduced the item number from 162 questions to 106. Then, the researchers eliminated questions that were redundant for a particular element or not expected to discriminate between novice and more seasoned human service professionals. Using these criteria, the researchers discussed the remaining questions and removed 46 more items from the test, reducing the length from 106 to 60 questions. With this last reduction, the researchers aimed to create a more succinct test that would elicit a higher completion rate and more thoughtful responses. Finally, the researchers reviewed the wording of the remaining questions again for relevance, clarity, and effectiveness (Babbie, 2015).

After the researchers finalized the 60-item test, the university IRB approved the instrument and the procedures for piloting it. In October 2018, two team members brought a version of the instrument, modified to be presentation-friendly, to the National Organization of Human Services (NOHS) 2018 Annual Meeting in Philadelphia. The team members presented test items, sought feedback from participants who were human services professionals via expert review, and included the suggestions from conference participants in a revision of the instrument. The two expert reviewers/consultants were key leaders with the NOHS and the Southern Organization for Human Services (SOHS) who had expertise in the national standards for human service professionals. As a result, several questions were re-worded, and two questions significantly revised to reflect the expertise of NOHS professionals. The amended instrument was re-approved by the IRB. This process of instrument creation, that is generating questions from the CSHSE standards and using content professionals to design and refine questions, contributed to the test's face validity and content validity.

Administration and Data Analysis

The researchers drew a convenience sample of 221 from a population that consisted of human services students, human services professionals and counselors, and others not affiliated with helping professions. The research team accessed the sample through the Counselor

Education and Supervision Network Listerv, human services related social media, and students in human services classes attending a CSHSE accredited bachelor's degree program. Participants completed the instrument which was hosted on SurveyMonkey. Following a predetermined schedule, investigators collected data between January 1st and March 1st, 2019. The team reviewed the data in Microsoft Excel. They removed incomplete responses from the dataset when respondents did not complete all (100%) of the test items. The instrument also included demographic questions. A small number of respondents ($N = 3$) did not complete all the demographic questions, but the team elected to retain their data. This rendered a final sample of 142, with the caveat that we know the human services educational backgrounds of 139 of the 142. Table 1 provides descriptive statistics of the sample.

Table 1
CSHSE Baccalaureate Standards and Questions

Standard	Description and Sample Question, with Answers in Bold
11	**History of how the profession evolved.** **Six items, .82 average score.** Which of the following legislative acts serves as the cornerstone of the present American social welfare system? **A. Social Security Act** B. The Human Services of America Act C. Medicare D. The Affordable Care Act
12	**Human systems: Individuals, groups, organizations.** **Seven items, .71 average score.** Which of the following best represents the HS approach? The HS professional __ A. is an expert and tells the client what to do. **B. facilitates problem solving by focusing on strengths and the present.** C. diagnosis and refers. D. completes an intake and conducts a home visit in order to obtain an idea of the client's living conditions.
13	**Human service delivery systems.** **Seven items, .81 average score.** Which person is **least** likely to be served by HS professionals? **A. A wealthy man going through a divorce** B. A child in a Headstart program C. A transgender person living in a shelter D. An elderly person living alone
14	**Information literacy and confidentiality.** **Four items, .81 average score.** You are considering making a referral to an Intensive Outpatient Program (IOP) for a more significant intervention for a client who struggles with opioid abuse. You want to make a referral that will most likely lead to good outcomes for your client. Which source would you consider to be the most credible? A. You met the IOP clinical director at a community luncheon and she impressed you as being a highly competent professional. **B. The clinic has been the site of several studies in peer-reviewed journals; the**

studies find that most people experience improvement.
C. healthgrades.com, a Internet-based site that rates helping professionals.
D. A recommendation from a professional colleague you respect.

15 **Program planning and evaluation, needs assessment.**
Five items, .68 average score.
You are leading a psychoeducation group for a local agency. The agency has said its funders would like you to provide them some data about how your program is working. Which of the following is a better outcome measure?
A. Results from a survey where group members reported they thought the group was beneficial.
B. Your impressions of how things are going
C. Testimonials your clients have written.
D. Participant score at intake and at present.

16 **Client intervention theories, strategies, and skills.**
Nine items, .71 average score.
Concerning the stages of grief, human service professionals should __
A. support clients in their denial
B. be present and supportive for clients as they experience different stages of grief
C. push clients to reach acceptance – the best stage.
D. refrain from discussing end-of-life issues

17 **Interpersonal communication.**
Two items, .58 average score.
Which of the following is most likely to help a client deescalate from anger?
A. Giving them a pillow to punch; catharsis is beneficial
B. Act angry also. Reflecting a client's feeling shows you understand their anger.
C. Reframe the anger as being an expression of how much they care.
D. Identify the emotion they are feeling as "anger" and acknowledge the legitimacy of their feeling.

18 **Administrative: effective direct and indirect services.**
Eleven items, .66 average score.
You are the director of a human service agency. One of your staff reports that a colleague leers at her in a way that feels sexually objectifying to her. Which of the following options seems like the best course of action to you?
A. Report this action to your Board of Trustees.
B. Do nothing.
C. Terminate the employee who is making the other colleague feel uncomfortable.
D. Interview the offending employee, clarify behavioral expectations, and clearly document the interview.

19 **Client-related values and attitudes, ethical practice.**
Eight items, .72 average score.
You are a case worker in Juvenile Court and you have to decide the consequences for a 14 year old female caught smoking pot. Which of the following consequences would reflect the principle of *least restrictive environment*?
A. Send her to an Alternative School with other juvenile offenders.
B. Require parenting classes of the parents and weekly outpatient treatment

	for the 14 year old. C. Send her to a residential treatment facility. D. Assign her to a juvenile detention center.
20	**Self-development, use of self, self-care, and diversity.** **Two items, .75 average score.** It is the ethical responsibility of human services professional to become familiar with the culture of the client so that __ . A. every possible culture that a client might represent is part of the human services professional's cultural competence repertoire. B. the client will like the human services professional. **C. cultural differences do not become obstacles to good communication.** D. the client does not create unnecessary stress for the human services professional.

We then exported the data into SPSS version 26 for analysis. Researchers calculated composite scores for each of the ten CSHSE domains. Finally, we completed descriptive analysis, including central tendencies and variation, for each of the ten domains and examined correlations among these categories and between certain relevant demographic characteristics and the total score on the instrument. Table 2 overviews the standards and notes a sample question, the number of questions for each standard, and average score for the standard.

Table 2
Descriptive Summary of Participants, n = 142 or as noted *

Variable	n	percent (%)
Gender		
Female	119	83.8
Male	23	16.2
Age		
18-22	67	47.2
23-29	34	23.9
30-49	23	16.2
50 and older	18	12.7
Professional human services (HS) experience		
None	16	11.2
Identify primarily as a student	71	52.1
0-23 months HS experience	26	18.3
2-7 years HS experience	16	11.3
More than 7 years HS experience	13	9.2
Human services educational level*		
None	16	11.5
Associates	21	15.1
Bachelors in process or completed	83	59.7
Masters in process or completed	11	7.9
Beyond masters degree	8	5.8

* The sum of numbers of Human services educational level is 139 because three participants did not identify their level.

Results

Average Scores across CSHSE Standards

The developed instrument did not use the same number of test items for each standard. The researchers created averages for each standard created by summing the average number correct per item and dividing by the number of items assessing for the standard. This resulted in a mean composite score for each standard.

Following this, the researchers used SPSS to identify Pearson Correlations among the different standard composite scores. Finally, because test takers were heterogeneous with regards to age and experience with human services education, the researchers analyzed data using Pearson Correlations and the variables of age and human services education attained (see Table 3 and 4).

Table 3
Correlations Among Standard Scores

	s11	s12	s13	s14	s15	s16	s17	s18	s19	s20
s11-History	-									
s12-Human Systems	.548**	-								
s13-Delivery	.596**	.583**	-							
s14-Information	.523**	.527**	.505**	-						
s15-Program	.466**	.449**	.500**	.467**	-					
s16-Client intervention	.580**	.668**	.621**	.576**	.596**	-				
s17-Interpersonal	.309**	.212*	.176*	.168*	.006	.208*	-			
s18-Administrative	.583**	.567**	.623**	.517**	.421**	.590**	.190*	-		
s19-Client related	.657**	.555**	.642**	.484**	.475**	.639**	.291**	.572**	-	
S20-self	.388**	.364**	.504**	.426**	.362**	524**	.131	.436**	.474**	-

Note. * $p < .05$, ** $p < .01$.

Table 4
Composite Score Correlated with Age and Amount of Human Service Education

	1	2	3
1. Human Service Education	-		
2. Age	.32**	-	
3. Total	.40**	.42**	-

Note. ** $p < .01$.

The researchers also conducted item analysis on responses to the assessment. This analysis revealed that the sample struggled with questions relating to Standard 15: Program Planning and Evaluation, and Needs Assessment. On two of five items (40%), fewer than half of participants chose the correct answer. No other salient patterns were seen.

Discussion

Correlations

The ten CSHSE Bachelor's Curriculum Standards define the Council's expectations for a graduate's knowledge and skill base. Inasmuch as the different standards draw upon similar knowledge, skills, and dispositions, one would expect a measure of the different domains to correlate with one another and show a degree of internal reliability. As the standards differ from one another, one would also expect the composite scores for the standards to not overlap perfectly. The standards were typically correlated with one another at statistically significant levels. The strongest correlation was .668 between Standard 16 (Client Intervention and Strategies) and Standard 12 (Human Systems). In contrast, Standard 17 (Interpersonal Communication) had weak relationships with all the other standards, and no relationship with Standard 15 (Program Planning and Evaluation).

One would predict that scores on a measure of human services knowledge and competence would increase with age. Copious research on reflective judgment, reasoning, and practical wisdom tracks higher with age and education (King & Kitchener, 2002; Kitchener &

King, 1981; Kitchener & King, 1990; Kitchener, King, & DeLuca, 2006). Age can be associated with years practicing in the field. Furthermore, one might also conjecture that age and lived experience could lead to accumulated practical wisdom concerning ill-structured human problems and interventions (King & Kitchener, 1981). Analysis of results did find a significant positive correlation with overall score and age (r = .419), although these findings are based on preliminary testing alone.

Furthermore, one could also predict that scores on the instrument would correlate with years of human service education. Pearson Correlations with years of human services education equaled .401. Considering the ill-defined nature of the object of our study, that is human service competence, correlations of .4-.5 would be considered relatively strong. Although similar studies from psychology used more fine-grained analysis, looking at relationships between specific courses or major GPA and MFT scores, our study's modest correlations are generally consistent with, or better than, what was observed with the ETS psychology MFT and the performance by psychology majors, where MFT scores were correlated with SAT scores, but not with the number of psychology courses taken (Frazier & Edmonds, 2002; Stoloff & Feeney, 2002; Van der Horst, 2014). However, caution should be noted in reviewing the results as much more rigorous statistical testing needs to be done before arriving at firm conclusions.

Implications for Human Service Programs

Academic human services programs benefit from the creation of an MFT. Even a nascent, early stage instrument initiates discussion and spurs other development, collaboration, and competing measures. All this stands to generate important options for academic program evaluation. A second benefit, an MFT moves human services forward toward a clearer identity. The CSHSE formed and revised academic canons for accredited programs. Prior to this instrument, there has not been a measure to assess performance and progress toward proficiency in applying this knowledge base. Jones et al. (2013) argue that efforts toward a major field test on that body of core skills aid the development of professional identity, which is a step toward stronger visibility in the helping professions. Eventually, this might contribute to the profession's inclusion in the U.S. government's Standard Occupational Classification system.

Limitations and Future Research

Limitations exist for all research, especially as this instrument is a first pilot of a new instrument. The researchers will continue to refine the test and address two small matters of test construction in its next iteration. First, the team would ensure that all standards were more equally represented in the test construction. Two items assessed Standards 17 (Interpersonal Communication) and 20 (Self-Development), while 11 items measured Standard 18 (Administrative). During the process of test construction, the team chose to overweight administrative questions. At the time, the team surmised that questions pertaining to managing human service organizations (ethics and risk management, supporting volunteers and professional staff, and fiscal decisions) reflected a more advanced and discerning skill set. Using only two items for Standard 17 may have contributed to its weak relationship with the other standards. We considered the unequal distribution of questions to be a limitation. Second, test items for the same standard were often consecutive. The questions themselves and the elements of the standards they measured varied widely. It is unlikely test takers noticed a pattern of like questions. Nonetheless, it would align with common practice to distribute questions for a particular standard broadly across the instrument.

Several opportunities exist to further this research. In addition to reconfiguring the test, as previously noted, the sample size could be increased, and additional demographic data collected. Specifically, it would be interesting to know the within major GPA of human services students taking the field test, along with the total number of human services courses completed by participants. Both of these criterion could contribute to external validation of the MFT, analogous to other studies conducted on ETS' psychology MFT (Frazier & Edmonds, 2002; Stoloff & Feeney, 2002; Van der Horst, 2014), though it should be noted that these efforts did not find the correlations expected with the ETS instrument. A revision of the instrument could include reverse scored items.

Future research could pilot the instrument on decidedly different samples. Students at the end of an associate's degree program could be compared with students at the end of a bachelor's or master's program. Challenges with IRB processes and coordinating a multi-site project prevented the researchers from implementing this in the initial pilot. Finally, analysis of results with a purposive sample that drew from unrelated or contrasting skill set, such as computer coding or military infantry, might render useful evidence in support of discriminant validity.

Opportunities to create complementary or competing field tests remain. Researchers might create MFTs for CSHSE Standards at the Associate's and Masters Level. Alternately, scoring norms for different degree levels could be established through further test administration. Development of a second instrument would contribute to each establishing the validity of the other. Moreover, programs would have options to select from, and hundreds of human services programs would stand to benefit.

Conclusion

This study sought to establish the current state of MFTs in the social sciences and human services in particular. A review of the literature found a small number of studies exploring the ETS psychology MFT and no instrument developed for human services, while the need for an end-of-program assessment is significant. The researchers proposed and conducted an initial pilot of a 60-item test that addressed the ten CSHSE Standards for baccalaureate programs. It is hoped that this first step in developing a human services MFT promotes further discussion, development, and validation of an academic field test for human services programs.

References

Babbie, E. R. (2015). *The practice of social research*. Toronto, Ontario: Nelson Education.

Banta, T.W., Rudolph, L.B., Van Dyke, J., & Fisher, H. S. (1996). Performance funding comes of age in Tennessee. *The Journal of Higher Education*, *67*(1), 23-45.

Borden, V. M. (2018). The need for and value of scholarship in institutional research. In *Building capacity in institutional research and decision support in higher education* (pp. 53-66). New York, NY: Springer.

Brown, S., & Knight, P. (2012). *Assessing learners in higher education*. London, UK: Routledge.

Council for Standards in Human Services Education [CSHSE] (2019a). *CSHSE accredited programs*. Retrieved from https://cshse.org/members-and-accredited-programs/cshse-accredited-programs/

Council for Standards in Human Services Education [CSHSE] (2019b). Standards. Retrieved from https://cshse.org/membership-resources/standards/

Bush, H. F., Duncan, F. H., Sexton, E. A., & West, C. T. (2008). Using the major field

test-business as an assessment tool and impetus for program improvement: Fifteen years of experience at Virginia Military Institute. *Journal of College Teaching & Learning*, *5*(2). doi:10.19030/tlc.v5i2.1314

Dolinsky, B., & Kelley, J. M. (2010). For better or for worse: Using an objective program assessment measure to enhance an undergraduate psychology program. *Teaching of Psychology*, *37*(4), 252-256. doi:10.1080/00986283.2010.510978

Educational Testing Service [ETS]. (2002). *Major field tests.* Retrieved from https://www.ets.org/Media/Tests/MFT/pdf/MajorFieldTestEconDescription.pdf

Educational Testing Service [ETS]. (2019a). *About the ETS major field tests*. Retrieved from https://www.ets.org/mft/about/

Educational Testing Service [ETS]. (2019b). *GRE subject test psychology*. Retrieved from http://www.ets.org/gre/subject/about/content/psychology

Educational Testing Service [ETS]. (2019c). *ETS major field test for criminal justice*. Retrieved from https://www.ets.org/mft/about/content/criminal_justice

Frazier, T. W., & Edmonds, C. L. (2002). Curriculum predictors of performance on the Major Field Test in Psychology II. *Journal of Instructional Psychology*, *29*(1), 29-33.

Hinkle, J. S., & O'Brien, S. (2010). The human services-board certified practitioner: An overview of a new national credential. *Journal of Human Services*, *30*(1), 23-28. doi:67335995

Jones, P. C., Roberts, G. E., Martin, E. P., Ahumada, E., King, S. M., & Kircher, P. (2013). The development of an MPA major field test. *Journal of Public Affairs Education*, *19*(1), 97-115. doi:10.1080/15236803.2013.12001722

King, P. M., & Kitchener, K. S. (2002). The reflective judgment model: Twenty years of research on epistemic cognition. In B. K. Hofer & P. R. Pintrich (Eds.), *Personal epistemology: The psychology of beliefs about knowledge and knowing* (pp. 37-61). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Kitchener, K. S., & King, P. M. (1981). Reflective judgment: Concepts of justification and their relationship to age and education. *Journal of Applied Developmental Psychology*, *2*(2), 89-116. doi:10.1016/0193-3973(81)90032-0

Kitchener, K. S., & King, P. M. (1990). The Reflective Judgment model: Ten years of research. In M. L. Commons, C. Armon, L. Kohlberg, F. A. Richards, T. A. Grotzer, & J. D. Sinnott (Eds.), *Adult development, Vol. 2. Models and methods in the study of adolescent and adult thought* (pp. 63-78). New York, NY: Praeger Publishers.

Kitchener, K. S., King, P. M., & DeLuca, S. (2006). Development of reflective judgment in adulthood. In C. Hoare (Ed.), *Handbook of adult development and learning* (pp. 73-98). New York, NY: Oxford University Press.

Krathwohl, D. R. (2002). A revision of Bloom's taxonomy: An overview: *Theory into Practice, 41*(4), 212-218. doi:10.1207/s15430421tip4104_2

Kuh, G. D. (2008). Excerpt from high-impact educational practices: What they are, who has access to them, and why they matter. *Association of American Colleges and Universities*, 19-34.

Kuh, G. D. (2009). What student affairs professionals need to know about student engagement. *Journal of College Student Development, 50*(6), 683-706.

Kuh, G. D., & O'Donnell, K. (2013). *Ensuring quality and taking high-impact practices to scale*. Washington, DC: Association of American Colleges and Universities

Neukrug, E. (2017). *Theory, practice, and trends in human services: An introduction* (6th ed.). Belmont,

CA: Cengage Learning.
Norcross, J. C., Hailstorks, R., Aiken, L. S., Pfund, R. A., Stamm, K. E., & Christidis, P. (2016). Undergraduate study in psychology: Curriculum and assessment. *American Psychologist, 71*(2), 89-101. doi:10.1037/a0040095
Peter, J., Leichner, N., Mayer, A. K., & Krampen, G. (2015). A short test for the assessment of basic knowledge in psychology. *Psychology Learning & Teaching*, *14*(3), 224-235. doi:10.1177/1475725715605763
Pinter, B., Matchock, R. L., Charles, E. P., & Balch, W. R. (2013). A cross-sectional evaluation of student achievement using standardized and performance-based tests. *Teaching of Psychology*, *41*(1), 20-27. doi:10.1177/0098628313514174
Sloan III, J. J., & Buchwalter, J. W. (2017). The state of criminal justice bachelor's degree programs in the United States: Institutional, departmental, and curricula features. *Journal of Criminal Justice Education*, *28*(3), 307-334. doi:10.1080/10511253.2016.1240212a
Sparkman-Key, N., & Neukrug, E. (2016). Inclusion of "human service professional" in the Standard Occupational Classification System. *Journal of Human Services*, *36*(1), 69-72.
Stoloff, M.L. & Feeney, K. J. (2002). The major field test as an assessment tool for an undergraduate psychology program. *Teaching of Psychology*, 29(2), 92-98.
Stoloff, M. L., Good, M. R., Smith, K. L., & Brewster, J. (2015). Characteristics of programs that maximize psychology major success. *Teaching of Psychology*, *42*(2), 99-108. doi:10.1177/0098628315569877
Van der Horst, J. J. (2014). *Patterns of student curricular experience in psychology as predictors of performance on the ETS Major Field Test*. (Unpublished doctoral dissertation). Brigham Young University, Provo, UT.
Van Vught, F. A., & Westerheijden, D. F. (1994). Towards a general model of quality assessment in higher education. *Higher Education*, *28*(3), 355-371.
Wilbrink, B. (1997). Assessment in historical perspective. *Studies in Educational Evaluation*, *23*(1), 31-48. doi:10.1016/S0191-491X(97)00003-5

Wellness and Burnout in Human Services Literature: A Content Analysis of the Journal of Human Services

Brett Gleason, Chris Wood, and Roy Teng, *University of Nevada, Las Vegas*

Abstract

In this qualitative content analysis, the authors explored wellness focused literature appearing in 40 years' worth of the *Journal of Human Services*. The articles identified as wellness focused (*N* = 10) were then coded for type of article (i.e., qualitative, quantitative, conceptual, book review), targeted population (i.e., human services professionals, clients, educators, students), and intervention focus (i.e., prevention, remediation). Findings highlight the need for research-based articles with a wellness focus and more articles with human services clients as a target population.

Keywords: Wellness, burnout, Journal of Human Services

Introduction

The helping professions have been concerned about burnout and wellness for decades (Cherniss, 1980; Freudenberger, 1974; Maslach & Pines, 1979; Ratliff, 1988). Due to the nature of their work, helping professionals are at greater risk for burnout (Hricova & Lovasova, 2019), which can lead to poor client care (Puig et al., 2012). The words wellness and burnout are not mentioned in the Ethical Standards for Human Services Professionals (National Organization for Human Services; NOHS, 2015) or the Council for Standards in Human Services Education (CSHSE, 2018). Yet wellness and burnout are indirectly addressed in both. So how often are these topics covered in the *Journal of Human Services* (*JHS*)?

NOHS published its first journal issue in 1979. The first issue of *JHS* was 59 pages in length and "essentially a collection of writings about human service education" (McClam & Diambra, 2006, p. 75). The first issue of *JHS* contained six articles total, including only one research article. By contrast, the 38th issue of *JHS* contained twelve articles: three classified as research articles, four conceptual pieces, two book reviews, and three brief reports. The most recent issue of *JHS* at the time of this writing (2018) was 117 pages. In the 39 years in between these two issues, the flagship journal for the field of human services has gone through numerous changes such as an expansion to contain more articles in later issues, the clear distinction in organization to show research-based articles and conceptual pieces, and the inclusion of book reviews. To date, 339 articles, brief reports, and book reviews have been published in the *JHS*.

The changes in the *JHS* across the last 40 years may be a reflection of the evolution of the human services profession. Compared to the first issue, the 38th issue nearly doubled the quantity of pages, with twice as many articles, and three times as many research articles. Such changes may be responding to the profession and exemplary of a greater demand for knowledge specific to the human services field. Moreover, the changes in the journal name may also be in response to the development of the human services field. For example, *JHS* changed in title from *Journal of the National Organization of Human Service Educators* (in 1979-1986), to *Human Service Education* (1987-2009), to its current title *Journal of Human Services* in 2010. These revised titles may reflect the professions' growth and an expansion of the target audience of *JHS* from primarily human services educators/students to consideration of human services practitioners (and a demand to serve the emerging needs of the individuals, groups, and communities served by the human services profession).

Overview of Wellness

Wellness is an area of interest in the human services related fields such as social work, counseling, psychology, and criminal justice (Brower, 2013; Maslach, Schaufeli, & Leiter, 2001; McGarrigle & Walsh, 2011; Myers & Sweeney, 2008). Myers, Sweeney, and Witmer (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 life more fully within the human and natural community" (p. 252). On the other end of the spectrum, burnout and other psychological injuries (i.e., compassion fatigue, vicarious traumatization) have been of concern for the profession for decades, as agencies and organizations have tried various ways of combatting the negative impact these issues can have for practitioners and clients (Newell & MacNeil, 2010). Stressors in the helping professions include oversized caseloads, high-need clients, and lack of personal or professional support, all of which have been linked to burnout rates (Lawson, 2007; Newell & MacNeil, 2010). Burnout is comprised of three components: exhaustion, cynicism (depersonalization), and reduced professional efficacy (Maslach et al., 2001).

NOHS and CSHSE have indirectly addressed wellness by including criteria in both the ethical framework (NOHS, 2015) and in curriculum standards (CSHSE, 2018). Specifically, the Ethical Standards for Human Services Professionals (NOHS, 2015) Standard 35 begins, "Human service professionals strive to develop and maintain healthy personal growth to ensure that they are capable of giving optimal services to clients," (p. 7) signaling the need for human services professionals (HSPs) to be in pursuit of a healthy lifestyle and to optimize their personal wellbeing in order to properly be available for their clients.

The Baccalaureate Degree National Standards by the CSHSE (2018) reiterates this need for self-care/personal wellness in HSPs with Standard 20: "The program shall provide experiences and support to enable students to develop awareness of their own values, personalities, reaction patterns, interpersonal styles, and limitations" (p. 10). This standard contains a measurement indicating that human services educational programs include, "strategies for self-care," as a marker for meeting this particular standard, signifying the recognition of the importance of self-care in the field of human services. Self-care is considered a part of overall personal wellness (Myers & Sweeney, 2004) and has been defined as "proactive efforts to live long and live well" (Myers & Sweeney, 2005, p. 269). By being purposeful in one's self-care, it teaches individuals to make self-care and wellness as a whole a priority (Gleason, 2015). Self-care is important to the helping professions, including human services, because it fosters resiliency against burnout, compassion fatigue, and vicarious traumatization (Killian, 2008).

In order to thoroughly discuss wellness, an understanding of the negative aspects of lack of wellness is also needed. This study explores burnout, compassion fatigue, and vicarious traumatization in addition to wellness and self-care. Burnout is defined as "a type of prolonged response to chronic emotional and interpersonal stressors on the job," (Maslach & Goldberg, 1998, p. 64). Burnout in the human services field is not uncommon (Light, 2003). Another negative aspect of lack of wellness is compassion fatigue. Compassion fatigue is often used to describe an emotional exhaustion experienced by a care worker when working with traumatized clients (Adams, Boscarino, & Figley, 2006). Similarly related, vicarious traumatization, also referred to as secondary traumatization, is the taking on of a client's stress and personal trauma, allowing it to alter the clinician's worldview (Dombo & Gray, 2013).

Burnout, compassion fatigue, and vicarious traumatization can contribute to two negative outcomes (a) job attrition (Kim & Stoner, 2008; Wright & Cropanzano, 1998); (b) and, inadequate client care (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Scott, Hwang, & Rogers, 2006; Puig et al., 2012). The Brookings Institute conducted a study using a national

random sample of 1,213 human services professionals (child care, child welfare, youth services, juvenile justice, and employment/training workers) primarily serving low-income individuals (Light, 2003). The majority of human services workers (81%) reported that it is easy to burn out in the work that they do. Equally concerning, 43% of new human services workers (less than five years in the field and within the 18-35 age range) said they plan to leave within the next five years.

Rationale

Given the seriousness of the dangers of job attrition and the importance of quality client care, it seems appropriate that the professional literature in the human services field would be addressing these matters. As the flagship journal of the human services profession, *JHS* publishes peer-reviewed articles that are vetted by experts in the field. For this reason, the journal is a good source for text that is highly relevant to the research questions posed by this study. In this study, content analysis was used as a means of learning how the concepts of wellness, self-care, and the antonyms burnout, compassion fatigue, and vicarious trauma are presented and discussed in the scholarly literature of the human services profession.

Method

Content analysis is a method for investigating the themes and content of written documents and has been used in multiple forms of qualitative research (Hays & Singh, 2012). Krippendorff (1989) described the frequent use of content analysis to examine the importance of a subject matter allotted by the writers and producers of the content being examined. More specifically "problem driven content analysis" (Krippendorff, 2013, p. 355) seeks to use texts examined via content analysis as a means for understanding phenomena inaccessible or not directly viewable. Content analysis would seem to afford the researchers an opportunity to understand the how and to what extent is the concept of *wellness* present in the human services profession.

In order to examine if and how wellness had been presented in the literature of *JHS*, the research team chose to employ content analysis to answer the following research questions (1) What has been published with a primary focus on wellness, self-care, burnout, compassion fatigue, and/or vicarious traumatization?; (2) What areas [type of article, population targeted, and intervention focus] are featured within and across these articles?

Sample

The sample for this study was a total of 38 issues of *JHS* comprised of 339 total articles. The research team downloaded 37 issues of the *JHS* from the NOHS website (www.nationalhumanservices.org), a feature available to all current NOHS members. The issues are identified by the year they were released. The website made issues from 1979-2017 available for download, with the years 1981, 1986, and 1988 omitted on the website. However, the year 1987 contained 2 issues, so there were only 37 of the 38 total issues available using this method. The lead researcher contacted a co-editor for *JHS* to obtain an electronic copy of the 2018 issue and to see if the 1981 issue was available. Unfortunately, the 1981 issue is not available. The 38 issues contained a total of 339 articles. A member of the research team identified 53 as containing the search terms. The research team determined that 10 of the articles had a primary focus of wellness, excluding 43 of the original articles.

The research team excluded articles from the study that lacked a primary focus of wellness related issues. For example, although Brawley (1984) mentions self-care once as a

topic, the article is focused on the need for training and further use of television, radio, and newspapers by HSPs to provide information and preventive care to the public. Similarly, Hill, Pusateri, Braun, and Maweu (2012), mentions the term *wellness* twice, but only as possible podcast topics- the primary focus of the article is technological innovations for the human services profession, thus not pertaining to the perimeters of this survey.

Procedure

Using the *find* feature available on Adobe Acrobat Pro 2017, the research team searched 38 issues of *JHS* for the terms *wellness*, *self-care*, *burnout*, *compassion fatigue*, and *vicarious traumatization*, to identify articles that potentially matched the focus of the study. In total, 15.6% ($N = 53$) out of the 339 available had at least one of the searched terms. The research team then examined all 53 articles to determine if the primary focus of the articles was on a wellness-related issue.

After identifying the 10 articles that held a primary focus of wellness related issues, the lead researcher developed a draft code book to help categorize the information in the articles. Using the draft code book, each member of the research team read and coded the same article separately and then discussed revisions needed for the code book. Sub-codes were added to the two codes identifying the type of research (i.e., qualitative, quantitative) in order to determine what populations the research was examining. Further, two codes that determined setting (i.e., field, education) were excluded, as it was determined that the information was repetitive and already captured in other codes. After the code book was revised, the third author coded all 10 articles independently and then met with the research team to confer on the findings.

Strategies for Trustworthiness

Creswell and Poth (2018) noted the importance of trustworthiness in qualitative research. Utilizing multiple strategies of trustworthiness can help maximize the trustworthiness of a qualitative study, but the rigor of a study cannot be fully established (Hays & Singh, 2012). The research team utilized the following strategies for trustworthiness: triangulation of investigators, simultaneous data collection and analysis, thick description, and an audit trail.

Triangulation of investigators is a strategy for trustworthiness in that it involves multiple individual researchers examining the same data (Hays & Singh, 2012). This was incorporated in this study by having a research team of three individuals all investigating the same research question through the same articles. One research team member coded the articles; however, the other two research team members then went over the findings together to see if the same conclusion was reached.

Last, an audit trail including meeting notes, code book revisions, table analyses, and email correspondence was collected as a measure to ensure trustworthiness. Upon request, the audit trail can be made available to readers for review.

Findings

The research team used the research questions to help guide the process of coding and analyzing the ten articles to identify patterns. The research examined three areas (i.e., type of article, populations targeted, intervention focus) as well as the intersections of these areas. Table 1 presents the findings by article type (research, conceptual, book review), population implicated (professionals, clients, educators, students), and rationale focus (prevention, remediation, or both).

Table 1: Article Breakdown

Article Information		Article Type				Population Implicated				Rationale Focus	
Year	Author(s)	Research: Qualitative	Research: Quantitative	Conceptual Piece	Book Review	Professionals	Clients	Educators	Students	Prevention	Remediation
1996	Arches		X			X			X	X	X
1996	Varni				X	X			X		X
2003	Morrissette			X		X	X		X		X
2006	Parker & Eber			X			X				X
2014	Lahikainen & Soysa		X						X	X	
2014	Waters				X	X			X	X	
2014	Cole, et al.			X		X				X	X
2015	Riley & Rouse			X				X	X	X	
2016	Banks, et al.			X		X			X	X	
2018	Penn & Baartsmans	X				X				X	X
Totals:		**1**	**2**	**5**	**2**	**7**	**2**	**1**	**7**	**7**	**6**

Type of Article

The research team classified 50% ($N = 5$) as conceptual pieces (Banks, Burch & Woodside, 2016; Cole, Craigen & Cowan, 2014; Morrissette, 2003; Parker & Eber, 2006; Riley & Rouse, 2015). The authors categorized 30% ($N = 3$) as research-focused articles (Arches, 1996; Lahikainen & Soysa, 2014; Penn & Baartmans, 2018); two quantitative (Arches, 1996; Lahikainen & Soysa, 2014) and the other qualitative (Penn & Baartmans, 2018). The researchers identified the remaining 20% ($N = 2$) articles as book reviews (Waters, 2014; Varni, 1996).

Populations Targeted

The targeted population was defined as the individuals or groups to which the articles directly applied in terms of wellness. Of the articles, 70% ($N = 7$) focused on HSPs (Arches, 1996; Banks et al., 2016; Waters, 2014; Cole et al., 2014; Morrissette, 2003; Penn & Baartmans, 2018; Varni, 1996), 70% ($N = 7$) on human services students (Arches, 1996; Banks et al., 2016; Waters, 2014; Lahikainen & Soysa, 2014; Morrissette, 2003; Riley & Rouse, 2015; Varni, 1996), 20% ($N = 2$) of the articles focused on the wellness implications for human services clients (Morrissette, 2003; Parker & Eber, 2006), and 10% ($N = 1$) article on human services educators (Riley & Rouse, 2015).

Many of the articles had multiple populations for which the article posed implications. For instance, Morrissette (2003) focused in on the wellness implications for human services professionals, human services clients, and human services students, representing three of the four populations for which the articles were coded (see Table 1).

Intervention Focus

The intervention focus of the articles was defined as whether the rationale for interventions they promoted were either preventative in nature or in remediation to an already occurring phenomenon or both. Of the articles, 40% ($N = 4$) only had a focus of preventative measures (Banks et al., 2016; Waters, 2014; Lahikainen & Soysa, 2014; Riley & Rouse, 2015). Another 30% ($N = 3$) of the articles were representative of both prevention and remediation measures (Arches, 1996; Cole et al., 2014; Penn & Baartmans, 2018). Last, 30% ($N = 3$) of the articles only had a focus of measures that were viewed as remediation (Morrissette, 2003; Parker & Eber, 2006; Varni, 1996).

Intersections of Areas

Researchers explored the intersections between the areas (a) type of article, (b) populations targeted, and (c) intervention focus in order to discern if any patterns exist. The intersection of all three areas did not all produce noteworthy patterns. However, exploring the intersections of type and population, as well as population and rationale highlights some significant deficits in the literature.

Type and population intersection. Only two articles had human services clients as the population of interest in terms of implications for wellness (Morrissette, 2003; Parker & Eber, 2006) and both of the articles were considered as conceptual pieces with no original research taking place as part of the article. Thus, there were no research articles that implicated wellness on behalf of human services clients in this study.

Population and rationale intersection. Seven total articles had implications for the population of human services students. Of those seven, four of them had a rationale focus of prevention only, two of remediation only, and only one of both prevention and remediation. Another finding in this intersection involved the two articles that contained implications for human services clients. Both articles had a rationale focus of remediation only.

Time

Arches (1996) and Varni (1996) were the earliest articles identified as having a specific focus on wellness in *JHS* for this study. The first 17 years of *JHS* saw zero articles with wellness as the primary focus. The next 18 years of *JHS* issues (1996-2013) only saw four articles with a focus of wellness. A majority of the articles (60%) identified as having wellness as a principal focus came in the last five years of *JHS* issues.

Summaries of Articles Identified

It may be helpful to the reader to have more information on the articles identified in this study. Below are brief summaries for each of the articles in chronological order.

Arches (1996) is a descriptive study on the causes of burnout for 275 social workers. Arches (1996) recommended empowering future professionals by focusing on theories and interventions that increase worker autonomy while also lessening the influence that funding sources have on clinical decision making.

Varni (1996) is a book review of the text *Overextended and Undernourished: A Self-Care Guide for People in the Helping Professions* (Portnoy, 1996). Varni (1996) indicated the usefulness of the text in the human services classroom, specifically in the field experience portion of the human services educational experience.

Morrissette (2003) authored the next identified article focused on wellness. Chronologically, this was the first conceptual piece for this study. The author stressed the need for uniformity when discussing psychological injuries and attempted to decipher the differences in several constructs.

Parker and Eber (2006) was another conceptual piece in which storytelling was identified as a skillset for the human services provider to help clients increase their emotional wellness. The authors introduced the concept of storytelling as a helping skill in effort to help clients process emotional turmoil.

Lahikainen and Soysa (2014) measured mindfulness outcomes of 174 undergraduate students in human services education and psychology. The researchers found that after completing a learning module about mindfulness, students were both more knowledgeable about the concept of mindfulness and more willing to try mindfulness for themselves.

Waters (2014) reviewed *Stories of Transformative Leadership in Human Services: Why the Glass is Always Full* (Burghardt & Tolliver, 2009) and discussed the benefits the text could have for both human services professionals and human services students.

Cole, et al. (2014) reviewed the literature on compassion fatigue and discussed the need for self-care in the human services field. The authors presented the concept of compassion fatigue, along with the signs and symptoms, risk and protective factors for HSPs, and provided examples of possible self-care activities and the benefits they can hold to both practitioners and clients.

In 2015, Riley and Rouse (2015) discussed infusing wellness into human services education programs, including assessing student wellness, in accordance with CSHSE standards. Similarly, Banks et al. (2016) explored the incorporation of mindfulness training in human services programs to help students with helping skills.

Last, the most recent article reviewed for this study, Penn and Baartsman (2018) was the only qualitative research study as part of this content analysis. This phenomenological investigation looked at the lived experiences of HSPs. Utilizing a focus group and individual interviews, the researchers explored the themes surrounding the participants' issues that they felt were impacting their work with clients. Having self-care plans as a priority were identified as a common theme from the participants, as they described the need to make self-care important in order to be optimal at their job.

Discussion

Only 30% ($N = 3$) of the 10 articles with a wellness focus were classified as research articles. (Arches, 1996; Lahikainen & Soysa, 2014; Penn & Baartsmans, 2018). The majority of the articles reviewed were either conceptual or book reviews (70%), showing a deficit of research in regard to wellness in the human services field. Research is an important part of the human services profession (NOHS, 2015) and allows HSPs to provide evidence-based care for their clients. Research in human services is still expanding as the field continues to grow and more academic programs are being established. Other helping professions like psychology and counseling that have had long-established academic programs may benefit from the graduate level focus of the importance of research in their respective fields. Human services graduate programs are becoming more common, but it is primarily at an associate's and bachelor's level academically.

The vast majority (80%) of the articles identified target population implications toward human services professionals and human services students. Neither human services educators nor human services clients were investigated in any of the research articles, thus there is a severe

underrepresentation of these two groups in the wellness literature of *JHS* and specifically in terms of research. Moreover, only one conceptual article had any type of discussion of wellness implications for human services educators. Riley and Rouse (2015) mention human services educator wellness as an aside during the literature review, signaling other fields of study showing the importance of teacher educators understanding and utilizing a model of wellness, while the primary focus of the article is on human services students. So of the ten articles in the content analysis, the one article that mentions human services educators does so only briefly in reference to other fields of study in the literature review. Human services educators are often seen as representatives of the field to students in their training program. Modeling is one of the most effective social learning tools available to teachers (Bandura, Blanchard, & Ritter, 1969). Gleason and Hays (2019) posited that modeling wellness was perceived as critical to learning how to do self-care by students in mental health training programs.

The other underrepresented population, human services clients, were mentioned in only two articles (Parker and Eber, 2006; Morrissette, 2003). Human services clients are not commonly the focus of articles primarily concerned with wellness-related issues despite viewed as important and oftentimes the reason for proper self-care utilization by human services professionals (NOHS, 2015, Standard 35). For instance, clients are mentioned in Penn and Baartsmans (2018) in that client progression is indicated as a support for human services professionals; however, there are no explicit implications for impacting the wellness of human services clients specifically.

Wellness research targeting clients is notoriously scarce in the mental health fields (Myers & Sweeney, 2008). However, as more research about this population's wellness becomes available, human services professions will better understand how to implement interventions with a wellness focus for their clientele. In addition to the lack of research for this population, the two articles implicating human services clients both had an intervention focus determined as remediation in nature. It is noteworthy that no preventative interventions were mentioned for human services clients, possibly showcasing a lack of wellness-focused interventions for the field as a whole. It is also worth pointing out that the majority (60%) of the wellness related articles came in the past five years of *JHS*, showing growth in both research and conceptual articles based on this interest over time. However, it has been over a decade since a wellness related article in *JHS* last discussed implications for human services clients (Parker, 2006).

Implications and Recommendations

There were only three research articles discovered in this study regarding wellness, showing a clear need for more research in this area represented in *JHS*. Researchers and authors in the human services field should strive to produce more research about wellness utilizing both qualitative and quantitative measures. Qualitative research lends itself to the study of wellness adequately, as wellness is a personal phenomenon for individuals and what works for some may not work for others (Gleason, 2015). Quantitative research is also important as it will allow for more generalizable studies regarding wellness (Lahikainen & Soysa, 2014; Penn & Baartsmans, 2018) and lend to the all-inclusive nature of the human services field.

Implications for Human Services Professionals and Students

As the field continues to grow, HSPs will be in need of evidence-based wellness interventions. In addition to the need for more research in the area of wellness in human services, it is important that HSPs continue to welcome researchers and help them to conduct studies with human services clients. This appreciation and understanding of research begins during the HSP's

educational experience. Students having more exposure and education around research in the human services field, may help to create a positive outlook on research, thus increasing the likelihood that they would help researchers to conduct studies in the actual field and also conduct more research on their own.

Implications for Human Services Educators

Human services educators' wellness was discussed in one article in this study. As mentioned previously, educators in the mental health professions serve as role models to their students (Gleason, 2019). Wester, Trepal, and Myers (2009) explored the wellness of counselor educators, a field often associated with human services, with the use of the Five Factor Wellness Inventory (5F-Wel, Myers & Sweeney, 2005), a commonly used assessment for wellness. A similar study on human services educators may be warranted. More information is also needed about how faculty self-care impacts their students' overall wellness so that human services students can be set up for success in the field.

Human Services Clients

As this study has shown, there is a need for more research involving actual human services clients. This lack of research for the client population in helping professions is not uncommon (Gleason, 2015). Access to this population can be difficult for many researchers, but as explained earlier, more education around research may help foster understanding for future professionals, allowing for more access. Conceptual articles are also needed for human services clients regarding strategies and practical applications that professionals can utilize to improve the wellness of this population.

Future Research and Limitations

This study was limited in that it only reviewed articles in one academic journal. Repeating the study with other journals and/or human services textbooks would be helpful to expand knowledge on this topic. The specific scope of this study in exploring the progression of wellness literature could be applied to other professional and academic journals in the mental health field. Doing so would allow readers to discover if the mentality or concepts of wellness and burnout differ between occupations. Perhaps a greater understanding of wellness across the spectrum of mental health professions would allow for common ground and more uniformed definitions in concepts such as self-care, wellness, and burnout.

Beyond a narrow scope, a full scale qualitative content analysis of *JHS*, analyzing themes over the last 40 years is warranted. McClam and Diambra (2006) completed a quantitative content analysis of *JHS* from 1979-2003, exploring the amount of research, conceptual articles, etc. that *JHS* had produced over the 25-year timespan. However, a qualitative content analysis exploring the total content and themes could give the stakeholders in human services a clearer understanding of the evolution of the professional literature in the field.

Conclusion

The results of this content analysis point to several considerations for the Journal and subsequently the profession. Specifically, the findings suggest an increased need for scholarly literature on wellness in several areas (a) greater quantity of publications of research; (b) more scholarly literature inclusive of the implications of research and application of wellness interventions targeted two neglected groups, human services clients and human services educators.

Moreover, while the articles seemed fairly balanced in terms of discussion of wellness as prevention and intervention, but a discussion of wellness as prevention for human services clients was completely absent. A strong body of research supports the efficacy of wellness activity/intervention in buffering against a multitude of negative outcomes (Myers & Sweeney, 2008). This finding presents the potential concern that HSPs may not be aware of wellness programming for clients and the relative potential therein for preventing problems faced by individuals/groups.

Stress-inoculation is one of the potential benefits of wellness promotion, both in human services profession and in educational programs (Gleason & Hays, 2019). Due in part to a lack of attention in the professional literature, HSPs may not be adequately integrating wellness/self-care as a key element of professional identity. Similarly, professors in human services education programs are unable to draw upon scholarly literature from *JHS* to guide the integration of wellness promotion into professional training programs. Without the benefit of professional literature from the flagship journal to introduce human services professionals and educators to the potential benefits of wellness interventions and programming, human services students may continue to be vulnerable to burnout and subsequently inferior client care.

References

Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry, 76*(1), 103-108. doi:10.1037/0002-9432.76.1.103

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association, 288*(16), 1987-1993. doi:10.1001/jama.288.16.1987

Arches, J. L., (1996). Burnout as a public issue. *Human Service Education, 16*(1). 37-45.

Banks, B., Burch, T., & Woodside, M. (2016). Introducing mindfulness and contemplative pedagogy as an approach to building helping skills in human services students. *Journal of Human Services. 36*(1). 47-60.

Bandura, A., Blanchard, E. B., & Ritter, B. (1969). Relative efficacy of desensitization and modeling approaches for inducing behavioral, affective, and attitudinal changes. *Journal of Personality and Social Psychology, 13*(3), 173-199.

Brawley, E. A. (1984). Using the news media to educate the public about the human services. *Journal of the National Organization of Human Service Educators, 6*(1), 14-19.

Brower, J. (2013). *Correctional officer wellness and safety literature review.* Retrieved from https://s3.amazonaws.com/static.nicic.gov/Public/244831.pdf

Burghardt, S., & Tolliver, W. (2014). [Review of the book *Stories of transformative leadership in the human services: Why the glass is always full* by K. Waters]. *Journal of Human Services. 34(1).* 100-101.

Cherniss, C. (1980). *Staff burnout: Job stress in the human services*. Thousand Oaks, CA: SAGE Publishing

Cole, R. F., Craigen, L. & Cowan, R. G. (2014). Compassion fatigue in human service practitioners. *Journal of Human Services. 34*(1). 117-120.

Council for Standards in Human Services Education [CSHSE]. (2018). *The baccalaureate degree national standards.* Retrieved from https://cshse.org/wp-content/uploads/2018/06/CSHSE-National-Standards-Baccalaureate-Degree-2018-1.pdf

Creswell, J. W. & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Thousand Oaks, CA: SAGE Publishing.

Dombo, E. A., & Gray, C. (2013). Engaging spirituality in addressing vicarious trauma in clinical social workers: A self-care model. *Social Work and Christianity, 40*(1), 89–104.

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues, 30*(1). 159-165.

Gleason, B. K. (2015). *A phenomenological investigation of wellness and wellness promotion in counselor education programs* (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses Global. (Order No. 3664102)

Gleason, B. K., & Hays, D. G. (2019). A phenomenological investigation of wellness within counselor education programs. *Counselor Education and Supervision*, 58(3). 177-194.

Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. New York, NY: The Guilford Press.

Hill, T. M., Pusateri, C., Braun, E., & Maweu, M. (2012). Technological innovations for the human service profession. *Journal of Human Services, 30*(1). 21-40.

Hricova, M., & Lovasova, S. (2019). Stress, secondary trauma and burnout – Risk characteristics in helping professions. *Journal of Interdisciplinary, 8*(2). 161-165.

Killian, K. D. (2008) Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology 14*(2). 32-44. doi:10.1177/1534765608319083

Kim, H., & Stoner, M. (2008) Burnout and turnover intention among social workers: Effects of role stress, job autonomy and social support. *Administration in Social Work, 32*(3). 5-25. doi:10.1080/03643100801922357

Krippendorff, K. (1989). Content analysis. In E. Barnouw, G. Gerbner, W. Schramm, T. L. Worth, & L. Gross (Eds.), *International encyclopedia of communication* (Vol. 1, pp. 403-407). New York, NY: Oxford University Press. Retrieved from http://repository.upenn.edu/asc_papers/226

Krippendorff, K. (2013). *Content analysis: An introduction to its methodology* (3rd ed.). Thousand Oaks, CA: SAGE Publishing.

Lahikainen, K., & Soysa, C. K. (2014). Teaching undergraduates about mindfulness. *Journal of Human Services. 34*(1). 5-23.

Lawson, G. (2007). Counselor wellness and impairment: A national survey. *Journal of Humanistic Counseling, Education & Development, 46*, 20-34. doi:10.1002/j.2161-1939.2007.tb00023.x

Light, P. C. (2003). *The health of human services workforce.* Retrieved from https://www.brookings.edu/wp-content/uploads/2016/06/humanservices.pdf

Maslach, C. and Goldberg, J. (1998). Prevention of burnout: New perspectives. *Applied and Preventive Psychology, 7*, 63-74. doi:10.1016/S0962-1849(98)80022-X

Maslach, C., & Pines, A. (1979). Burn-out: The loss of human caring. In A. Pines and C. Maslach (Eds.), *Experiencing social psychology: Readings and projects*. New York, NY: A. A. Knopf.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52*(1). 397-422. doi:10.1146/annurev.psych.52.1.397

McClam, T., & Diambra, J. (2006). Cover to cover: A twenty-five year analysis of the development and content of *Human Service Education. Human Service Education, 26*(1). 74-81.

McGarrigle, T., & Walsh C. A. (2011) Mindfulness, self-care, and wellness in social work: Effects of contemplative training. *Journal of Religion & Spirituality in Social Work: Social Thought, 30*(3), 212-233. doi:10.1080/15426432.2011.587384

Morrissette, P. J. (2003). A review of prominent psychological injury constructs. *Human Service Education, 23*(1). 75-86.

Myers, J. E., & Sweeney, T. J. (2004). The indivisible self: An evidence-based model of wellness. *Journal of Individual Psychology*, 60(3), 234-245.

Myers, J. E., & Sweeney, T. J. (2005). *The Five Factor Wellness Inventory, Adult (5F-Wel-A)*. Palo Alto, CA: Mindgarden.

Myers, J. E., & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. *Journal of Counseling & Development*, *86*, 482-493. doi:10.1002/j.1556-6678.2008.tb00536.x

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

National Organization of Human Services [NOHS]. (2015). *Ethical standards for human services professionals.* Retrieved from https://nohs.memberclicks.net/ethical-standards-for-hs-professionals

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health, 6*(2). 57-68.

Parker, T., & Eber, P. (2006). Storytelling for the human service providers. *Human Service Education, 26*(1). 25-32.

Penn, S., & Baartmans, H. (2018). A phenomenological study on meaningful professional experiences for human services professionals. *Journal of Human Services. 38(1).* 35-44.

Portnoy, D. (1996). [Review of the book *Overextended and undernourished: A self-care guide for people in the helping professions,* by C. Varni]. *Human Service Education, 16*(1). 85-86.

Puig, A., Baggs, A., Mixon, K., Park, Y. M., Kim, B. Y., & Lee, S. M. (2012) Relationship between job burnout and personal wellness in mental health professionals. *Journal of Employment Counseling*, *49*, 98-109. doi:10.1002/j.2161-1920.2012.00010.x

Ratliff, N. (1988). Stress and burnout in the helping professions. *Social Casework*, *69*(3), 147–154. doi:10.1177/104438948806900303

Riley, L. D., & Rouse, G. G. (2015). Promoting wellness in human services training: Infusing a wellness model across the undergraduate human services curriculum. *Journal of Human Services, 35*(1). 86-97.

Scott, L. D., Hwang, W. T., & Rogers, A. E. (2006). The impact of multiple care giving roles on fatigue, stress, and work performance among hospital staff nurses. *The Journal of Nursing Administration, 36*(2). 86-95.

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

Wright, T. A., & Cropanzano, R. (1998). Emotional exhaustion as a predictor of job performance and voluntary turnover. *Journal of Applied Psychology, 83*(3). 486.493. doi:10.1037/0021-9010.83.3.486

Advancing the field of Human Services: LGBT Competencies

Narketta Sparkman-Key, Nicola Meade, and Ne'Shaun Borden, *Old Dominion University*

Abstract

Ethical Standards for Human Services Professionals and Generic Human Services Professional Competencies adopted by the National Organization for Human Services do not include language or competencies specific to lesbian, gay, bisexual and transgender (LGBT) communities. Without a specific ethical code and/or competency outlined by the field, human services practitioners do not have clear guidelines for their work with these populations. Additionally, researchers lack a way to formally measure professionals' abilities with these populations. This leaves potential for these historically marginalized populations to continue to be in a vulnerable position. To address these needs, authors reviewed established competencies in other helping professions (i.e., counseling and social work fields) relative to LGBT populations, and argue that creating LGBT specific competencies in the human services field will lead to more competent practice and support the purpose of ethical guidelines which in part is to serve as a basis for self-monitoring and improving practice. In addition, the development of these competencies would meet the goal of ethical guidelines, which serves to provide a framework for accountability. The authors also recommend developing one document focused on LGB clients as well as a stand-alone document outlining specific recommendations for working with transgender communities. Within the body of the article, the authors advocate for the adoption of specific competencies by human services professional organizations and governing bodies.

Keywords: LGBT, competencies, human services standards, NOHS

Introduction

According to the National Organization for Human Services' (NOHS) Ethical Standards for human services professionals (2015a) and Generic Human Services Professional Competencies (Johnson & Bonner; 2013; NOHS, 2015b), human services professionals (HSPs) have a responsibility to clients which requires them to recognize and build on clients' strengths. In order to do this while serving diverse populations, HSPs must be culturally competent. However, best practices or advanced competencies for service delivery with lesbian, gay, bisexual, and transgender (LGBT) populations in the field of human services has yet to be defined.

Advancing the human services field by developing specific LGBT competencies offers an opportunity to set the standard for working with these populations and contributes to establishing a preventative culture. A preventative culture encompasses an ethics ideology which has a focus on preventing recurring ethical issues by developing ethical guidelines and quality control measures to address systemic gaps. The ultimate goal of this culture is to minimize or prevent future conflicts and improve service delivery to these populations (Foglia, Fox, Chanko & Bottrell, 2012; Levine & Arriff, 1990). Winfield, Sparkman-Key, and Vajda (2017) called on human services professional organizations to establish a preventative culture in the human services field. Winfield et al. (2017) argued that through the establishment of a preventative ethics culture in the human services field, organizations could better plan for situations that require intervention. Specific LGBT ethical codes and/or competencies would address this call by supporting the intent of ethical guidelines which are to: (a) educate professionals and the

general public about responsibilities; (b) provide a framework for professional accountability; and (c) serve as a basis for self-monitoring and improving practice (Corey, Corey, Corey, & Callanan, 2015).

Additionally, the distinctive lived experience of individuals within LGBT communities requires unique competencies for human services practitioners. Specifically, what is needed are competencies that affirm LGBT communities by promoting and embracing LGBT relationships and identities while also acknowledging the impact of homophobia, transphobia, and heterosexism. However, presently there is no mention of this history detailed by NOHS, which allows any instruction regarding these populations to become subsumed under multicultural competencies, thereby often not giving professionals adequate training on working with these populations (Bidell, 2013; Bidell, 2014; Dickman Portz et al., 2015; Fredricksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, & Hooyman, 2014; Graham, Carney, & Kluck, 2012).

The NOHS Generic Human Services Competencies (Johnson & Bonner, 2013; NOHS, 2015b) and the NOHS Ethical Standards for Human Services Professionals (2015a) are considered to be the guiding principles for service delivery in the field of human services. Thus, it is problematic that neither includes competencies for working with specific populations. It can be argued that many human services agencies and human services professionals within the membership look to the NOHS Generic Human Services Competencies (2015b) and the NOHS Ethical Standards for Human Services Professionals (2015a) as a guide for human services practice. Without established competencies for work with LGBT communities, agency and practitioner interactions with LGBT populations could create barriers to competent service delivery, further oppress these populations, and/or be less affirming. Also, without an established standard for competent service delivery with this specific group of individuals, there is no standard by which to measure competent service delivery to these communities.

Other social services fields, like counseling and social work, have begun to address these concerns by articulating competencies specific to LGBT communities (e.g., AMCD, 2003; NASW, 2004). Presently, the human services literature lacks a discussion on the potential benefits of competencies for effective practice with LGBT populations. This article intends to start that conversation by contending that in order to better serve LGBT populations, consideration should be given to the development of competencies specific to the LGB populations as well as the transgender population.

Brief Examination of Other Field's LGBT Competencies History

Social workers pioneered developing specific competencies for working with lesbian, gay, and bisexual (LGB) individuals. In 2003, the National Association of Social Workers (NASW) published a policy statement on LGB issues. The next year this policy statement was then used to affirm the association's position in support of same-sex marriage (NASW, 2004). In 2008, the Social Worker Policy Institute stated that the 2003 policy would be the gold standard when researching issues related to LGB populations. Fredricksen-Goldsen et al. (2014) then used this document to offer key competencies and strategies for appropriate practice with LGB older adults.

In the same year, the Association for Multicultural Counseling and Development, a division of the American Counseling Association (ACA), adopted a statement that governed practice with LGBT individuals and was included in the multicultural competencies (AMCD, 2003). After a careful review of LGBT competencies in counseling, Perosa, Perosa, and Queener (2008), identified a need for competencies specific to transgender individuals. This was resolved when the Transgender Committee of the Association for Lesbian, Gay, Bisexual, and

Transgender Issues in Counseling (ALGBTIC) developed counseling competencies specific to working with transgendered persons that were stated to be "collaborative with and celebratory of transgender experiences, individuals, and communities" (Singh & Burnes, 2010, p. 131). Harper et al. (2013) then went on to create competencies for counseling lesbian, gay, bisexual, transgender, queer, questioning, intersex, and ally individuals. These movements within ACA advanced efforts within the field of counseling in providing competent practice with LGBT individuals and recognized the unique qualities and needs of these populations.

In both the social work and counseling fields, competencies agreed upon by the field's respective professional associations have been the framework for competent practice with LGBT populations. Researchers also use the competencies as a standard by which to measure how well the field is doing in providing ethical services, both in workplaces and in educational institutions. For example, Graham et al. (2012) found that most counseling students' self-perception of their competency was higher than their scored competency and recommended additional training through a counselor's work span. In support of their findings, LGBT-focused training assisted school counselors to increase affirming behaviors and to meet competency standards (Hall, McDougald, & Kresica, 2013). Furthermore, other researchers have made similar suggestions that additional training on LGBT issues and more exposure to LGBT issues increases participants' capacities to meet LGBT competencies (Bidell, 2013; Byrd & Hays, 2013; Porter & Krinsky, 2014; Rock, Carlson, & McGeorge, 2010).

Researchers in the social work field reached similar conclusions (Porter & Krinsky, 2014). In a social worker study, using the competent practice guidelines offered by Fredricksen-Goldsen et al. (2014), researchers found that most social workers lacked the appropriate knowledge and training to meet standards (Dickman Portz et al., 2015). After social workers received training specific to work with older LGBT populations, it was found that providers were more aware of issues faced by aging LBGT persons, were more likely to dispute homophobic remarks, and had more knowledge of policies that directly impact LGBT persons (Porter & Krinsky, 2014). Using the professional organizations' competency standards to examine professionals' self-perceptions of their competencies against their true competency scores is one way in which competency standards might be useful in the human services field.

These fields' competencies/policy statements and subsequent studies highlight an important relationship. The competencies/policy statements articulated a field's values at a particular moment in time, after which investigations were conducted to determine how well the field is meeting those standards. Thus, the competencies/policy statements became a benchmark by which a field could evaluate its adherence to these delimited expectations (Bidell, 2013; Bidell, 2014; Dickman Portz et al., 2015; Graham et al., 2012; Hall et al., 2013; Perosa et al., 2008; Singh & Burnes, 2010). In the same way, these competencies have aided the counseling and social work fields, and so could a human services LGBT competency document equally assist the field of human services. A document such as this would give professionals a clear guideline when working with LGBT clients. Additionally, such a document would support human services researchers in being able to evaluate how well organizations and institutions are meeting those agreed upon value codifications.

This article will examine the latest LGBT competency documents from the fields of social work and counseling in order to note the nuances of each field's documents. This examination is intended to offer to the human services field a starting place from which to consider what human services LGBT competencies might contain. Following a summary of these competency documents, this article will then compare and contrast their usefulness from the perspective of the human services field. Next, suggestions will be made to identify key

objectives that should be considered when developing human services' field LGBT competency standards. Finally, we will discuss how the suggested competencies might impact the field along with suggested ways to initiate the conversation. It is important for the reader to keep in mind that each fields' culture and history plays a fundamental role in the development of competencies, and thus the culture and history of human services should be a critical element influencing the development of human services LGBT competency standards.

NASW Competencies of Practice

The NASW produced a document on work with LGBT clients entitled *Lesbian, Gay, and Bisexual Issue*s (2015a). It gives a concise and thorough history of systemic discrimination experienced by LGBT communities and points out that, despite progress, systemic discrimination still exists in the United States and globally. The document showcases some negative mental health impacts experienced by LGBT clients and emphasizes advocating on behalf of these communities as a critical component in ensuring culturally competent social work practice. It calls on social workers in all types of locations to affirm non-discriminatory practices and work towards ending all prejudices, discriminations, and oppressions impacting LGBT individuals. The document articulates standards, expectations, and codes of conduct: nondiscrimination and equality, professional and continuing education, education and public awareness, health and mental health services, policy action and advocacy, and research.

ACA Competencies of Practice

The latest ACA document related to LGBT issues arose out of work by ALGBTIC and details *Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals* (Harper et al., 2013) with a separate document *Competencies for Transgender Clients* (Burnes et al., 2010). Competencies for counseling lesbian, gay, bisexual, queer, and questioning (LGBQQ) individuals are divided into eight sections (a) human growth and development; (b) social and cultural diversity; (c) helping relationships; (d) group work; (e) professional orientation and ethical practice; (f) career and lifestyle development; (g) assessment; and (h) research and program evaluation. Related to working with allies, there are four competencies (a) awareness; (b) knowledge; (c) supporting individuals who are coming out; and (d) facilitate supportive environments. The document also addresses working with intersex individuals, specifically definitions and common issues, a listing of conditions that might cause intersex, how common it is, considerations if a child is considered intersex, and then the issue of concealment versus client-centered models.

Similarities/Difference in Competence of Helping Professions

Within the fields of social work and counseling, each national organization formed task groups to create documents that articulate the organizations' stances on LGBT issues. Both documents contain statements of non-discrimination and support of actions that increase the well-being of LGBT individual. They also emphasize the need for educated membership and the need for formal advocacy efforts. Some notable differences also exist between the two documents. NASW focuses on systemic change (laws and discrimination policies), while ACA focuses on the mental and emotional health and well-being of LGBT clients. Finally, the ACA document contains content that the NASW does not, including the importance of understanding development specific to each population, how members can assist clients with work and career goals, how members can best assist clients in appraisal of presenting problem and other starting

relationship potential issues, and the need to be sensitive to research that might not be applicable to these populations.

Implications for Human Services

The authors have included a discussion of documents developed by the sister fields of social work and counseling to serve as a guide for the field of human services. The authors suggest using competencies already outlined by NOHS in the NOHS Generic Human Services Competencies (2015b) as a foundation for developing two stand-alone documents that outline specific competencies: one that would focus on working with LGB individuals and another that would focus on transgender individuals. The authors' suggestions seek to capture key elements included in documents in use by the social work and counseling fields, which are supported by empirical research. (Burnes et al., 2010; Harper et al., 2013; NASW, 2015a; NASW; 2015b). The suggestions made in Table 1 and Table 2 also capture recommendations for best practices for working with LGB (Budge, Israel, & Merrill, 2017; Bhugra, 2016; Gedro, 2010; McNamara & Ng, 2016) and transgender individuals (Chang, Singh, Gonsiorek, & Dickey, 2016; Frohard-Dourlent, 2016; Garrett, 2018; Köllen, 2016; Riggs & Bartholomaeus, 2015) that are supported by the current research with these populations.

Table 1
Current Human Services Competencies and Suggestions for LGB Competencies

Generic Human Services Competencies	Suggestions for LGB Competencies
Understanding the nature of human systems: individual, group, organization, community and society, and their major interactions. All workers will have the preparation which helps them to understand human development, group dynamics, organizational structure, how communities are organized, how national policy is set, and how social systems interact in producing human problems (para.15).	● Include specific language highlighting the history of discrimination toward LGB individuals. ● Include specific language highlighting the importance of continued professional development as a way to gain knowledge of historical and current issues of discrimination and marginalization in the LGB community. ● Include specific language about the LGB communities and supports offered.
Understanding the conditions which promote or limit optimal functioning and classes of deviations from the desired functioning in the major human systems. Workers will have an understanding of the major models of causation that are concerned with both the promotion of healthy functioning and with treatment-rehabilitation. This includes medically oriented, socially oriented,	● Include specific language highlighting the importance of human services practitioners' awareness of the historical and systematic conditions that promote a limited optimal functioning. ● Include affirming language that emphasizes the importance of creating a SAFE space for LGB individuals.

psychologically-behavioral oriented, and educationally oriented models (para.16).	● Include specific language that highlights the need for advocacy by human services practitioners and organizations for LGB individuals.
Skill in identifying and selecting interventions which promote growth and goal attainment. The worker will be able to conduct a competent problem analysis and to select those strategies, services or interventions that are appropriate for helping clients attain the desired outcome. Interventions may include assistance, referral, advocacy, or direct counseling (para.17).	● Specific language should be included that highlights the importance of human services practitioners' awareness of community services, agencies, and resources tailored to LGB individuals. ● Specific language should be included highlighting the need for culturally sensitive interventions when working with LGB individuals. ● Specific language should be included highlighting the need for ongoing professional development related to LGB issues.
Skill in planning, implementing and evaluating interventions. The worker will be able to design a plan of action for an identified problem and implement the plan in a systematic way. This requires an understanding of problems analysis, decision-analysis, and design of work plans. This generic skill can be used with all social systems and adapted for use with individual clients or organizations. Skill in evaluating the interventions is essential (para.18).	● Specific language should be included emphasizing the importance of human services practitioners' awareness of effective service delivery models specific to working with LGB individuals. ● Specific language should be included emphasizing the importance of continued professional development. ● Include specific language highlighting the importance of measuring competencies for work with these populations based on current research.
Consistent behavior in selecting interventions which are congruent with the values of one's self, clients, the employing organization and the Human Service profession. This cluster requires awareness of one's own value orientation, an understanding of organizational values as expressed in the mandate or goal statement of the organization, human service ethics, and an appreciation of the client's values, lifestyle and goals (para.19).	● Specific language should be included highlighting the importance of human services researched focused on working with LGB individuals. ● Include specific language highlighting the importance of professional development. ● Include specific knowledge highlighting the importance of competent skill delivery. ● Include specific language emphasizing the importance of human services

	agencies developing statements that are LGB affirming.
Process skills which are required to plan and implement services. This cluster is based on the assumption that the worker uses himself as the main tool for responding to service needs. The worker must be skillful in verbal and oral communication, interpersonal relationships and other related personal skills, such as self-discipline and time management. It requires that the worker be interested in and motivated to conduct the role that he has agreed to fulfill and to apply himself to all aspects of the work that the role requires (para.20).	● Include specific language highlighting the importance of practitioners' knowledge of the literature on LGB populations. ● Include specific language related to using appropriate language when working with LGB individuals. ● Include specific language that encourages self-reflection and checking biases.

Table 2
Current Human Services Competencies and Suggestions for Transgender Competencies

Generic Human Services Competencies	Suggestions for Transgender Competencies
Understanding the nature of human systems: individual, group, organization, community and society, and their major interactions. All workers will have the preparation which helps them to understand human development, group dynamics, organizational structure, how communities are organized, how national policy is set, and how social systems interact in producing human problems (para.15).	● Include specific language highlighting the importance of knowing the present cultural and systemic issues confronted by transgender individuals, particularly as it relates to the discourse regarding gender and sex. ● Include specific language highlighting the importance of familiarity with current research focused on transgender individuals. ● Include specific language highlighting the importance of measuring competencies for service delivery with these populations.
Understanding the conditions which promote or limit optimal functioning and classes of deviations from the desired functioning in the major human systems. Workers will have an understanding of the major models of causation that are concerned with both the promotion of healthy functioning and with treatment-rehabilitation. This includes medically oriented, socially oriented,	● Detail the medical complications and hurdles experienced solely by transgender individuals. ● Emphasize the importance of using affirming language when working with transgender individuals. ● Include specific language that highlights the need for advocacy by human services practitioners and

psychologically-behavioral oriented, and educationally oriented models (para.16).	organizations for transgender individuals.
Skill in identifying and selecting interventions which promote growth and goal attainment. The worker will be able to conduct a competent problem analysis and to select those strategies, services or interventions that are appropriate for helping clients attain the desired outcome. Interventions may include assistance, referral, advocacy, or direct counseling (para.17).	● Specific language highlighting the importance of human services practitioners' awareneess of community services, agencies, and resources specific to transgender individuals. ● Specific language highlighting the need for culturally sensitive interventions when working with transgender individuals that have intersectional historically marginalized identities.
Skill in planning, implementing and evaluating interventions. The worker will be able to design a plan of action for an identified problem and implement the plan in a systematic way. This requires an understanding of problems analysis, decision-analysis, and design of work plans. This generic skill can be used with all social systems and adapted for use with individual clients or organizations. Skill in evaluating the interventions is essential (para.18).	● Specific language emphasizing the importance of human services practitioners' awareness of effective service delivery models specific to working with transgender individuals, including the obstacles that might be encountered that are specific for these populations. ● Specific language emphasizing the importance of continued professional development specific to working with transgender individuals, including research focused on these populations.
Consistent behavior in selecting interventions which are congruent with the values of one's self, clients, the employing organization and the Human Service profession. This cluster requires awareness of one's own value orientation, an understanding of organizational values as expressed in the mandate or goal statement of the organization, human service ethics, and an appreciation of the client's values, lifestyle, and goals (para.19).	● Include specific language highlighting the importance of continued professional development for working with transgender individuals. ● Include specific knowledge highlighting the importance of competent skill delivery with transgender individuals, along with unique possible struggles of intervention implementation. ● Include specific language emphasizing the importance of human services agencies developing statements that are transgender affirming.

Process skills which are required to plan and implement services. This cluster is based on the assumption that the worker uses himself as the main tool for responding to service needs. The worker must be skillful in verbal and oral communication, interpersonal relationships and other related personal skills, such as self-discipline and time management. It requires that the worker be interested in and motivated to conduct the role that he has agreed to fulfill and to apply himself to all aspects of the work that the role requires (para.20).	● Include specific language encouraging self-reflection and checking biases when working with transgender individuals. ● Unique skills needed in order to advocate for transgender clients, including within own organization if needed. ● Include specific language highlighting the importance of language when working with transgender individuals.

Recommendations for Human Services

Currently, there are six competencies outlined in the NOHS Generic Human Services Competencies (2015b). These competencies delineate professionals' responsibility to clients and the profession and highlight the importance of culturally competent human services practice; however, they are broad and general. Thus, an HSP working with LGBT individuals looking for guidance could lean on these competencies, but they lack the specific way NOHS would recommend work with LGBT individuals. Furthermore, this article has used the language LGBT as a possible means to classify sexual minorities, as these are the categories used by NASW and ACA. However, there is new research from Legate and Rogge (2019) that offers a data-driven classification system, which might better serve NOHS. Winfield et al. (2017) state that NOHS has been leading the profession in developing ethical guidelines. The authors recommend that leadership organizations in the field of human services should create a task force to develop competencies to be endorsed by the members and the organization.

Conclusion

The unique needs of LGB and transgender populations have not yet been adequately addressed by the human services field through the creation of a population-specific competency statement. Consequently, the field of human services is behind other helping professions in embracing a specific guideline that sets a standard for competent service delivery to LGB and transgender individuals. The commonalities found in social work and counseling documentation of service delivery to LGB and transgender individuals highlight the importance of stand-alone documents that include the following elements: professional development, need for advocacy, history of discrimination, and best practices for working with LGB and transgender individuals. It is the national organization's responsibility to lead HSPs to competent service delivery, and the first step for these populations lies in the development of specific competencies that detail human services practices with LGB and transgender individuals.

References

Association of Multicultural Counseling and Development (AMCD). (2003). *AMCD multicultural counseling competencies.* Retrieved from https://www.counseling.org/resources/competencies/multcultural_competencies.pdf

Bhugra, D. (2016). Cultural variations in LGBT issues. *European Psychiatry, 33*, S70. doi:10.1016/j.eurpsy.2016.01.982

Bidell, M. P. (2013). Addressing disparities: The impact of a lesbian, gay, bisexual, and transgender graduate counselling course. *Counselling and Psychotherapy Research, 13*(4), 300-307. doi:10.1080/14733145.2012.741139

Bidell, M. P. (2014). Are multicultural courses addressing disparities? Exploring multicultural and affirmative lesbian, gay, and bisexual competencies of counseling and psychology students. *Journal of Multicultural Counseling and Development, 42*(3), 132-146. doi:10.1002/j.2161-1912.2014.00050.

Byrd, R. & Hays, D. G. (2013). Evaluating a safe space training for school counselors and trainees using a randomized control group design. *Professional School Counseling, 17*(1), 20-31. doi:10.5330/PSC.n.2013-17.20

Budge, S., Israel, T. & Merrill, C. R. S. (2017). Improving the lives of sexual and gender minorities: The promise of psychotherapy research. *Journal of Counseling Psychology, 64*(4), 376-384. doi:10.1037/cou0000215

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. doi:10.1080/15538605.2010.524839

Chang, S., Singh, A., Gonsiorek, J. C., & Dickey, L. (2016). Affirming psychological practice with transgender and gender nonconforming people of color. *Psychology of Sexual Orientation and Gender Diversity, 3*(2), 140-147. doi:10.1037/sgd0000153

Corey, G., Corey, M. S., Corey, C., & Callanan, P. (2015). *Issues and ethics in helping professions*. (9th ed.). Pacific Grove, CA: Cengage Learning.

Dickman Portz, J., Retrum, J. H., Wright, L. A., Boggs, J. M., Wilkins, S., Grimm, C., . . . & Gozansky, W. S. (2015). Assessing capacity for providing culturally competent services to LGBT older adults. *Journal of Gerontological Social Work*, *57*(2-4), 305-321. doi:10.1080/01634372.2013.857378

Foglia, M. B., Fox, E., Chanko, B., & Bottrell, M. M. (2012). Preventive ethics: Addressing ethics quality gaps on a systems level. *The Joint Commission Journal on Quality and Patient Safety*, *38*(3), 103-111.

Fredricksen-Goldsen, K. I., Hoy-Ellis, C. P., Goldsen, J., Emlet, C. A., & Hooyman, N. R. (2014). Creating a vision for the future: Key competencies and strategies for culturally competent practice with lesbian, gay, bisexual, and transgender (LGBT) older adults in the health and human services. *Journal of Gerontological Social Work, 57(2-4), 80-107.* doi:10.1080/01634372.2014.890690

Frohard-Dourlent, H. (2016). "'I don't care what's under your clothes": The discursive positioning of educators working with trans and gender-nonconforming students. *Sex Education: Sexuality, Society and Learning, 16*(1), 63-76. doi:10.1080/14681811.2015.1022819

Garrett, M. (2018). Working with transgender individuals in case management practice. *Professional Case Management, 23*(1), 19-24. doi:10.1097/NCM.0000000000000251

Gedro, J. (2010). Understanding, designing, and teaching LGBT issues. *Advances in Developing Human Resources, 12*(3), 352-366. doi:10.1177/1523422310375029

Gegenfurtner, A., & Gebhardt, M. (2017). Sexuality education including lesbian, gay, bisexual, and transgender (LGBT) issues in schools. *Educational Research Review, 22*, 215-222. doi:10.1016/j.edurev.2017.10.002

Graham, S. R., Carney, J. S., & Kluck, A. S. (2012). Perceived competency in working with

LGB clients: Where are we now? *Counselor Education & Supervision, 51*(1), 2-16. doi:10.1002/j.1556-6978.2012.00001.x

Hall, W. J., McDougald, A. M., & Kresica, A. M. (2013). School counselors' education and training, competence, and supportive behaviors concerning gay, lesbian, and bisexual students. *ASCA Professional School Counseling, 17*(1). 130-141. doi:10.1177/2156759X0001700108

Harper, A., Finerty, P., Martinez, M., Brace, A., Crethar, H. C., … & Hammer, T. (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. doi:10.1080/15538605.2013.755444

Johnson, K., & Bonner, M. (2013). Utilizing the six generic human service competencies and ecological systems theory as a basis to understanding barriers faced by marginalized clients. *Journal of Human Services, 33*(1), 49-57.

Köllen, T. (2016). *Sexual orientation and transgender issues in organizations: Global perspectives on LGBT workforce diversity*. Vienna, Austria: Springer International Publishing.

Legate, N., & Rogge, R. D. (2019). Identifying basic classes of sexual orientation with latent profile analysis: Developing the Multivariate Sexual Orientation Classification System. *Archives of Sexual Behavior 48*(5), 1403-1422. doi:10.1007/s10508-018-1336-y

Levine-Ariff, J. (1990). Preventive ethics: The development of policies to guide decision making. *ACCN Clinical Issues in Critical Care Nursing*, *1*(1), 169-177.

National Organization of Human Services [NOHS]. (2015a). *Ethical standards for human services professionals.* Retrieved from http://www.nationalhumanservices.org/ethical-standards-for-hs-professionals

National Organization of Human Services [NOHS]. (2015b). *What is human services?* Retrieved from http://www.nationalhumanservices.org/what-is-human-services

National Association of Social Workers [NASW]. (2003). Lesbian, gay, and bisexual issues. *Social work speaks: National Association of Social Workers policy statements 2003–2006* (6th ed., pp. 224–235). Washington, DC: NASW Press.

National Association of Social Workers [NASW]. (2004, June). *Same-sex marriage position statement.* Retrieved from http://www.naswdc.org/diversity/lgb/062804.asp

National Association of Social Workers [NASW]. (2008). *Code of ethics.* Retrieved from https://www.socialworkers.org/LinkClick.aspx?fileticket=KZmmbz15evc%3D&portalid=0

National Association of Social Workers [NASW]. (2015a). Lesbian gay and bisexual issues. *Social work speaks: National Association of Social Workers policy statements, 2015-2017* (10th ed., pp. 198-206). Washington, DC: NASW Press.

National Association of Social Workers [NASW]. (2015b). Transgender and gender identity issues. *Social work speaks: National Association of Social Workers policy statements, 2015-2017 (10th* ed., pp. 311-315). Washington, DC: NASW Press.

McNamara, M., & Ng, H. (2016). Best practices in LGBT care: A guide for primary care physicians. *Cleveland Clinic Journal of Medicine, 83*(7), 531-541. doi:10.3949/ccjm.83a.15148

Perosa, L. M., Perosa, S. L., & Queener, J. (2008). Assessing competencies for counseling lesbian, gay, bisexual, and transgender individuals, couples, and families. *Journal of LGBT Issues in Counseling, 2*(2), 159-169. doi:10.1080/15538600802125613

Porter, K. E., & Krinsky, L. (2014). Do LGBT aging trainings effectuate positive change in mainstream elder service providers? *Journal of Homosexuality, 61*(1). 197–216. doi:10.1080/00918369.2013.835618

Riggs, D. W., & Bartholomaeus, C. (2015). The role of school counsellors and psychologists in supporting transgender people. *Australian Educational and Developmental Psychologist, 32*(2), 158-170. doi:10.1017/edp.2015.19

Rock, M., Carlson, T., & McGeorge, C. (2010). Does affirmative training matter? Assessing CFT students' beliefs about sexual orientation and their level of affirmative training. *Journal of Marital and Family Therapy, 36*(2), 171-184. doi:10.1111/j.1752-0606.2009.00172.x

Singh, A. A., & Burnes, T. R. (2010). Introduction to the special issue: Translating the competencies for counseling with transgender clients into counseling practice, research, and advocacy. *Journal of LGBT Issues in Counseling, 4*(3-4), 126-134. doi:10.1080/15538605.2010.524837

Smith, L. C., Shin, Q., & Officer, L. M. (2012). Moving counseling forward on LGB and transgender issues: Speaking queerly on discourses and microaggressions. *Counseling Psychologist, 40*(3), 385-408. doi:10.1177/0011000011403165

Social Work Policy Institute. (2008). *Lesbian, gay, bisexual, and transgender persons.* Retrieved from http://www.socialworkpolicy.org/research/lesbian-gay-bisexual-and-transgender-persons.html

Winfield, C., Sparkman-Key, N., & Vajda, A. (2017). Professional standards: Embracing preventive ethics in human services. *Journal of Human Services*, *37*(1), 55-62.

Preparing Practice-Ready Collaborative Healthcare Human Services Students: Considerations on Developing Interprofessional Education Competencies in Human Services

Kyulee Park, Francisca Rivas, Ne'Shaun Borden, and Kristy L. Carlisle, *Old Dominion University*

Abstract

Interprofessional collaboration, consultation, and cooperation have long been a direct and indirect professional responsibility of human services practitioners in integrated healthcare settings. In order to effectively educate and train practice-ready human services students for rapidly changing healthcare settings, it is critical that human services organizations and programs examine the need for interprofessional competency education. This article provides timely considerations on developing interprofessional education competencies in human services education.

Keywords: human services education, interprofessional collaboration, integrated healthcare

Introduction

In response to rapidly increasing needs for interprofessional, or interdisciplinary collaboration in patient care, the World Health Organization ([WHO], 2010) published the Framework for Action on Interprofessional Education & Collaborative Practice. According to this Framework, interprofessional education "occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes (WHO, 2010, p. 13). The WHO describes interprofessional collaboration as an innovative healthcare strategy, which would prepare a collaborative practice-ready workforce, produce optimal health services, strengthen the healthcare system, and improve general health outcomes. Interprofessional collaboration in healthcare settings is projected to make a considerable impact in ensuring the continuity of care within multiple disciplines and improving the fragmented healthcare and management systems in the United States. In order to effectively prepare practice-ready human services professionals (HSPs), it is critical to include interprofessional collaboration in human services education curriculum. Many healthcare-related higher education programs, as well as accreditation boards have incorporated interprofessional collaboration competencies as part of their educational framework (IPEC, 2016).

Unlike other helping professionals, such as mental health counselors or social workers, HSPs are trained as generalists and often work in a wide variety of helping arenas (Johnson, Sparkman-Key, & Kalkbrenner, 2017). Interprofessional collaboration is not only an innate component of the human services practice, but also a disciplinary foundation of the field. Although interprofessionalism has always been present in human services education, literature specific to interprofessional collaboration has only emerged in recent years (Johnson et al., 2017). In order to successfully and effectively train human services students as interprofessional practitioners, it is important that we continue to explore ways to incorporate interprofessional education (IPE) into human services training programs. In this article, the importance of developing human services interprofessional competencies will be reviewed and discussed.

Review of Current Human Services Organizations' Positions on IPE

National Organization for Human Services (NOHS)

In 2015, NOHS developed the Ethical Standards for Human Services Professionals, outlining HSPs' responsibilities to clients, colleagues, the profession, the public and society, employers, self, and students. Among these fundamental values and ethical guidelines of the profession, standards that directly address interprofessional collaboration are:

- *Standard 19:* Human service professionals avoid duplicating another professional's helping relationship with a client. They consult with other professionals who are assisting the client in a different type of relationship when it is in the best interest of the client to do so. In addition, human services professionals seek ways to actively collaborate and coordinate with other professionals when appropriate (p. 5).
- *Standard 29:* Human service professionals promote cooperation among related disciplines to foster professional growth and to optimize the impact of inter-professional collaboration on clients at all levels (p. 6).

Although NOHS actively promotes interprofessional practice and advocates for the human services profession in interprofessional collaboration, it is important to note that NOHS and the Ethical Standards do not have an emphasis on IPE competencies or curricula.

Council for Standards in Human Service Education (CSHSE)

The CSHSE was established in 1979 and is the current accrediting body for human services education programs. It details the importance of including interdisciplinary training and knowledge in the curriculum for HSPs, which can be found throughout the CSHSE National Standards for an Associate, Baccalaureate, and Master's Degree in Human Services (CSHSE, 2018).

- *Standard 2e*: Describe the multidisciplinary, interdisciplinary, or transdisciplinary approach to knowledge, theories, and skills included in the curriculum (p. 2).
- *Standard 6a(1)*: Include curriculum vitae of full-time and part-time faculty who teach human services courses. The vitae must demonstrate that: Faculty have education in various disciplines and experience in human services or related fields (p. 5).
- *Standard 19f*: Interdisciplinary team approaches to problem solving (p. 12).

The CSHSE asserts that human services faculty are trained in and have knowledge of interprofessional or interdisciplinary approaches. However, there is no definition or core competencies of interprofessional practice provided in the Standards, which could be subject to individual program's interpretation and implementation of IPE.

Human Services Board Certified Practitioner (HS-BCP)

The HS-BCP credential is offered through the Center for Credentialing & Education (CCE), which was developed in partnership with NOHS and CSHSE. Although many HS-BCPs in the United States innately work in collaboration with various disciplines, such as counseling, social work, education, and medicine, at this time, there is no specific literature published by the CCE that directly addresses HS-BCP's IPE or training.

IPE in Other Disciplines of Helping/Healthcare Professions

As aforementioned, IPE is minimally discussed in the three main human services organizations in the United States. In this section, three educational program accreditation boards in related fields (i.e., counseling, social work, and medicine) are reviewed on their standards on IPE. The fields were selected based on most common interprofessional relationships that human services trainees can encounter. According to the 38 examples of occupational titles of human service workers that NOHS (n.d.) provided on their website, a great majority of them are relevant in behavioral and mental health care settings (e.g., residential counselor, mental health aide), social work settings (e.g., case worker, social work assistant), as well as in care management settings (e.g., home health aide, client/patient advocate). Additionally, mental health counseling, social work, and medical fields have recognized the growing needs for interprofessional collaboration in their training programs and have established national organization IPE guidelines as early as 2009 (Shannon, 2015). Authors of this article believe that this review would provide a valuable and practical framework for IPE development in human services field.

Council for Accreditation of Counseling and Related Programs (CACREP)

The counseling field encompasses a wide array of settings, specializations, and licensures (Mellin, Hunt, & Nichols, 2011; Johnson & Freeman, 2014). With counselors deployed in a variety of settings with complex issues, counselors and their professional organizations have begun to promote interprofessional collaboration as a way to effectively address such complex human issues in treatment (Mellin et al., 2011). The accreditation board for graduate level counseling programs, CACREP (2015) has incorporated the necessity of integrated and interprofessional care into their standards of practice. Examples of the CACREP standards that address interprofessional collaboration include:

- *2.F.1.b*: The multiple professional roles and functions of counselors across specialty areas, and their relationships with human service and integrated behavioral health care systems, including interagency and interorganizational collaboration and consultation (p. 9).
- *2.F.1.c*: Counselors' roles and responsibilities as members of interdisciplinary community outreach and emergency management response teams (p. 9).
- *5.D.2.b*: Relationships between clinical rehabilitation counselors and medical and allied health professionals, including interdisciplinary treatment teams (p. 25).
- *5.D.3.b*: strategies for interfacing with medical and allied health professionals, including interdisciplinary treatment teams (p. 27).
- *5.H.3.l*: consultation with medical/health professionals or interdisciplinary teams regarding the physical/mental/cognitive diagnoses, prognoses, interventions, or permanent functional limitations or restrictions of individuals with disabilities (p. 33).

Johnson and Freeman (2014) addressed the need for mental health counselors and counselor educators to become familiar with IPE and to incorporate IPE into counseling programs. Through IPE, counselors are able to better address complex issues in practice, understand other professionals and their roles and power, and gain a better understanding of their own counselor identity (Johnson & Freeman, 2014; Bridges, Davidson, Odegard, Maki, & Tomkawiak, 2011).

Council for Social Work Education (CSWE)

CSWE's Commission on Educational Policy and the CSWE Commission on Accreditation revised their Educational Policy and Accreditation Standards in 2015.

- *Competency 1*: …Social workers also understand the role of other professions when engaged in inter-professional teams… (p. 7).
- *Competency 6*: …Social workers value principles of relationship-building and inter-professional collaboration to facilitate engagement with clients, constituencies, and other professionals as appropriate… (pp. 8).
- *Competency 7*: …Social workers recognize the implications of the larger practice context in the assessment process and value the importance of inter-professional collaboration in this process… (p. 9).
- *Competency 8*: Social workers value the importance of inter-professional teamwork and communication in interventions, recognizing that beneficial outcomes may require interdisciplinary, interprofessional, and inter-organizational collaboration… (p. 9).
- *Educational Policy M2.1*: …Specialized practitioners synthesize and employ a broad range of interdisciplinary and multidisciplinary knowledge and skills based on scientific inquiry and best practices, and consistent with social work values… (p. 12).

CSWE (2015) adopted a competency-based educational framework, in which its educational curriculum is developed based on "a shared view of the nature of competence in professional practice" and professional competence can be demonstrated in educational settings via "knowledge, values, skills, and cognitive and affective processes" (p. 6).

Accreditation Council for Graduate Medical Education (ACGME)

Similar to the human services field, interprofessional and integrated behavioral practice is an innate and critical component of the medical profession. Over the years, medical and healthcare fields have been in the forefront of promoting and fostering IPE and practice, evident by the Common Program Requirements developed by the ACGME (2019). The Common Program Requirements are used across the United States for medical residency and fellowship accreditation. They include IPE-friendly language throughout the handbook and firmly address IPE or IP training as part of the accreditation requirements. Examples include:

- *IV.A.5.f.5*: Residents are expected to work in interprofessional teams to enhance patient safety and improve patient care quality (p. 22).
- *VI.A.1.a.1.b*: The program must have a structure that promotes safe, interprofessional team-based care (p. 34).
- *VI.A.1.a.3.b*: Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.
- *VI.A.1.b.3.a*: Residents must have the opportunity to participate in interprofessional quality improvement activities (p. 35).
- *VI.E.2*: Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system (p. 45).

In many other medical professions (e.g., nursing), IPE and training/practice has been a staple in their program accreditation requirements and educational curricula (Abu-Rish et al., 2012; Roth, Duenas, Zanoni, & Grover, 2016). With the support of powerful national organizations as well as the recognition of increasing needs for integrated patient care, there are already a number of articles in the medical field addressing theoretical frameworks for IPE development and

implementation, learning and exit outcome evaluation tools, and patient satisfaction assessments (Abu-Rish et al., 2012; IPEC, 2016; Paradis, Pipher, Cartmill, Rangel, & Whitehead, 2017).

Current Trends in IPE

With the increasing international and national recognition and support on IPE, in 2011 the Interprofessional Education Collaborative (IPEC) Panel first published a report on Core Competencies for Interprofessional Collaborative Practice. The report defines interprofessional competencies in health care as: "integrated enactment of knowledge, skills, and values/attitudes that define working together across the professions, with other health care workers, and with patients, along with families and communities, as appropriate to improve health outcomes in specific care contexts" (IPEC, 2011, p. 2). Currently, a total of 20 national associations, such as American Psychological Association (APA), Association of American Medical Colleges (AAMC), Association of Schools and Programs of Public Health (ASPPH), Association of Schools of Allied Health Professions (ASAHP), and Council on Social Work Education (CSWE), serve as IPEC's institutional members (IPEC, 2016). IPEC continues to advance interprofessional collaborative practice by providing professional development opportunities, such as Interprofessional Education Collaborative Institute, Leading Collaborative Change Conference, and SAMHSA/IPEC Addiction Education Interprofessional Summit (IPEC, 2016). CSWE is the only helping professional organization amongst various medical professional organizations in IPEC at the moment, but it can be positively projected IPEC would be joined by a diverse variety of helping and health management disciplines in the near future.

IPE competencies are highly relevant and appropriate to be included in human services educational curriculum as a majority of human services graduates join the healthcare and management workforce as mental health technicians, behavioral health aids, substance abuse counselors, case managers, etc. CSHSE in their National Standards for an Associate, Baccalaureate, and Master's Degree in Human Services (CSHSE, 2018) advocated for an interdisciplinary approach to problem solving and providing education and training for interdisciplinary skills. Furthermore, NOHS Ethical Standards for Human Services Professionals (NOHS, 2015) discussed collaboration, consultation, and cooperation between HSPs and other professionals for continuity of care, best practices, and professional development. The movement towards and promotion for interprofessional collaboration and interprofessional education are clearly present in the human services field. It is timely and necessary to respond to this current trend via developing concrete IPE competencies in order to prepare competent, practice-ready human services students.

Review of Core Competencies for Interprofessional Collaboration

Competence-based training and education first emerged in order to supplement common limitations of knowledge and attitude-based approaches (Barr, 1998). It is now widely trusted that competence-based training models for healthcare practitioners are better suited to optimize complex patient/client health outcomes (IPEC, 2011). IPEC first developed four main domains of Interprofessional Collaborative Practice, which comprises of (a) Values and ethics for interprofessional practice; (b) Roles and responsibilities for collaborative practice; (c) Interprofessional communication practices; and (d) Interprofessional teamwork and team-based practice. Under these guidelines, interprofessional collaborators are expected to effectively advocate for their individual professions with respect for other professions, contribute to healthcare delivery within their scope of practice while communicating with other professions,

practice team-based problem solving, and apply patient-centered and community-focused approaches in healthcare in an efficient manner.

In 2016, IPEC revised and republished its core- and sub-competencies in order to better affirm the value of interprofessional collaboration, organize the competency topics, and address the Triple Aim (i.e., improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care). IPEC's 2016 expanded competencies outline more streamlined clinical collaboration geared towards public health professionals, clinical care providers, and other various professionals. The updated competencies are as follows

- Work with individuals of other professions to maintain a climate of mutual respect and shared values
- Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of patients and to promote and advance the health of populations
- Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease
- Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable. (p.10)

On an organizational scale, IPEC's Core Competencies continue to influence national educational accreditation guidelines, as evident in various fields including nursing, public health, and pharmacy (IPEC, 2011). A major change in the update is the emphasis on promoting population health and health equity, as well as the impact of diverse, cultural identities has on health outcomes. These values align well with human services field's mission to advocate for equality, equity, and diversity in educational and professional settings.

IPEC's Core Competencies are easily applicable to many innate characteristics of helping professions, such as the human services field. In fact, Vanderbilt University's Schools of Medicine and Nursing developed Vanderbilt Program in Interprofessional Learning (VPIL) in conjunction with Belmont University and Lipscomb University Colleges of Pharmacy as well as Tennessee State University's Department of Social Work (Vanderbilt University, n.d.). VPIL is specifically designed so that learners from multiple disciplines learn and practice in clinical settings as a team from a patient, family, and community-centered orientation. Similarly, the Eastern Virginia Medical School (EVMS) and Old Dominion University in Southeastern Virginia collaborated on the Professionals Accelerating Clinical and Educational Redesign (PACER) program, in which medical, nursing, physical therapy, counseling and dental hygiene students participated in interprofessional care learning (EVMS, 2018). Students were given opportunities to practice comprehensive screening for socioeconomic and environmental health-related issues, to identify social determinants and barriers to health, and to assess complex and unique needs of patients with low socioeconomic status as part of the Interprofessional Care Clinic (IPC).

Human Services Implications

Human services undergraduate and master's students are trained with a systemic and community-based theoretical lens, which would better prepare them to effectively work in a diverse array of interprofessional settings (Johnson et al., 2017). One of many human services practitioners' key responsibilities is to identify and address patient/clients' basic human needs as generalists, working alongside with a variety of professionals, and medical and healthcare professionals have just begun to recognize the importance of collaborating with helping professionals in order to optimize health outcomes. HSPs are a much-needed addition to this shifting IP health care frame. Thus, incorporation of IP competencies and frameworks in human services education and training would provide them with a unique toolset in a rapidly evolving healthcare system in the United States. In the sections below, the critical connection between human services field and competency-based education is explained in depth and consideration points for developing human services-specific IPE competencies are discussed.

Human Services Education

Competency-based education (CBE) is effective and popular in fields in which the practical application of knowledge is essential (Johnstone & Soares, 2014). CBE program curricula and individual course structure are common and expected in human services education, due to the field's explicit needs for training practice-ready students. CSHSE-accredited human services programs have incorporated competency-based guidelines as they are equipping learners with theories, knowledge, and skills necessary in practice. Two major benefits of competency-based education are that CBE (a) reduces barriers between academics and labor markets via demonstration of mastery and application of skills; and (b) is an affordable and cost-effective approach in education without having to compromise the quality of education (Johnstone & Soares, 2014). Due to the innate nature of human services (i.e., skills application of human services theories), CBE is directly and indirectly integrated in human services education.

Johnstone and Soares (2014) developed five core principles of CBE in higher education programming, including (a) the degree reflects robust and valid competencies; (b) students are able to learn at a variable pace and are supported in their learning; (c) effective learning resources are available anytime and are reusable; (c) the process for mapping competencies to courses, learning outcomes, and assessments is explicit; and (d) assessments are secure and reliable. In the human services educational context, interprofessional competencies can be implemented in a program or course curriculum to clarify and highlight the level of competencies that are needed to successfully prepare students to practice in integrated behavioral settings. Thus, it would not only be timely, but also integral to consider developing IPE competencies in human services education to systematically and effectively prepare practice-ready students.

Considerations in Developing IPE Competencies Relevant to Human Services

In the following section, key considerations in IPE development, implementation, and assessment in the human services field will be discussed. These sections are conceptually based on the three main themes of IPE research identified by Abu-Rish et al. in 2012. The main themes include (a) the conceptual basis for IPE and related competencies; (b) strengthening research methods of IPE; and (c) developing IPE implementation models that fit current health professions curricula.

Expansion of IPEC's core competencies. IPEC (2011; 2016) noted that the Core Competencies for Interprofessional Collaborative Practice should serve as a shared foundation across all professions in interprofessionalism (IP); however, the competencies are addressed in a general manner so that individual professions or institutions can tailor them to better fit their IPE/training needs. For instance, University of Virginia's Schools of Nursing and Medicine developed the Collaborative Care Best Practice Models (CCBPMs), which identified the four original IPEC Core Competencies and added the fifth, *Professionalism* (Brashers, et al., 2016; IPEC, 2011; University of Virginia, n.d.). In developing the IP competencies most relevant to the profession as well as the institution, the faculty were asked to identify IPE learning modules already placed in their previous educational curriculum and further developed that data into institutionally specific IP competencies (i.e., communication, professionalism, shared problem-solving, shared decision making, and conflict resolution). In IPEC's 2016 update, it included information regarding the IPEC Faculty Development Institutes, which trained more than 1,400 educators and practitioners in best practices in interprofessional collaboration. Human services organizations and programs may seek opportunities such as the Faculty Development Institutes to further conceptualize and synergize IP and human services education in creating IPE competencies.

Continued research on IPE in human services. Developing reliable and valid learning outcomes assessment is as important as identifying human services specific and relevant IPE competencies to ensure quality of the intervention. In a systematic review of 107 IPE evaluations, Barr, Koppel, Reeves, Hammick, and Freeth (2008) reported a predominance of positive learning outcomes of IPE programs, which supports previous literature that interprofessionalism can be developed and fostered through competency-based IPE in educational settings. It is also important to note that many healthcare and helping IPE programs strongly emphasize the clinical practice of interprofessionalism as an integral part of IPE in addition to the conceptual, knowledge-based learning of interprofessionalism (Barr et al., 2008). It is especially important to note, as most human services undergraduate and graduate programs require practicum or internship, in which instructors and supervisors can collaboratively encourage and prepare students for entry-level interprofessional work that would in return enrich human services students' conceptual understanding of interprofessionalism.

Abu-Rish and colleagues (2012) reviewed a total of 83 peer-reviewed manuscripts on qualitative, quantitative, and mixed-method reports on IPE in health professions field. The review identified small group discussion as the predominant IPE format (n = 48, 57.8%), followed by case studies (n = 40, 48.2%), large group lectures (n = 31, 36.1%), and so on. In regard to IPE learning outcomes, student attitudes towards IPE was most commonly reported (n = 64, 77.1%), followed by student gains in IPE knowledge, satisfaction, skills, and patient-oriented outcomes. This review provides numerous valuable considerations in implementing and assessing IPE curricula, such as barriers to IPE implementation (e.g., scheduling, learner-level compatibility, preparation time required, funding, outcomes measurement, negative interdisciplinary interactions/hierarchies, administrative support, and unprepared faculty). The authors also suggest that there is room for improvement. Some key results indicated that the majority of reviewed IPE programs have been in place for 5 or less years (n = 59, 71.1%); did not indicate in what ways IPE faculty was trained (n = 68, 81.9%); and offered IPE program as a one-time event, such as a workshop or seminar (n = 48, 57.8%). Currently, there is limited empirical research and instruments on IPE available on human services; continued development of learning outcome assessment tools, longitudinal research on the effects of IPE, and quality

improvement projects are strongly recommended to improve human services student and faculty development on IPE.

In order to overcome shared limitations across current IPE outcomes studies, Abu-Rish and colleagues (2012, pp. 449-450) developed the Replicability of Interprofessional Education (RIPE), which outlines 13 guidelines that are required in order to replicate IPE studies, including:

> (a) theoretical framework, (b) stated objectives of the intervention, (c) development and design of the intervention, (d) voluntary/required nature of the IPE intervention, (e) level and numbers of students and health professions, (f) frequency and duration of the IPE intervention, (g) teaching strategies, (h) faculty development, (i) validation of the tools used to assess/measure outcomes, (j) cost and resource utilization to implement the intervention, (k) institution leadership support, (l) barriers/facilitators of implementation and (m) community partnerships.

The authors contend that the RIPE template is an appropriate and applicable guideline for IPE outcomes reports in human services, which would enable to more readily compare human services IPE studies to identify themes in best practices in the future.

Implementation of sustainable IPE models. According to Abu-Rish's 2012 review, very few studies outlined theoretical frameworks used in developing and implementing IPE programs. The authors further argued for a stronger connection between educational theories and practical implementation in helping and health professions. IPE theoretical framework provides the foundation for the program fit, research objectives, teaching methods, and outcome measures (Abu-Rish et al., 2012). IPE has been influenced by a wide variety of theories, such as adult learning, psychodynamic, social learning, contact, activity, and practice theories (Hean, Craddock, Hammick, & Hammick, 2012). Hean and colleagues (2012) argue that theoretical frameworks are necessary in order to better understand practical application. Theoretical frameworks also provide educators, learners, and practitioners with an outline that enables them to test theoretical hypotheses in daily practices as well as empirical research. The authors further suggest that when choosing which theory to use, it is important to assess "its suitability to articulate or improve understanding of interprofessional education in a particular context" (Hean et al., 2012, p. 81). In the human services context, perhaps theories that address social determinants of health, ecological barriers to care, or intersectionality may be better suited than others.

As IPE in human services is a rather recent movement that is not yet widely established, grounded theory approach may also provide crucial insight. Hean et al. (2012) further suggested a review of pedagogical approaches (i.e., problem-based learning, practice-based learning, guided discovery learning, experiential learning, and reflective practice) that already have been implemented in IPE and training settings. There needs to be a more comprehensive and human services-relevant systemic review of IPE frameworks and learning theories that can guide the development of interprofessional committees in various human services organizations and programs. Furthermore, it would be important to include not only student learning plans in theory development, but also IPE faculty development and training as well as community-based or interdisciplinary networking into consideration.

Additionally, the IPE theoretical framework needs to address faculty development and training, community-based or interdisciplinary networking, ways to integrate IPE in pre-qualifying, pre-existing programs, culture of positive and well-supervised experiences of interprofessional practice, and continuing education/training opportunities on IPE (Barr et al.,

2005). These considerations closely align with fundamental values of the human services profession, as the community collaboration and life-long learning are an important ongoing theme in the field (Hoover, Jacobs, Anderson, & Bateman, 1999; Johnson et al., 2017). For continuity of IPE and training, it would also be critical for human services programs to develop and implement institutional plans to collect data on student/supervisor experience in integrated settings, conduct internship site visits for learners in integrated settings, provide theoretical IPE training opportunities for HSPs in integrated settings, create opportunities for HSPs in integrated settings to mentor students, and administer exit interviews with students and faculty that partook in IPE.

Future Directions

In order to better prepare future human services students and practitioners to serve in IP healthcare settings, it is critical that national human services organizations focus on researching human services-specific interprofessional and multidisciplinary models of education and identify IPE competency frameworks as the first step. Johnson et al. (2017) recommended that the IPE is added to the CSHSE accreditation standards. Human services undergraduate and graduate programs can then redesign their programs to incorporate IPE to improve faculty understanding of IPE and strengthen students' skillsets. Inter-departmental collaborations within universities may serve as a critical resource for many helping and healthcare educational programs. In the meantime, human services faculty and clinical supervisors can foster environments in which IPE and training are infused in their educational and training curricula, which could range from inviting HSPs in IP settings as guest speakers to assigning IP research projects. Potential IP opportunities in higher education could include projects such as: creating medical literacy glossary for HSPs, providing focused training on IP ethics, instituting IP career fair, and offering interdepartmentally cross-listed IP courses. Furthermore, for practicing HSPs, it is recommended that they continue to advocate for the importance of human services work and interprofessional collaboration in their work setting, actively collaborate and consult with other professionals, and participate in interprofessional networking events, conferences, and organizations to increase HSP presence in healthcare settings.

Although interprofessional collaboration is an innate characteristic of human services field, little to no organizational attention has been given on IPE. By learning how to work as a team, human services students can practice critical thinking, collaborate in complex problem-solving, and learn diverse perspectives of other professions HSPs work closely with. In social and health care settings, HSPs are in a perfect position to advocate for patient-, family-, and community-centered approaches, effectively make referrals and act as a bridge between multiple professions, and offer unique ecological, systemic frameworks in better understanding and caring for patient/client. There is still much to be understood about IPE best practices and IPE in general in the field of human services; however, it is undoubtedly and inevitably essential to restructure and incorporate IPE in human services to meet the changing needs of the multidisciplinary collaboration.

References

Abu-Rish, E., Kim, S., Choe, L., Varpio, L., Malik, E., White, A. A., … & Thigpen, A. (2012). Current trends in interprofessional education of health sciences students: A literature review. *Journal of Interprofessional Care, 26*(6), 444-451.

Accreditation Council for Graduate Medical Education [ACGME]. (2019). *Common program requirements.* Retrieved from

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf
Barr, H. (1998). Competent to collaborate: Towards a competency-based model for interprofessional education. *Journal of Interprofessional Care, 12,* 181-187.
Barr, H., Koppel, I., Reeves, S., Hammick, M., & Freeth, D. (2008). *Effective interprofessional education: Argument, assumption and evidence*. Oxford, UK: Blackwell.
Brashers, V., Erickson, J. M., Blackhall, L., Own, J. A., Thomas, S. M., & Conaway, M. R. (2016). Measuring the impact of clinically relevant interprofessional education on undergraduate medical and nursing student competencies: A longitudinal mixed methods approach. *Journal of Interprofessional Care, 30*(4), 448-457.
Bridges, D., Davidson, R., Odegard, P., Maki, I., & Tomkawiak, J. (2011). Interprofessional collaboration: Three best practice models of interprofessional collaboration. *Medical Education Online, 16,* 1-10. doi:10.3402/meo.vl6i0.6035
Council for Accreditation of Counseling and Related Programs [CACREP]. (2015). *2016 CACREP standards.* Retrieved from http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf
Council on Social Work Education [CSWE]. (2015). *Education policy and accreditation standards for baccalaureate and master's social work programs.* Retrieved from https://www.cswe.org/getattachment/Accreditation/Standards-and-Policies/2015-EPAS/2015EPASandGlossary.pdf.aspx
Eastern Virginia Medical School [EVMS]. (2018). *PACER team report summary.* Retrieved from https://pcpacer.org/wp-content/uploads/2018/12/PACER-Team-Final-Summary-Report_EVMS.pdf
Hean, S., Craddock, D., Hammick, M., & Hammick, M. (2012). Theoretical insights into interprofessional education: AMEE guide No. 62. *Medical Teaching, 34*(2), 78-101.
Hoover, L., Jacobs, D., Anderson, D., & Bateman, D. F. (1999). Sculpting interprofessional alliances in human service education. *Human Service Education, 19*(1), 25-34.
Interprofessional Education Collaborative (IPEC). (2016). *Core competencies for interprofessional collaborative practice: 2016 update.* Washington, D.C.: Interprofessional Education Collaborative.
Interprofessional Educational Collaborative. (2011). *Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel.* Washington, D.C.: Interprofessional Education Collaborative.
Johnson, K. F., & Freeman, K. L. (2014). Integrating Interprofessional Education and Collaboration Competencies (IPEC) into mental health counselor education. *Journal of Mental Health Counseling*, *36*(4), 328–344. doi:10.17744/mehc.36.4.g47567602327j510
Johnson, K. F., Sparkman-Key, N., & Kalkbrenner, M. T. (2017). Human service students' and professionals' knowledge and experiences of interprofessionalism: Implications for education. *Journal of Human Services, 37*(1), 5-13.
Johnstone, S. M., & Soares, L. (2014). Principles for developing competency-based education programs. *Change: The Magazine of Higher Learning, 46*(2), 12-18.
Mellin, E., Hunt, B., & Nichols, L. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling & Development, 89*(2), 140-147.
National Organization for Human Services [NOHS]. (2015). *Ethical standards for human services professionals.* Retrieved from https://www.nationalhumanservices.org/ethical-standards-for-hs-professionals

National Organization for Human Services [NOHS]. (n.d.). What is human services? Retrieved from https://www.nationalhumanservices.org/index.php?option=com_content&view=article&id=88:what-is-human-services?&catid=19:site-content&Itemid=89

Paradis, E., Pipher, M., Cartmill, C., Rangel, J. C., & Whitehead, C. R. (2017). Articulating the ideal: 50 years of interprofessional collaboration in medical education. *Medical Education, 51*, 861-872. doi:10.1111/medu.13331

Roth, M. E., Duenas, G. G., Zanoni, A., & Grover, A. B. (2016). Designing and evaluating an interprofessional experiential course series involving medical and pharmacy students. *American Journal of Pharmaceutical Education, 80*(5), Article 85.

Shannon S. C. (2015, October). *Press release: Collaboration to advance medical education: IPE and IPP.* Retrieved from https://www.aacom.org/news-and-events/press-releases-and-statements/press-release-details/2015/11/20/collaboration-to-advance-medical-education-ipe-and-ipp

University of Virginia. (n.d.). *Interprofessional core competencies*. Charlottesville, VA: Author. Retrieved from http://ipe.virginia.edu/what-is-ipe/

Vanderbilt University. (n.d.). *Vanderbilt Program in Interprofessional Learning.* Retrieved from https://medschool.vanderbilt.edu/vpil/

World Health Organizations [WHO]. (2010). *Framework for action on interprofessional education & collaborative practice.* Retrieved from https://apps.who.int/iris/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf?sequence=1

Trauma-Informed Career Counseling: Identifying and Advocating for the Vocational Needs of Human Services Clients and Professionals

Jennifer Barrow, Suzan Zuljani Wasik, Livia B. Corry, and Caroline A. Gobble, *North Carolina Central University*

Abstract

Trauma-informed intervention has broad application in the field of human services. This article examines how violence, poverty, veteran status, and historical trauma can impact career development as well as employment opportunities across the lifespan for clients and human service professionals in a variety of settings. Trauma-informed career counseling is discussed as a perspective in assisting clients around employment needs. Trauma-informed strategies and interventions are offered to address how to best identify, increase awareness of, and foster the growth of healthy career development for clients who may have a history of trauma, while also being mindful of addressing the potential for vicarious trauma in human services professionals.

Keywords: trauma-informed career counseling, trauma-informed care, human services, poverty, career services

Introduction

Human service professionals (HSPs) serve a wide ranging population of clients having a variety of needs and presenting issues. HSPs may work in hospitals, public health agencies, mental health agencies, and schools (Neukrug, 2017). Regardless of setting, HSP's clients may have the common characteristic of having experienced a traumatic event that, even if experienced in the distant past, may impact current functioning in several aspects of life. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014a), trauma can be the result of "an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being (p. 7)."

Traumatic experiences may include sexual and physical abuse, experiencing or witnessing violence, accidents, natural disasters, poverty, and victimization through crime (Nijdam, et.al, 2018). Other types of trauma include school violence, accidents, medical procedures, bullying, mental illness, terrorism, war, and political violence (Strauser, Lustig, Cogdal, & Uruk, 2006). According to the Sidran Institute (2016), 70% of adults in the United States have experienced a traumatic event at least once in their lives, 20% of whom may develop Post-Traumatic Stress Disorder (PTSD) as a result. Thus, it is necessary for professionals working in human services to be able to identify various forms of trauma clients may have experienced and recognize the many ways in which trauma might impact their personal and vocational lives.

Trauma-Informed Care

Trauma-Informed Care (TIC) is an approach in the human services field that assumes an individual is more likely than not to have a history of trauma, identifies trauma symptoms in others, and is aware of the role(s) trauma may play in one's life (SAMHSA, 2014a). TIC is a strengths based approach designed to respond to a client's physical, psychological, and

emotional safety while creating opportunities to establish a sense of control and empowerment (Hopper, Bassuk, & Olivet, 2009).

Human services professionals work with a wide variety of clients, many of whom may be affected by past or current trauma. When providing TIC, the clinical focus is on client safety, social connections, and effective management of emotions. Key goals of TIC include processing emotions rationally, engaging in mindful thinking, and the development of skills to reflect on feelings, identify impulses, and promote self-regulation (Bath, 2008). In order for this to occur, providing a safe environment for individuals, both emotionally and physically, is paramount.

A safe environment may require an office location to remain anonymous in public listings or in how a client accesses services. For example, domestic violence survivors may need a location that is not labeled on office directories, free of surveillance, or is housed in a location providing concurrent services (e.g., a crisis center with an HSP prepared to address career and economic needs; Clarke & Wydall, 2015). HSPs may consider providing blankets and pillows in their office so that clients are able to reach for a comforting item. In this way, HSPs help trauma survivors feel safe in accessing services and in the office so that they may begin recovery feeling supported and safe.

TIC promotes safety-based environments of healing and recovery rather than practices and services that may inadvertently re-traumatize clients. Safety is not just a primary survival need, it also fosters attachment and self-efficacy (Bandura, 2006; Creasey, Mays, Lee, & Santiago, 2016). Those who do not feel safe cannot securely attach to others and as a result may be mistrustful. Positive human relationships are important in the trauma recovery process, and healthy connections help nurture the potential of healing and growth in the creation of a new life narrative (Bath, 2008).

According to the Institute on Trauma and Trauma-Informed Care (ITTIC, 2015), five essential principles in trauma recovery are safety, choice, collaboration, trustworthiness, and empowerment. After ensuring a physically and emotionally safe environment, establishing a trustworthy relationship with individuals is necessary. A trustworthy alliance between HSPs and clients allows for the creation of respectful professional boundaries. A collaborative process with providers also helps clients have an increased sense of choice and control in their treatment which can lead to a sense of empowerment and increased participation and success in treatment. "Focusing on an individual's strengths and empowering them to build on those strengths while developing stronger coping skills provides a healthy foundation for individuals to fall back on if and when they stop receiving services" (ITTIC, 2015, p. 2).

Trauma-Informed Career Counseling in the Human Services Profession

In addition to negatively impacting a client psychologically and psychosocially, trauma put the clients' vocational life in jeopardy. Trauma can have an adverse effect on a client's work performance thus impacting a client's employability, vocational development, and financial health (Nijdam, et al., 2018). As a result of trauma-related experiences, individuals returning to work may face issues with decreased motivation and interest, work attendance, poor boundaries, catastrophizing, and difficulty with transitions (Borgen, Butterfield & Amundson, 2010). Employees who have survived a traumatic experience are frequently also at risk of developing depression which can lead to burnout. Burnout is related to low levels of effectiveness, low energy, and low levels of involvement and dedication to the workplace.

Other residual effects of trauma that can adversely impact a client's work life include: social isolation, lack of support, disconnection, feelings of powerlessness, difficulties navigating social services institutions, lack of transportation, anxiety, depression, recurring feelings of

trauma, and difficulties securing mental health treatment due to a lack of funding and insurance (Ballou, Balogun, Gittens, Matsumoto, & Sanchez, 2016; Barclay & Stoltz, 2016; Bath, 2008; Blustein, Kenna, Gill & Devoy, 2008; Borgen et al., 2010). Such experiences can create significant barriers for clients to continue finding and keeping gainful employment.

Having a trauma-informed career counseling framework allows HSPs to effectively work with clients needing specific career-related strategies, guidance, and resources intentionally designed to provide positive outcomes in a client's vocational endeavors. Trauma-informed career counseling and services address the unique career development and vocational issues that individuals with complex experiences of adversity and trauma might face. Additionally, it provides a lens through which HSPs can help individuals become aware of how trauma may be having a negative residual impact on their career and vocational development. Advocacy, counseling, and intervention strategies (e.g., role play, job coaching) are utilized to help clients overcome related vocational barriers that may have resulted from previous traumatic experience such as violence, poverty, and threats of violence (Barclay & Stoltz, 2016; Bath, 2008; Blustein et al., 2008; Nassar-McMillan, 2014).

Identifying Trauma-Related Factors in Human Services

Trauma can impact anyone regardless of race, background or socioeconomic status. In the human services field, there is an increased likelihood that many clients can be affected by trauma in various ways which can also lead to Post-Traumatic Stress Disorder (PTSD; also known as Post Traumatic Stress or PTS). PTSD affects eight million adults in any given year (SAMHSA, 2014a). PTSD tends to be more common among women, those who have experienced prolonged or extremely severe trauma, individuals with a co-occurring mental health problem such as depression or alcohol and drug use, those with less education, and younger individuals (Hughes, Lusk, & Strause, 2016). Although eight million people might seem a significant figure, it represents but a small percentage of those who survive trauma. While an estimated 70% of adults in the United States experience a traumatic event in their life, only 20% of these survivors develop PTSD (Sidran Institute, 2016; Benfer et al., 2018).

There is a demonstrated need for training, education, and career integration efforts in human services. When reviewing national statistics, it becomes apparent how the intersection of poverty, gender, race, immigrant status, and disability are significant contributing factors that may create institutionalized obstacles to employment and career advancement (Fontenot, Semega, & Kollar, 2018). Thus, it is essential for HSPs to consider a client's risk of having experienced trauma in order to discern the need for TIC and career counseling. The following is a brief overview of factors that can contribute to a heightened likelihood of trauma experience in human services' clients as well as models to address specific concerns.

Poverty and the I-CARE Model

A household income of less than $24,638 for a family of four constitutes poverty and increases by approximately $4420 for each additional family member (Fontenot et al., 2018). Approximately 13.8% of men and 16.3% of women live in poverty accounting for 39.7 million people (Poverty USA, 2019). Many of these individuals are likely to be human services related clients. As such, it is important to consider the impact of poverty on a client's career exploration and vocational development.

According to Shamai (2018) individuals living in poverty may experience food insecurity, unreliable transportation, lack of social support, residing in unsafe and violent neighborhoods, limited vocational choices, and chronic risk of utilities being disconnected.

These factors increase the potential of clients having trauma-related experiences including anxiety, depression, and social isolation. Furthermore, the experience of poverty may be a trauma-inducing factor impacting not only individual human services clients, but a collective experience affecting a generation of a family resulting in chronic lack of gainful employment, social isolation, educational challenges, and health disparities (Fothergill & Peek, 2004; Prohaska, 2013; Stewart, Nodoushani, & Stumpf, 2018).

A useful therapeutic approach when working with impoverished individuals is the I-CARE Model (Foss-Kelly, Generali & Kress, 2017). HSPs can begin with *I* (or internally reflecting and identifying your own opinions on poverty and people living poverty) and consider how they were affected by poverty during their lifespan or if their affluence served as a protective factor. The I-CARE Model continues as follows in a bulleted format:

- *C* (or cultivate a relationship based on collaboration and empathy) helps clients become more cognizant of the stigma society places upon those in poverty and the shame this causes the client.
- *A* (acknowledge realities) helps HSP's understand realities such as the client might be hungry, dirty, or tired during their session. The mental fatigue of living in poverty is an additional factor to address.
- *R* (remove barriers) refers not only to physical barriers such as lack of transportation and geographic limitations on industry or job opportunities, but also consider emotional barriers and traumas that can prohibit growth.
- Finally, *E* (expand on strengths) is a way to measure a client's positive traits and characteristics. Living in poverty requires a strength and resilience often not possessed by those with financial security. This helps clients expand on strengths that promote wellness, as well as psychological growth (Chronister & McWhirter, 2003; Foss-Kelly et al., 2017).

Utilizing the I-CARE model allows for the combined and collaborative efforts of the HSP and client to address career needs. The I-CARE model offers opportunities to reflect on biases that may be impeding a productive, therapeutic relationship focused on generating positive career outcomes for the client. Further, addressing the variety of barriers impoverished clients face may require an HSP to conduct mock interviews, work side-by-side to complete an initial job application, and create opportunities to model advocacy. All of these intentional techniques based on the I-CARE model can serve as foundational activities to building resilience and confidence.

Veteran Status and Trauma-Informed Care

Thirty percent of veterans suffer from PTSD, traumatic brain injury or depression, while only approximately 40% receive services (Rausch, 2014). Since the veteran population has a stronger likelihood of being affected by trauma, it is important for HSPs to consider how trauma can play an influential factor in a veteran's career and employability (Rosebush, 1998). Counseling needs for veterans include working with those struggling with PTSD, traumatic brain injury, or functional impairments. In addition, veterans may also experience significant challenges when transitioning back to civilian life and in their reintegration into society after being a part of combat and a unique military culture with its own rules, values, and language (Rausch, 2014). HSPs may need to inform themselves of the unique language used to describe job titles, rank, and job responsibilities used in a specific branch of the military. In addition, veterans are particularly susceptible to challenges with reintegration, culture shock, and early

military retirement issues (Rausch, 2014). These factors lead to unemployment or underemployment of veterans and financial fragility for their families. Well-informed practitioners offering holistic career services will more effectively meet the needs of this population.

Rausch (2014) goes on to state "strategies taught during deployment, such as denial and emotional detachment, assist soldiers in dealing with combat-associated stressors. These coping strategies, although initially effective, may negatively affect post-deployment societal functioning" (p. 90). Furthermore, consider one of the slogans used by the U.S. Army, "Army Strong." Unspoken military culture can discourage service members from seeking mental health counseling out of a fear of looking weak or incapable of performing their duties (Rausch, 2014). Therefore, many service members choose to seek mental health care outside of the military, thus requiring civilian practitioners to possess the necessary skills to work with this population. A practitioner who is not sensitive to the unique needs of service members and the accompanying stigma they face when seeking help may have difficulty in gaining the trust necessary to build a therapeutic alliance with a veteran (Danish & Antonides, 2009).

Veterans report securing a career as a top post-deployment concern (Rausch, 2014). When working with veterans, effective trauma-informed career counseling should recognize military culture, impacts of serving, family needs, co-occurring substance/alcohol abuse, and past/repeated traumas. The career the service member had in the military was likely not chosen based on their desires or values, but rather on the needs of the military at that time (Clemens & Milsom, 2008). Working to identify values and career interests is a viable starting point for the veteran population. Collaborative short and long-term goals should be set as goal-setting can help combat the anxiety of the reintegrating veteran (Rausch, 2014). Common goals include obtaining specific job training and working through dysfunctional thinking. Equally helpful is assistance with writing resumes and guidance navigating the G.I. Bill (Clemens & Milsom, 2008). Setting goals helps to establish a structure that is comforting and familiar to the service member as it is similar to the structure they were familiar with when they were active duty.

Historical Trauma and Cultural Considerations

Historical trauma is a form of trauma that impacts entire communities. It is the cumulative emotional and psychological wounding, as a result of group traumatic experiences that is transmitted across generations within the community (Walkley, & Cox, 2013). Unresolved grief and anger often accompany this trauma and contribute to physical and behavioral health disorders. Historical trauma is often associated with racial and ethnic population groups in the United States who have suffered major intergenerational losses and assaults on their culture and well-being (SAMHSA, 2014). According to Mohatta, Thompsona, Thaib, and Tebesa (2014):

> Although historical trauma was originally introduced to describe the experience of children of Holocaust survivors, in the past two decades, the term has been applied to numerous colonized indigenous groups throughout the world,... as well as African Americans, Armenian refugees, Japanese American survivors of internment camps, Swedish immigrant children whose parents were torture victims, Palestinian youth, the people of Cyprus, Belgians, Cambodians, Israelis, Mexicans and Mexican Americans, Russians, and many other cultural groups and communities that share a history of oppression, victimization, or massive group trauma exposure. (p. 1)

Smith (2004) coined the phrase *racial battle fatigue* to describe psychological attrition that people of color experience as they encounter discrimination. Racial battle fatigue results in

people of color being on guard and prepared for discrimination which often leaves them frustrated, angry, withdrawn, or inclined to verbally or physically fight back (Metz, Fouad, Inle-Helledy, 2010; Smith, 2004). This may impact a candidate of color's ability to seek and secure employment.

Work provides the individual more than a means of survival. It also serves as a way to gain psychological, economic, and social power, as well as independence. Working provides access to money and credit and social resources including, status, mobility, prestige, and privilege (Blustein et al., 2008). The evidence suggests HSPs must consider racial insecurity as a trauma-inducing situation and consider its impact on career exploration and acquiring work. When working with those affected by historical trauma, HSPs can consider that those who have been subjected to generational trauma and cultural degradation may be distrusting of outside help (SAMHSA, 2014b). HSPs can be aware of cultural values and belief systems as well. When working with Native Americans, for example, one may work directly with tribal leaders and tribal liaisons to provide services. HSPs can ask what services would best benefit this population and know it will take time to form a collaborative relationship to grow (SAMHSA, 2014b). Also, HSPs can be aware that personal reminders are experienced uniquely and individually and relate to historical trauma through an individual's personal narratives (Mohatta et al., 2014).

Mohatta et al. (2014) also explain the importance of understanding both private and public narratives when working with those who have experienced historical trauma and suggest that "affiliation with group identity and knowledge of the narratives of that group can be a source of resilience for marginalized groups" (p. 7). Understanding an individual's personal and public narrative regarding historical trauma can help HSPs better understand their cognitions related to trauma, as well as possible triggers or flashbacks. If a client is triggered in a session or during some aspect of treatment, HSPs can help the client focus on what is happening in the here and now; that is, use grounding techniques. Examples may include, breathing exercises, meditation, focusing on items in surrounding, tactile stimulation, or mantra recitation to re-orient a client to the present. Behavioral health service providers should be prepared to help the client get re-grounded so that they can distinguish between what is happening now versus what had happened in the past.

Domestic Trauma and Resilience-Related Behavior

Wachter Morris, Shoffner & Newsome (2009) found that women aged 20-24 report the highest incidences of interpersonal violence, and that this is the age range that coincides directly with early career development and exploration. Counselors serving domestic violence survivors should be aware of the potential for arrested career development, a lack of readiness to engage in career decision making, unclear career identity, and dysfunctional career thoughts as a consequence of exposure to domestic abuse (Brown, Trangsrud, & Linnemeyer, 2009; NOHS, 2015; Wachter Morris, Shoffner & Newsome, 2009). Young women leaving abusive relationships are at the greatest risk of being unable to successfully find employment due to the psychological impacts of their trauma. As such, HSPs should help clients rework negative outcome expectations into positive outcome expectations.

Domestic violence, such as emotional, physical, sexual, and economic trauma, can be particularly relevant for women. Research suggests a woman may try as many as seven times to leave an abusive relationship, and this indicates leaving is more a process than a single event (Khaw & Hardesty, 2007). Domestic violence survivors may struggle to find adequate housing for themselves and their children, while addressing psychological barriers to finding a job. Much of the available research regarding battered women provides guidelines for leaving violent

situations, however very little research provides guidelines for career and educational opportunities following violence apart from short-term employment suggestions (Triplett, Higgins, & Payne, 2013).

Shamai (2018) suggests focusing on "resilience-related behavior" such as working towards lessening shame felt when asking for help and redirecting aggressive behavior into assertive behavior (p. 1724). Shamai (2018) found four universal experiences including: the shortage of basic needs, the challenges of parenting, loneliness, and anger directed towards HSPs (Shamai, 2018). Regarding the anger towards HSPs, Shamia (2018) suggests it results from viewing HSPs as government representatives unable to solve their problems (Shamai, 2018). HSPs working to ensure physical safety provide the groundwork for next addressing financial security and building client trust in the recovery process.

Vicarious Trauma and Its Effect on Human Services Professionals

Of key importance to HSPs is having awareness of the effects that working with primary victims of trauma can have on the psychological well-being of the professional. HSPs are at increased risk of experiencing vicarious, or secondary, trauma because of the frequency in which they interact with and serve trauma survivors. Vicarious trauma is defined as a transformation that occurs in the therapist's inner experience as a result of listening to, interacting with, and working through clients' traumatic experiences and is not uncommon among helping professionals (Trippany, White Kress, & Wilcoxon 2004).

HSPs who are unaware of the potential of such occupational hazards may simply leave the field due to its difficult nature and difficulty in coping. If aware of the challenging nature of the work and potential for compassion fatigue, HSPs new to the field may be more willing to process upsetting material and seek assistance through supervision from others. In particular, HSPs trained to pay attention to their own reactions to clients may be able to identify their own compassion fatigue-related symptoms. Consequently, quality of care is enhanced and the client population is protected when mental health professionals obtain educational training and supervision in this area (Simpson & Starkey, 2006).

Vicarious trauma may manifest as symptoms similar to posttraumatic stress reactions including flashbacks, nightmares, obsessive thoughts, disassociation, and burnout (Smullens, 2015). Maslach (1993) suggested burnout progresses sequentially through three dimensions including emotional exhaustion, depersonalization/personal detachment (or having a negative attitude towards clients), and reduced commitment to the profession and clients. Bell, Kulkarni, and Dalton (2003) suggested burnout be addressed at an organizational level through workspace, professional development, support, and supervision. When possible, trauma cases should be distributed among a number of HSPs who possess the necessary skills and experience and not assigned to a single HSP. When addressing the workspace, offices may utilize motivational posters and scenic landscape posters throughout the office to acknowledge staff need a respite, including having a break room separate from clients. These spaces may have kitchen and vending equipment, music, essential oil diffusers, and comfortable furniture with reading materials available.

Additionally, Bell et al. (2003) emphasized the importance of support in the form of training. HSPs need trauma-specific professional development to diminish the impact of vicarious trauma and provide a framework for understanding and responding to client experiences. Professional development may take the form of formal education, retreats, informal peer-to-peer supervision, group supervision, and structured team treatment meetings.

Addressing Trauma in Career Development

Knowing how to best serve the needs of survivors of trauma is a crucial skill for those in the human services professions (Nijdam, et al., 2018). Career adaptability is defined as the competency to cope with work tasks, transitions, and stressors (Prescod & Zeligman, 2018). Consider all the ways a practitioner can see trauma manifested in their clients. Many career-related reactions to trauma (e.g., loss of control, job and financial concerns) may be measured in relation to the concept of career adaptability.

When individuals are compelled to make a career choice in stressful times, two themes emerge: indecision or uncertainty with respect to career choice and dissatisfaction with career choice. This is referred to as the career decision state (Bullock-Yowell, Peterson, Reardon, Leierer, 2011). Clients may have a lack of career role models or perceived opportunities, thus impacting their career searches and ability to control and support confidence in their career choices. In this situation, the use of a career genogram may be useful in that it can reveal that a client has selected a career based on exposure and family history. Using a family career genogram allows for the exploration of common themes, patterns, experiences, and career exposure to determine if career options are based on interests and values or limited to familial or geographic familiarity (Malott & Magnuson, 2004; Storlie, Hilton, McKinney, & Unger, 2019).

Career Strategies for Trauma Survivors

Career-focused HSPs (e.g., vocational rehabilitation, disability services, veteran services) might find it helpful to use common trauma-informed counseling approaches in their career work. Bronfenbrenner's (1977) ecological model of human development offers a holistic framework for conceptualizing ways in which systemic factors have influenced trauma survivors. HSPs addressing career exploration and career reintegration may find prioritizing client safety, avoiding re-traumatization, and processing conflict resolution with clients who are trauma survivors to be most effective in addressing systems impact job outlook (Bronfenbrenner, 2004).

Another guiding model is Social Cognitive Career Theory (SCCT): a choice-based model of career development (Chronister & McWhirter, 2003). Individuals evaluate self-efficacy and outcome expectations combined with perceived barriers and supports while simultaneously analyzing their career interests, goals and behavior (Brown et al., 2009). SCCT can help in highlighting the intersection of how the individual client, their environment, and their behavior affect their goals, actions, and achievements. Further, a person's belief in their ability to accomplish tasks, the outcomes of accomplishing these tasks, and the intentions to act on their goals are the elements that most affect achieving career goals (Rojewski, 2005; Chronister & McWhirter, 2003).

If looking for a specific tool or activity to align with these models, utilizing a card sort may be a helpful technique for the trauma population. Once a client's strengths and interests are identified, potential jobs that align with these strengths and interests are listed on cards. The client then sorts these cards into categories: would choose, would not choose, or unsure. From there, the HSP and client work together to understand the reasoning behind why each job was placed in each category, thereby fostering even deeper insight into the client's interests and values (Esquibel, Nicholson, & Murdock, 2015).

When working with veterans and persons of color, a useful approach may be to address the narratives of clients in order to move them toward positive outcomes (Mohatta et al., 2014). Employing a narrative approach allows the client to deconstruct what they have believed about self or been told about self (e.g., through media, microaggressions, discrimination) and construct a preferred, new life narrative (Hartung & Vess, 2016). To empower clients and help them to

maintain control of their job search experience and strategically deal with potential stress or feelings of being overwhelmed, HSPs can employ techniques such as modeling, simulated job interviews, and identifying desired behaviors and characteristics (e.g., resilience, addressing disappointment, and respect) when helping clients better align with their desired job.

HSPs should also be mindful that trauma often presents with other harmful comorbid conditions and symptoms (e.g., anxiety, drug use, depression). Moreover, while HSPs assist clients in developing effective coping skills, it is important to also consider how these coping skills can translate into a client's vocational life. Employment related support group counseling may be an effective strategy to address social skills rehearsal, self-efficacy development, intrinsic motivation enhancement, and universality of experiences (Barclay & Stoltz, 2016; Rojewski, 2005).

Other Tools for Human Services Students and Professionals

Career-related counseling and social support are important for behavior change and attainment of skills for the world of work. Support systems, including HSPs, are especially necessary for trauma survivors re-entering the world of work. Toporek and Cohen (2017) suggest the resume be the focus of career counseling. Designed to address societal narratives and personal narratives, a resume can provide a positive identity and a successfully executed employment search which addresses the negative messaging assumed from traumatic experiences.

McBride (2011) suggests a skills escalator for orientation and career advancement within businesses and organizations. HSPs may find the use of praise, support, guidance, and encouragement useful in addressing the affective responses and maladaptive self-talk. HSPs serving as liaisons with business and community partners may need to coach employers on providing constructive feedback and assuring the skill set of the client meets the demands of the position (Gilmore, Morris, Murphy, Grimmer-Somers, & Kumar, 2011).

The use of a skills escalator will require HSPs to extend their role by aiding clients in identifying barriers to employment. These barriers may be intrapersonal (e.g., efficacy, need for advanced skill set, confidence) or external to client (e.g., workplace barriers, clear responsibilities, lack of new hire orientation or mentor). McBride suggests a six- to eight-week employment orientation, open door policies to access bosses and mentors in order to build confidence, and opportunities for feedback and encouragement. The skills escalator is designed to create pathways to confidence, success, and career advancement (Gilmore, et al., 2011; McBride, 2011).

Adopting a similar skills escalator HSPs can create a module based learning program to facilitate the client's relationship with their HSPs. First, providing a structured and guided job search will narrow the client's focus while aligning career goals with personal values while honoring their experiences and current needs. Secondly, HSPs may help with the development of a resume catered to a specific industry or skill set. The use of a functional resume will allow the client to highlight their skills and experiences and de-emphasize work history and employment gaps. Furthermore, HSPs may advance the client's confidence through mock interviewing and role playing work-based scenarios to prepare for the nuances of work culture.

Recommendations for Practice and Future Research

A primary focus of human services work is designed to support and empower clients. This critical work may be impacted by previous or current trauma, specifically in the area of career counseling. Designed to address trauma and career counseling the I-CARE Model allows

HSPs to look within for biases and external to the client to provide services to meet outcome or treatment goals.

HSPs should center their efforts on collaboration, reducing shame and guilt, confronting trauma, and recovery. HSPs should focus on short- and long-term goals to support client confidence through goal attainment. This may include obtaining training for specific careers, addressing dysfunctional thinking, and managing conflict and anger. Specific actions should be attached to each goal along with a time frame to complete each task. This will allow the HSP's client to achieve greater confidence and higher levels of efficacy.

There is a paucity of research in the area of trauma informed career counseling. Future research may focus on the implementation of models like the I-CARE model and the skills escalator to demonstrate their effectiveness. These models are worthy of further research with specific populations including veterans, domestic violence survivors, and survivors of historical trauma. An interested researcher may explore the following questions: What role does the I-CARE model play in recovery and career placement? How are the career needs of trauma survivors addressed by HSPs or local businesses? How can HSPs provide training to community partners, including employers to address employment barriers? How are the professional development needs of HSPs being met in addressing the specific career needs of trauma survivors?

Conclusion

HSPs should be mindful of barriers individuals may face when attempting to return to work including social isolation, lack of support, feelings of powerlessness, navigating social services institutions, anxiety, depression, recurring feelings of trauma, difficulties securing health care services, and psychological barriers. Psychological barriers may also include a fear of success, fear of the unknown, and difficulty trusting others. Effective HSPs "will infuse work on coping skills into their career counseling to ensure clients have healthy coping skills for moving forward in all areas of their lives, including vocational areas" (Prescod & Zeligman, 2018, p. 11). It is essential that HSPs' efforts are focused on counseling and interventions based on safety, trust, collaboration, choice, and empowerment when working with individuals who have experienced trauma in order to promote healing and reduce possible re-traumatization.

Although ensuring a client's physical and emotional safety are essential first steps in working with those who have experienced trauma, it is also important for HSPs to implement the five principles of TIC to build a trusting, collaborative relationship to help empower clients and promote resilience. As trauma victims return to work, career counseling focused on improving interpersonal skills, engaging in resume writing, understanding one's narrative, building on strengths, and offering a structured, supported job search are ways to support clients and process their feelings as they explore careers (SAMHSA, 2014a). Offering praise, support, guidance, and encouragements helps clients as they develop a positive sense of self and identity in their world of work.

References

Bandura, A. (2006). Guide for constructing self-efficacy scales. In F. Pajares & T. Urdan (Eds.), *Self-efficacy beliefs of adolescents* (pp. 307-337). Charlotte, NC: Information Age.

Ballou, M., Balogun, O., Gittens, G., Matsumoto, A., & Sanchez, W. (2016). Trauma and returning to work: Women's lived experiences and its implications for vocational rehabilitation counseling. *Journal of Applied Rehabilitation Counseling, 46*(1), 25-33.

Barclay, S. R., & Stoltz, K. B. (2016). The life-design group: A case study assessment.

The Career Development Quarterly, 64, 83-96. doi:10.1002/cdq.12043
Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth, 17*(3), 17-21.
Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society, 84*(4), 463-470. doi:10.1606/1044-3894.131
Benfer, N., Bardeen, J. R., Cero, I., Kramer, L. B., Whiteman, S. E., Rogers, T. A., Silverstein, M. W. & Weathers, F. W. (2018). Network models of posttraumatic stress symptoms across trauma types. *Journal of Anxiety Disorders, 58*, 70-77. doi:10.1016/j.janxdis.2018.07.004
Blustein, D. L., Kenna, A. C., Gill, N., & DeVoy, J. E. (2008). The psychology of working: A new framework for counseling practice and public policy. *The Career Development Quarterly, 56*(4), 294-308.
Borgen, W. A., Butterfield, L. D., & Amundson, N. E. (2010). The experience of change and its impact on workers who self-identify as doing well with change that affects their work. *Journal of Employment Counseling, 47*(1), 2-11. doi:10.1002/j.261-1920.2010.tb00085.x
Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist, 32,* 513–531. doi:10.1037/0003-066X.32.7.513
Bronfenbrenner, U. (2004). *Making human beings human*. Thousand Oaks, CA: SAGE Publishing.
Brown, C., Trangsrud, H. B., & Linnemeyer, R. M. (2009). Battered women's process of leaving: Implications for career counseling. *Journal of Career Assessment, 17*(4), 439–456.
Bullock-Yowell, E., Peterson, G. W., Reardon, R. C., Leierer, S. J., & Reed, C. A. (2011). Relationships among career and life stress, negative career thoughts, and career decision state: A cognitive information processing perspective. *The Career Development Quarterly, 59*(4), 302-214. doi:10.1002/j.2161-0045.2011.tb00071.x
Chronister, K. M., & McWhirter, E. H. (2003). Applying social cognitive career theory to the empowerment of battered women. *Journal of Counseling and Development, 81*(4), 418-425.
Clarke, A., & Wydall, S. (2015) Creating a safe space? *Criminal Justice Matters, 99*:1, 20-21. doi:10.1080/09627251.2015.1026566
Clemens, E. V., & Milsom, A. S. (2008). Enlisted service members' transition into the civilian world of work: A cognitive information approach. *The Career Development Quarterly, 56*(3), 246-256. doi:10.1002/j.2161-0045.2008.tb00039.x
Creasey, G., Mays, J., Lee, R., & D'Santiago, V. (2016). A survey to assess barriers to urban teaching careers. *Urban Education, 51*(7), 748-769. doi:10.1177/0042085914549359
Danish, S. J., & Antonides, B. J. (2009). What counseling psychologists can do to help returning veterans. *The Counseling Psychologist, 37*(8), 1076-1089. doi:10.1177/0011000009338303
Esquibel, J. A., Nicholson, B., & Murdock, J. (2015). Understanding the impact of career values on career satisfaction: Utilizing card sorts in career counseling. *Career Planning and Adult Development Journal, 30*(4), 234-246.
Foss-Kelly, L. L., Generali, M. M., & Kress, V. E. (2017). Counseling strategies for empowering people living in poverty: The I-CARE Model. *Journal of Multicultural Counseling and Development, 45*(3), 201–213. doi:10.1002/jmcd.12074

Fontenot, K., Semega, J., & Kollar, M. (2018). *Income and poverty in the United States: 2017, current population reports.* Washington, DC, U.S. Census Bureau: U.S. Government Printing Office.

Fothergill, A., & Peek, L.A. (2004). Poverty and disasters in the United States: A review of recent sociological findings. *Natural Hazards 32,* 89–110.

Gilmore, L. G., Morris, J. H., Murphy, K., Grimmer-Somers, K., & Kumar, S. (2011). Skills escalator in allied health: A time for reflection and refocus. *Journal of Healthcare Leadership, 3*, 53-58. doi:10.2147/JHL.S24271

Hartung, P. J., & Vess, L. (2016). Critical moments in career construction counseling. *Journal of Vocational Behavior, 97,* 31-39. doi:10.1016/j.jvb.2016.07.014

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2009). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 2*, 131–151.

Hughes, C., Lusk, S. L., & Strause, S. (2016). Recognizing and accommodating employees with PTSD: The intersection of human resource development, rehabilitation, and psychology. *New Horizons in Adult Education & Human Resource Development, 28*(2), 27-39. doi:10.1002/nha3.20136

Khaw, L., & Hardesty, J. L. (2007). Theorizing the process of leaving: Turning points and trajectories in the stages of change. *Family Relations, 56*(4), 413-425. doi:10.1111/j.1741-3729.2007.00470.x

McBride, A. (2011). Lifting the barriers? Workplace education and training, women and job progression. *Gender, Work & Organization*, *18*(5), 528–547. doi:10.111/j.1468-0432.2011.00574x

Maslach, C. (1993). Burnout: A multidimensional perspective. In W. B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Accent developments in theory and research* (pp. 19-32). Washington, DC: Taylor & Francis.

Malott, K. M., & Magnuson, S. (2004). Using genograms to facilitate undergraduate students' career development: A group model. *The Career Development Quarterly, 53*(2), 178-186.

Metz, A., Fouad, N., & Inle-Helledy, K. (2010). Career aspirations and expectations of college students: Demographic and labor market comparisons. *Journal of Career Assessment, 17*, 155-171.

Mohatta, N. V., Thompsona, A. B., Thaib,. D., & Tebesa, J. K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social Science Medicine*, *106*, 128–136. doi:10.1016/j.socscimed.2014.01.043

Nassar-McMillan, S. C. (2014). A framework for cultural competence, advocacy, and social justice: Applications for global multiculturalism and diversity. *International Journal for Educational and Vocational Guidance, 14*(1), 103-118. doi:10.1007/s10775-014-9265-3

National Organization for Human Services [NOHS]. (2015). Ethical standards for human services professionals. Retrieved from https://www.nationalhumanservices.org/ethical-standards#public

Neukrug, E. S. (2017). *Theory, practice, and trends in human services: An introduction* (6th ed.). Belmont, CA: Cengage Learning.

Nijdam, M. J., van der Meer, C. A. I., van Zuiden, M., Dashtgard, P., Medema, D., Qing, Y.,…& Olff, M. (2018). Turning wounds into wisdom: Posttraumatic growth over the course of two types of trauma-focused psychotherapy in patients with PTSD. *Journal of Affective Disorders, 227*, 424-431. doi.10.1016/j.jad.2017.11.031

Poverty USA. (2019). Facts. Retrieved from http://povertyusa.org/facts

Prescod, D. J., & Zeligman, M. (2018). Career adaptability of trauma survivors: The moderating role of posttraumatic growth. *The Career Development Quarterly, 66*, 107-120. doi:10.1002/cdq.12126

Prohaska, A. (2013). "Beyond my imagination": Learning the sociology of poverty through service after the Tuscaloosa tornado. *Journal of Community Engagement and Scholarship, 6*(1), 19-27.

Rausch, M. A. (2014). Contextual career counseling for transitioning military veterans. *Journal of Employment Counseling, 51*(2), 89-96. doi:10.1002/j.2161-1920.2014.00044.x

Rojewski, J. (2005). Occupational aspirations: Constructs, meaning, and application. In S. Brown & R. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (pp. 131-154). New York, NY: John Wiley

Rosebush, P. A. (1998). Psychological intervention with military personnel in Rwanda. *Military Medicine, 163*(8), 559-563.

Shamai, M. (2018). Is poverty a collective trauma? A joint learning process with women living in poverty in the city of Haifa in Israel. *The British Journal of Social Work, 48(6),* 1718-1735. doi:10.1093/bjsw/bcx116

Sidran Institute. (2016). Post-traumatic stress disorder fact sheet. Retrieved from https://www.sidran.org/resources/for-survivors-and-loved-ones/post-traumatic-stress-disorder-fact-sheet-2/

Simpson, L. R., & Starkey, D. S. (2006). Secondary traumatic stress, compassion fatigue, and counselor spirituality: Implications for counselors working with trauma. Retrieved from http://www.counselingoutfitters.com/Simpson.htm

Smith, W. A. (2004). Black faculty coping with racial battle fatigue: The campus racial climate in a post–civil rights era. In D. Cleveland (Ed.), *Broken silence: Conversations about race by African Americans at predominately White institutions* (pp. 171-190). New York, NY: Peter Lang.

Smullens, S. (2015). *Burnout and self-care in social work: A guidebook for students and those in mental health and related professions*. Washington, DC: NASW Press.

Stewart, C., Nodoushani, O., & Stumpf, J. (2018). Cultivating employees using Maslow's hierarchy of needs. *Competition Forum, 16*(2), 67.

Storlie, C.A., Hilton T. M.L. Hilton, McKinney, R., & Unger, D. (2019). Family career genograms: Beginning life design with exploratory students. *Family Journal, 27*(1), 84. doi:10.1177/1066480718819866

Strauser, D. R., Lustig, D. C., Cogdal, P. A., & Uruk, A. C. (2006). Trauma symptoms: Relationship with career thoughts, vocational identity, and developmental work personality. *Career Development Quarterly, 54*(4), 346-360.

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014a). SAMHSA's concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014b). *Understanding historical trauma when responding to an event in Indian country*. Retrieved from https://store.samhsa.gov/product/Understanding-Historical-Trauma-When-Responding-to-an-Event-in-Indian-Country/sma14-4866

The Institute on Trauma and Trauma-Informed Care (ITTIC). (2019). *What is trauma-informed care?* Retrieved from http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

Toporek, R. L., & Cohen, R. F. (2017). Strength-based narrative résumé counseling: Constructing positive career identities from difficult employment histories. *The Career Development Quarterly, 65*(3), 222-236. doi:10.1002/cdq.12094

Triplett, R., Higgins, G., & Payne, B. K. (2013). Experiences of domestic violence as a child and career choice. *Journal of Family Violence, 28*, 289-297. doi:10.1007/s10896-013-9499-8

Trippany, R. L., White Kress, V. E., & Wilcoxon S, A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development, 82*(1), 31-37. doi:10.1002/j.1556-6678.2004.tb00283.x

Wachter Morris, C. A., Schoffner, M. F., & Newsome, D. W. (2009). Career counseling for women preparing to leave abusive relationships: A social cognitive career theory approach. *Career Development Quarterly, 58*(1), 44-53.

Walkley, M., & Cox, T. L. (2013). Building trauma-informed schools and communities. *Children & Schools, 35*(2), 123-126.

Envisioning the Future of Traditional Hawaiian Cultural Practice-Adapted Treatment: Current Status and New Directions

Izaak L. Williams, William C. Rezentes III, and George K. Makini, Jr., *University of Hawaii*

Abstract

Culturally relevant addiction treatment options incorporating Native Hawaiian cultural themes rest mostly on a stand-alone acute service delivery model detached from the broader Native Hawaiian healthcare system. Federal policy changes and funding shifts in the addiction treatment marketplace have placed a greater emphasis on the medicalization of substance use disorders. Normative mainstream treatment and prevention literature holds that the current status of stand-alone, acute care treatment is largely an anachronism. This paper proposes new directions for human services professionals who wish to advocate for viable culturally responsive treatment models in the foreseeable future. By aligning specialty substance use disorder treatment providers with the expectations and requirements of the broader healthcare funding legal framework, service providers can help usher in a sustainable, transdisciplinary, and integrated model of culture-adapted addiction treatment in the era of health care reform.

Keywords: substance use disorders, health care reform, progress monitoring, culturally adapted treatment, Native Hawaiians

Introduction

Substance use treatment falls within the scope of practice of human service professionals (HSP) and students studying the human services discipline (Dice & Rehfuss, 2017). As generalists, HSPs can work as case managers, counselors, program support staff, and administrators (Bureau of Labor Statistics, 2011; Neukrug, 2017; Winfield, Cole, & Craigen, 2016). The work these professionals do in the field is informed by ethical standards and a practice ethos that promote improved service delivery, better accessibility, greater accountability, and more comprehensive coordination among professionals and agencies (Alle-Corliss & Alle-Corliss, 2015; Cousins, 2014; National Organization for Human Services [NOHS], 2015a, 2015b; Neukrug, 2017). More specifically, the human services field is characterized by four themes identified by Kincaid (2009), which are endorsed by The National Organization for Human Services (NOHS, 2015b) and are reflected in its universal definition of human services (Sparkman & Lott, 2014): (a) integrated interdisciplinary knowledge, (b) client self-determination, (c) processes to facilitate change, and (d) systemic change at all levels of society.

By extension of this commitment, the human services discipline endeavors to afford the necessary education, requisite training, and practice skills to encompass interdisciplinary knowledge (Martin, 2014; Winfield et al., 2016). However, when considering culture-based addiction treatment in particular, Winfield et al. (2016) note that substance use treatment and addiction dynamics tend to be overlooked as one of the focal points of human services training and education. A related point of under emphasis within the HSP discipline is interprofessionalism or transdisciplinary delivery and coordination of services with professionals in related practice fields (Johnson, Sparkman-Key, & Kalkbrenner, 2017). Since addiction treatment systems are under health reform pressure to merge with mental health and primary care to achieve integrated health care, interprofessionalism is a task increasingly faced by professionals (Johnson et al., 2017; Office of the Surgeon General. 2016).

Policies trending toward integrated care include the 2010 Patient Protection and Affordable Care Act (ACA), which updated the 1996 mental health parity act, and other momentous legislation that have ushered in a new era of health reform (Office of the Surgeon General, 2016). Specifically, there has been a gradual transformation of the addiction treatment system landscape, from a stand-alone and acute delivery model of treatment singularly focused on substance use, to one of chronic disease management integrated with the broader health care environment (Knudsen & Studts, 2017). In the wake of the ACA and other substance use and prevention policy initiatives, this article builds on the work of Winfield et al. (2016) by offering a discussion, absent from the extant literature, on how addiction-specific policy changes have impacted specialty culture-based treatment models. With a primary focus on addiction within the Native Hawaiian culture, the purpose of the article is to inform professionals of relevant policy and strategies for adapting specialized culture-based treatment models to the expectations of health care reform.

Legislative Policy and Native Hawaiian Culture-Based Treatment Programs

In 1972, Native Hawaiians were officially subsumed under the American Indian/Alaskan Native legislation by the Congress (Select Committee on Indian Affairs, United States Senate, 1992a). This legislative change is reflected in corresponding programs introduced and implemented by the Administration for Native Americans (ANA). The ANA's first Native Hawaiian grantee was ALU LIKE, Inc., a Native Hawaiian non-profit in the state of Hawai‘i (Akau et al., 1998). Furthermore, *E Ola Mau, The Native Hawaiian Health Needs Assessment* commissioned by ALU LIKE in 1985 set a health care agenda for local agencies and the Hawaiian community to address the critical needs and disparate health outcomes of Native Hawaiians (Select Committee on Indian Affairs, United States Senate, 1992a, 1992b).

The major goal of the 1985 *E Ola Mau* agenda was to galvanize the U.S. Congress to make "rais[ing] the health status of Native Hawaiians to the highest possible level" an official policy (Papa Ola Lokahi, 2016, p. 1). These efforts resulted in the adoption of the 1988 Native Hawaiian Health Care Act (Public Law [P.L.] 100-579). At that time, Papa Ola Lokahi was formed from 25 public health agencies and private organizations to administer the Act (Akau et al., 1998). In 1992, Public Law 100-579 was re-authorized as the Native Hawaiian Health Care Improvement Act (NHHCIA; P.L. 102-396), with one more re-authorization taking place in 2010. Papa Ola Lokahi's first major overarching program initiative was to establish a culturally acceptable health care system infrastructure for Hawaiians in urban and rural communities within the Hawaiian islands (Papa Ola Lokahi, 2016). Work toward this goal led to the establishment of five individual, community-based, and independently functioning native Hawaiian Health Care Systems: (a) Hui Malama Ola Na ‘Oiwi (Island of Hawai‘i), (b) Hui No Ke Ola Pono (Island of Maui), (c) Na Pu‘uwai (Moloka‘i and Lana‘i), (d) Ke Ola Mamo (Island of O‘ahu), and (e) Ho‘ola Lahui Hawai‘i (Islands of Kaua‘i and Ni‘ihau; Papa Ola Lokahi, 2016).

The United States affirmed the historical and unique legal relationship to the Hawaiian people by authorizing the provision of drug treatment services specifically to Native Hawaiians through the adoption of the Anti-Drug Abuse Act of 1986 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). The Alcohol, Drug Abuse and Mental Health Services Administration (ADAMHA) Reorganization Act of 1992 (*PL 102-321*) later attached a legal clause to federal funding provided for the continuation of programs under allotments to the State of Hawai‘i for comprehensive substance use disorder programs and relevant mental health treatment for Native Hawaiians. At present, stand-alone Native Hawaiian culturally based addiction treatment programs are not incorporated into the Hawaiian healthcare infrastructure.

Prevalence of Drug Use Among Individuals Who Identify as Native Hawaiian

Survey data collected since the implementation of the 1985 *E Ola Mau, The Native Hawaiian Health Needs Assessment* reveal that Hawaiians are an ethnocultural group with relatively high substance use rates (Nigg, Wagner, Garza, & Goya, 2017). Papa Ola Lokahi (2016) notes that "Hawaiians are more likely to use and abuse alcohol, nicotine, and other drugs at rates greater than other ethnic groups; *wahine* [women] have higher rates of smoking during pregnancy" (p. 3). Statewide epidemiological data confirms Hawaiian adolescents and adults continue to demonstrate greater comparative illicit substance use rates to other ethnocultural groups in Hawai'i (Nigg et al., 2017). Literature reviews relevant to drug use pertaining to Hawaiians by Durand, Cook, Konishi, and Nigg (2016) and Edwards, Giroux, and Okamoto (2010) suggest Hawaiians are affected by a greater preponderance of hardship risk factors conducive to catalyzing early initiation or onset of drug use. These risk factors include intergenerational poverty, lack of economic mobility, educational and social opportunity, institutional racism, and familial arrangements impacted by systemic oppression (Szalay, Strohl, & Doherty, 1999). When taken together, such risk factors create a generalized stress burden on Hawaiian identity, developed in a context of colonization and settler dominance in Hawai'i (Fujikane & Okamura, 2008). For instance, Hawaiians are disproportionately overrepresented among the homeless population and subjected to criminalization and harsher punishment by the judicial system (Office of Hawaiian Affairs, Justice Policy Institute, University of Hawai'i, & Georgetown University, 2010). The illegal overthrow of the Hawaiian Kingdom in 1893 provides a deeper nuanced understanding of the contemporary social determinants of health (Blaisdell, 1983). Hawaiians have since been dispossessed of self-government and subsequently relegated to the bottom rank of virtually every health and well-being index (Mokuau et al., 2017). Hawaiian substance use statistics related to contemporary social and health issues are but one thread of a larger tapestry of inequality in the context of enduring American colonial occupation of the Hawaiian Islands (Blaisdell, 1983).

The Knowledge Gap Surrounding Treatment Options

Since available epidemiological data and school-based questionnaires consistently portray substance use by Native Hawaiians as exceeding that of other ethnic/racial groups across drug use categories surveyed (Durand et al., 2016; Edwards et al., 2010; Nigg et al., 2017), Native Hawaiian culture-based treatment programs have emerged to address the need for services. The core rationale for these programs is that they are generally assumed within the Hawai'i addiction treatment system to be inherently culturally competent and, as such, more responsive to the needs of Hawaiians than treatment-as-usual models that are without Native Hawaiian cultural activities and practice features (Williams, 2018). In turn, the therapeutic sensibilities of Hawaiian culture-based services are thought to lead to better retention and outcomes.

While there is no evidence underscoring treatment-as-usual as culturally insensitive to Hawaiians, or that cultural factors are largely responsible for driving disparities in substance use among Native Hawaiians (Williams, 2018), researchers have felt compelled to call for culturally appropriate programs tailored specifically for Hawaiian populations (e.g., Nigg et al., 2017, p. 45). Supporters of such programs not only cite the absence of Native Hawaiian practices and activities (e.g., *hula* or dance), but the lack of prominence of the National Registry of Evidence-Based Programs and Practices (NREPP) to show that treatment-as-usual is without cultural attributes and may not be well-suited to address substance use issues for Hawaiians. According

to the definition on the SAMHSA government website, the NREPP is "an evidence-based repository and review system designed to provide the public with reliable information on mental health and substance use interventions" (SAMHSA, n.d., para. 1). The NREPP provides a list of treatment approaches in mental health and substance abuse that have scientific support. Kim and Jackson (2009) note that while the NREPP "includes approximately 160 programs labeled as Model, Effective, or Promising, there have not yet been any substance abuse treatment programs identified as effective for Native Hawaiian youth" (p. 43).

The NREPP was discontinued in January 2019. At that time, its registry had increased to include over 300 programs and 400 plus interventions. Despite more than doubling the number of methods it had reviewed and approved, there were still no substance use disorder interventions or treatment protocols specifically for Native Hawaiians (SAMHSA, n.d.). In other words, treatment-as-usual does not have the option of adopting an established NREPP for Hawaiian populations to explicitly engage cultural participation as a component in the delivery of addiction treatment services.

It is possible to use evidence-based curriculum in a generic fashion and incorporate treatment approaches to adapt elements from one culture-based program specific to a different ethnic/racial demographic for use with Hawaiian clients. However, these supplements are not suitable substitutes for a program developed from the ground up directly responsive to the cultural ecology of Hawaiian participants. That is because culturally adapted interventions are typically context-dependent and limited to a specific cultural group, and the more effective approaches are not easily generalizable to other cultures (Barrera, Berkel, & Castro, 2017).

Future Directions and Implications for Human Services

Culturally appropriate service provision could improve the lives of minority community members. The strength of Hawaiian culturally-based treatment lies in its potential to deliver beneficial services to a segment of the addiction population (e.g., Hawaiians and their respective families who have lost their elders and connection to the culture) desiring a different treatment experience than expected from treatment-as-usual. However, the ACA, Medicaid expansion, American Recovery and Reinvestment Act [ARRA] of 2009, 21st Century Cures Act (Public Law 114–255), and Opioid Crisis Response Act, among other macro policy trends and contextual factors impacting the field of addiction, have increased the accessibility and funding of treatment without focusing on culturally-specific programming. Here, the limitation of Native Hawaiian culturally based programming lies in its long-term financial sustainability and viability of diversifying its demographic profile to compete for (non-criminal justice; parole, probation, drug court) referrals in the addiction marketplace.

SAMHSA's Center for Substance Abuse Treatment's Treatment Improvement Protocols (TIP 38; CSAT, 2000 and TIP 61; CSAT, 2019) provide key insight into federal directions in behavioral healthcare instructive to human services delivery, specifically related funding and national trends for treatment programs operating under the recent policy-related, administrative, and legislative mandates. TIP 61, for example, provides general guidance specific to culture-based treatment models for evolving and staying relevant in light of policy shifts and subsequent demands for management information systems to develop economically viable public health driven business models. In response to the need to change the current treatment model and decrease the heavy dependence on Substance Abuse Block Grant (SABG) funding and court-referrals for the sustainability of Native Hawaiian addiction treatment, we argue human services practitioners have a role in implementing the following measures:

1. Comprehensive service delivery that would address the diverse needs of the treatment population.
2. Introducing a treatment model that would strive for long-term financial sustainability.
3. Obtaining empirical evidence to support future applications for Native Hawaiian culture-based treatment funding (these applications would focus on cost-savings, which could be achieved by redeploying funds from the less effective state services).

Human services professionals, by dint of their training (e.g., process skills) instilled by the discipline (NOHS, 2015b; Proehl, 2001) and their professional competencies, are well-poised to initiate change through the aforementioned measures. By implementing Native Hawaiian culture-based services in a meaningful way that both enhances their practice and addresses the foundational issue of the acute care model, HSPs can promote Hawaiian culture-based treatment in a way that is in line and in tune with the standards and responsibilities of their profession (NOHS, 2015).

Transdisciplinary Service Delivery

Since substance use disorders commonly include both psychiatric and medical conditions, health reform is designed to support treatment models demonstrating a more comprehensive understanding of health. In the case of Hawaiians, this might require a synergy of a medical model with traditional Native Hawaiian healing practices (*laau lapaau* [herbal healing], *lomilomi* [message], *laau kahea* [faith healing], and *haha* [diagnosis by feeling the body]). Such practices are supported under federal legislation, such as Public Law 100-579 (reauthorized in 1992 as P.L. 102-396 (S. 2681)) or the Native Hawaiian Health Care Act (Kapulani & Judd, 1998). Whether an addiction treatment is culturally responsive and appropriate is determined by the extent to which it addresses the salient issues and needs of the intended clients. In contrast to a medical model that focuses on the disease itself, Native Hawaiian indigenous health methodologies prioritize a social perspective on health. In addition to medical treatment, then, culture-based services would develop practical strategies that fit within the worldview of the local community being served.

Comprehensive Service Model

Native Hawaiian addiction treatment programs are a specialty service specifically designed for the singular treatment of substance use disorders. However, the acute model of care is slowly being curtailed by increasing limited reimbursement schemes from third parties (insurance companies, Medicare and Medicaid, SABG funds, local grants). Given decreasing federal, state, and local funding, the future of Native Hawaiian culture-based addiction treatment programs lies in its compliance with health reform measures, by either: a) integrating services with a neighboring outpatient community health care clinic, or b) forming service partnerships with independent providers to establish a seamless treatment service and coordination hub, ideally a one-stop service, transdisciplinary in nature, for client convenience. Native Hawaiian culture-based programs might achieve a more accessible one-stop service delivery model by merging their current care with a community health center or outpatient clinic classified as a Federally Qualified Health Center (FQHC). Alternatively, specialty culture-based treatment centers may also find new funding opportunities by integrating services with an FQHC primary care provider organizations that will also receive additional funding under the ACA (Brolin et al., 2012).

The benefit of stand-alone culture-based treatment integrating into an already established FQHC is that health reform demands considerable administrative and system changes that are

likely to be cost-prohibitive. Thus, for relatively small-scale free-standing treatment operations, particularly non-profits, an FQHC, by virtue of such designation, is equipped with health reform compliant transdisciplinary human resources, insurance billing systems, and electronic patient records. Other vital technological resources are devoted to providing comprehensive and coordinated care in FQHC systems (Aletraris, Roman, & Pruett, 2017; Andrews et al., 2015; Clark, 2017; Knudsen & Studts, 2017; Quinn, Stewart, Brolin, Horgan, & Lane, 2017).

A Consortium of Native Hawaiian Culture-Based Service Practitioners

Since referrals from primary care to health care reform compliant addiction treatment services are likely to continue increasing (Aletraris et al., 2017), Native Hawaiian culture-based addiction treatment would need to create Memoranda of Agreements (MOAs) with healthcare systems. Culture-based treatments may advantageously position themselves by targeting a particular demographic (e.g., Hawaiian populations) as a contracted service provider of addiction treatment referrals. Cultural-based programming can also form cooperatives with other independent practitioners to better service the community, perhaps in application to the designation of a patient-centered medical home (PCMH) or accountable care organization (ACO).

Under such agreements, Native Hawaiian health and behavioral health service providers could give their clients access to additional health care services. As part of a consortium, specialty Native Hawaiian substance use treatment would operate in partnership, irrespective of whether physically co-located, with other service providers outside of health centers (e.g., providing an in-house psychiatric nurse practitioner to assess and monitor medical health and disease trajectory). This would create an embedded referral track, allowing the client to go through a single round of admission only to gain access to any provider within the network (doing away with the burden of going through multiple rounds of cumbersome screening, intake, admissions, and billing processes with each provider).

Sustainable Business Model

At present, publicly funded Native Hawaiian culture-based programs (excluding those for adolescents and methadone maintenance) are completely dependent on the criminal justice system to identify their treatment population. In a case study of Massachusetts reform under ACA mandates, Quinn and colleagues (2017) offer some explanations about the emergence of this business model. They note that a decrease in the number of referrals from individuals involved in criminal justice led to a decrease of reimbursement price-points from third parties. Furthermore, Quinn et al. (2017) noted that despite the joint effort of many organizations in Massachusetts in adapting to ACA mandates, these organizations still lacked sustainable funding.

Legislative reform policies of the 21st century completely upended the business model of many old-guard acute care institutions—as more formerly uninsured people are now with insurance, less out-of-pocket money is going to treatment facilities, and insurance companies are providing less payment for services by negotiating reimbursement prices (Maclean & Saloner, 2018). Overall, this business situation is aggravated by a marked decline in the share of financing that comes from state behavioral health authorities and traditional sources of local community grant funding for specialty center-based provider services (see also Levit et al., 2013).

In order to more broadly appeal to the larger community and reconfigure the business-as-usual approach to become economically viable with less dependence on the Centers for Medicare and Medicaid Services (CMS), SABG funds and court referrals, Native Hawaiian culture-based

addiction treatment will need to restructure its current business model and diversify its treatment services and referral source portfolios (Maclean & Saloner, 2018). To this end, the following measures could be implemented:

- Creating a sustainability planning team that will incorporate central decision makers (e.g., elected officials, administrators, program planners, finance staff).
- Establishing revenue-generating formulas in planning products and services that can be sold (*konane, moa*, etc. [ancient games] boards, replica traditional native Hawaiian artifacts, and craft workshops).
- Selling Hawaiian botanical plants used in traditional healing and medicinal practices, such as *la'au lapa'au* (herbal medicine), from own nursery.
- Incorporating a consortium that would act as a place of culturally competent learning and teaching. This consortium would be made up of Hawaiian practitioners representing diverse disciplines across the medical field. Workshops, seminars and web-based distant learning offered would qualify as certified content with the necessary authorities (e.g., Single State Agency) to provide CEUs for professionals. This consortium would be also contracted with the medical and educational systems as a semester-long cultural immersion training course incorporating traditional healing practices for student interns (Kamaka, 2010).
- Petitioning the Office of Hawaiian Affairs (OHA) for recognition as a Hawaiian program aligned with the goals and objectives of OHA's master plan and request funding from preferential funding streams (OHA, Native Hawaiian Rehabilitation Fund, etc.).
- Leveraging statutory bodies and existing federal and state laws (mentioned above) for additional sources of revenue to conform to federal policy mandates and more fully develop and expand the reach of services. For instance, freestanding Native Hawaiian addiction treatment programs have no formal service partnership with Papa Ola Lokahi Federally Qualified Health Center (FHQ), Native Hawaiian public health structure and 42 U.S.C.11704 (d).

Culture-Based Skills Promoting Health and Wellness

The impact of culture-based practices might potentially go beyond clinical interventions geared to the remission of substance use disorder symptoms. By initiating meaningful changes in ethnic and cultural identification, they might also offer sociocultural benefits for their clients. This appears to have already happened with health and wellbeing initiatives that have used hula (dance) as part of chronic disease management for hypertension, obesity, and diabetes (Kaholokula, Ing, Look, Delafield, & Sinclair, 2018). Ensuring both cultural integrity and fidelity to respective cultural protocol by directly involving the supervision of well-trained and respected Kumu hula (hula experts), program participants viewed hula not only as a clinical intervention or physical activity, but as a "means to preserve a strong Native Hawaiian identity and to overall wellbeing" through "its focus on cultural values and connection to other persons and the natural world" (Kaholokula et al., 2018, p. 259). In the context of addiction treatment, certain Hawaiian cultural practices may serve a similar function by addressing identity issues, values, social support, and motivation, all of which are part of the recovery experience (Murphy & Sparks, 2018). Culture-based programs, then, could afford clients opportunities to encounter alternative reward reinforcement, which could contribute to prosocial behavior and promote a drug-free lifestyle.

Cultural approaches could possibly help programs take advantage of annual SABG funding granted to each Single State Authority from SAMHSA, which are increasingly shifting away from supporting the standard delivery of treatment service. Instead, SAGB funds will emphasize non-clinical collaborative team-based approaches to address client needs, or supportive services that wraparound all aspects of the client (Aletraris et al., 2017). Specialty addiction treatment programs may see a repurposing of SAGB funds for nonmedical, community-based recovery support and rehabilitative services that are not always adequately covered by Medicaid or private insurance (Aletraris et al., 2017; Andrews, Grogan, Brennan, & Pollack, 2015; Levit et al., 2013). For instance, skill-building services based on engendering cultural experiences with Hawaiian traditions and promoting substance use disorder remission could support long-term recovery maintenance. Cultural activities may qualify for such interventions and do so more affordably than the treatment-as-usual model's standard approach marked by acute and recurring treatment episodes (Andrews, Grogan, et al., 2015; Maclean & Saloner, 2018; McCabe & Wahler, 2016; White, 2014).

The question of what kind of cultural services clients should engage in to increase their likelihood of recovery and remission is raised within the framework of health and wellbeing. Health, however, is a widely contested concept, as it has both medical and social dimensions. Managed care that is largely informed by a medical model, then, may inadequately distinguish the shades of grey of substance use symptomology in line with the *Diagnostic and Statistical Manual of Mental Disorders'* severity continuum ranging from mild, moderate to severe (APA, 2013). This can lead to treating all cases of drug use identically, without distinguishing whether and where each specific substance use case lies on the continuum. An example of this lack of prudent discrimination is reflected in some insurance carriers' and CMS's propensity for a medicalized model-centric stance that abstinence is both the ultimate frontline intervention and the end-goal of treatment. Since providers are encouraged to target abstinence, urine drug screens results testing positive for illicit substances or even alcohol are often interpreted as a sign of an addiction problem. It has been our experience that the yardstick insurance carriers (and the criminal justice system) use to determine success of treatment is overdetermined by testing for the presence of drug metabolites at the expense of measurable progress made by clients across the multidimensional assessment guidelines of the American Society for Addiction Medicine (ASAM, 2013; Mee-Lee et al., 2013). Approval for treatment by insurance companies is further limited by the stringent limitations on the duration of service coverage and the use of continuing reviews to manage costs and access to treatment (Aletraris et al., 2017; Clark, 2017; Knudsen & Studts, 2017; Quinn et al., 2017).

The culture-based services to engage clients in, then, are those that can provide measurable outcomes and can be efficiently coordinated (Neukrug, 2017), meaning they can meet documentation requirements and facilitate authorization of services (for discussion see Maniss & Pruit, 2018). The question, ultimately, is about which endpoints deliver the best quality of life for clients with a given problem (e.g., cultural connection to Hawaiian identity), and whether the person with a substance use disorder ultimately benefited in the end by teasing out treatment effects from standard, potentially confounding, measures of global health and positive social functioning (Kiluk, Fitzmaurice, Strain, & Weiss, 2019). The stringent, if not at times myopic, application of a medical model of addiction devalues moderation, harm reduction, and medication-assisted treatment. When the medical model is the sole barometer, whatever is achieved with medication is treated as an unqualified success, or not at all in the presence of other illicit substance use, regardless of whether the client can achieve sustainable life improvement. Reimbursement may drive care, but managed care should be aware that abstinence

as an endpoint does not inexorably result in improvement in functional status. To illustrate, for Hawaiians, the traditional paths to illness and healing are integrated. In this holistic perception, "*ola* is a way of living, rather than simply a state of being healthy" in mind, body, spirit, and environment (Chun, 2011, p. 142). With regard to compulsive substance use, living *pono* (in a state of health mindedness) would entail individuals' learning relevant strategies and techniques to manage the symptoms of their disorders (e.g., urges/cravings) in order to reduce or stop their substance use, but more importantly sustain a sense of recovery in mind, body, spirit, and environment—that is, *Ola Lokahi* (Chun, 2011). One implication of culturally-driven treatment then is that it leaves the question of appropriate care open for consideration, recognizing that culturally-based contextual factors play an important role in substance use, recovery, and remission. For instance, can cultural activities produce clinically meaningful results by reducing a level of risk? Can cultural activities make a strong contribution to the client becoming more involved in the broader community, and thereby manifest a lifestyle at odds with addiction, giving way to less negative psychosocial functioning related to drug use? Culture-based treatment has the advantage of providing a platform for program participants to experience Hawaiian activities and practices, and their own *Hawaiian-ness*, in a positive way, with the emphasis on the sense of unity, community, connection, and relatedness. In practice, families and communities participating in the work of such a platform might offer access to culture, which could positively impact the client's health and wellbeing and eventually lead to substance use disorder remission and recovery becoming nested in the community.

Data-Driven Arguments to Secure Greater Support and Further Funding

Efforts to support cultural adaptations of evidence-based programs (EBPs) at the state and federal levels, as well as tailoring psychosocial interventions to Native Hawaiian cultural practices, must be careful not to support less effective treatment measures at the expense of programs with better outcomes. As Blase and Fixsen (2013) point out, "there is little empirical evidence to support assertions that the components named by an evidence-based program developer are, in fact, the functional or only functional core components necessary for producing the outcomes" (p. 6). In other words, policy makers, funders and program administrators need to be aware, however, that not all EBPs (evidence-based curricula and adapted psychosocial intervention) are measures appropriate for dealing with substance use among Hawaiians.

At the same time, proponents of culture-based treatment services face a major challenge when it comes to the available data. Population-based evidence for Native Hawaiians is largely lacking, and most of the evidence available of efficacious treatment approaches arises from other racial/ethnic groups. There is, therefore, a significant risk that the administration or provision of treatment services for Native Hawaiians will be based not on cogent empirical evidence but, instead, on practice-based evidence or approaches that may or may not be efficacious when applied in Hawaiian contexts. Yet there is often a tacit assumption that non-Hawaiian treatment intervention, particularly the ones referred to as *evidence-based*, are superior or yield stronger evidential backing without taking into account the role of cultural differences among Hawaiians in securing positive outcomes. Not all evidence-based practices are identical, and some of them do not warrant being bracketed from cultural approaches or interventions that effectively demonstrate cross-cultural sensitivity and responsivity. One such example is the *Partners for Change Outcome Management System* (PCOMS*)* which has over 1.5 million administrations both in the United States and twenty other countries (She et al., 2018). PCOMS is different in that it is neither theoretically nor diagnostically based, which are the main culprits when it comes to injecting ethnocentric biases into treatment (Duncan & Sparks, 2018). PCOMS has no built-in

assumptions about people or how to help them (Duncan & Sparks, 2018). Moreover, it is a hybrid measurement tool, as it serves both as an outcome measure and as a communicative device to unfold the idiosyncratic cultural experiences of each client (Duncan & Sparks, 2018). PCOMS, then, addresses cultural competence by design (Duncan & Sparks, 2018; Sparks & Duncan, 2018).

Moreover, relying on a generalized (EB) treatment method is also complicated by the fact that diversity of cultural background, race, language, and ethnicity—not to mentioned varied sociological experiences—makes it difficult if not impossible to identify a single treatment method or culturally adapted evidence-based intervention that is best suited for an entire population. With so much diversity and so much lived variation within those diverse groups, it should be expected that some Native Hawaiian program participants will respond in a therapeutically beneficial way to a more traditional Hawaiian healing approach, while others may get better results from treatment-as-usual (Bernal & Adames, 2017; Wendt & Gong, 2012). Given these considerations, federal and state funds are better directed towards truly individualizing care and helping cultural programs develop a more efficacious regiment of care that would be truly evidence-based (for instance, by including standardized measures to track the treatment population's progress and collecting feedback about treatment response; see Lambert, Whipple, & Kleinstäuber, 2018). As noted by Overington and Ionita (2012), using standardized tools that have been specifically designed to monitor changes throughout the therapeutic process—"collectively referred to as progress monitoring measures"—can help practitioners better identify when the treatment population shows little progress, which increases the effectiveness of therapy and provides valuable data for further quality improvement (Overington & Ionita, 2012, p. 82; see also Boswell, Kraus, Miller, & Lambert, 2015; Kelly & Mee-Lee, 2019; Prescott, Maeschalck, & Miller, 2017). PCOMS measures, for instance, are beneficial for treatment or services in all major domains of life (individual, interpersonal, and social) for individuals from any culture. This means the ORS can reliably and validly measure instances in which a Native Hawaiian culture-based treatment method, service, or treatment is designed to impact change in any or all of these areas when specified during treatment (Duncan, 2014; Sparks & Duncan, 2018).

Conclusion

Culture-based treatment, as it pertains specifically to Hawaiians, may generally be more culturally diverse practice environments, which HSPs typically value and seek to work within (Cousins, 2014; Weiner, 2014). Human services professionals understand the importance of having culturally responsive programs and treatment methods for minority or marginalized populations (Kincaid, 2009; NOHS, 2015b; Weng, 2014, p 332). In this context, it is worthwhile to turn to Dressler's (2017) delineation of culture within the paradigm of cognitive culture theory: "Culture includes everything that humans do. There is nothing that is not cultural. As such, the explanation of any phenomenon [e.g., drug use] as a result of culture becomes tautological. People do things because of their culture…Because of this, culture recedes as an explanatory variable…[and] an analytic variable, because it doesn't vary. Everything is culture" (p.11).

It suggests that, first, culture is within and carried by each and every individual person, program participant, or client. By extension, all treatment programs are culture-based in which clients participate culturally. However, what really matters for our discussion is the fit between the individual's culture and the broader cultural *milieu* of the treatment environment (Dressler, 2017), which implies that there is an urgent need to take an individualized approach to each

client and display awareness of the larger cultural context of the practice environment. Thus, until programs normalize the use of individualized outcomes monitoring and effective documentation of implemented service interventions, along with the identification and discontinuation of ineffective services, we cannot know how much of a difference cultural practices make in a clinical practice (Williams, 2018). This means that, even for Native Hawaiian culture-based programs that use an evidence-based curriculum (EBP) and are sanctioned by the NREPP, the evidence may not be rigorous or relevant to real-world outcomes or expectations (Burkhardt et al., 2015; Gorman, 2017; Green-Hennessy, 2018; Henry, Tolan, Gorman-Smith, & Schoeny, 2017; Hoffmann, 2016).

Secondly, culture-based program that tend to show signs of comprehensiveness operate with culturally-adapted evidence-based curricula and psychosocial interventions designed and tailored to the specific treatment population (Castro, Barrera, & Holleran Steiker, 2010; Castro & Yasui, 2017). Cultural practices may therefore be a helpful ancillary option to evidence-based treatment—at least to the extent that culture can augment clinical protocols—as well as be beneficial to clients in appreciably improving treatment responsiveness, retention, and outcomes (Chu & Leino, 2017). However, the findings of past investigators (Williams, 2018) suggests the existence of a general zeitgeist that demands a benefit of the doubt appraisal of Native Hawaiian culture-based treatment. Hence a longstanding history of unsubstantiated yet widely accepted claims made by academics, stakeholders, funders, single state agency (or Hawai'i state auditing authority for addiction treatment programs and charged also with allocating federal and state funds is the Alcohol and Drug Abuse Division (ADAD) within the Hawai‘i Department of Health), and administrators of such programs' treatment efficacy. Consequently, there has been a lack of adequate research pressure and evaluative inquiry into the kinds of interventions and outcomes produced by Native Hawaiian culture-based treatment; notably, some proponents of these programs see this lack of empirical investigation as confirmation of the marginalized status of Native Hawaiians and, therefore, the need for culturally sensitive treatment programs (Williams, 2018).

Further drawing on Dressler's (2017) work, while Native Hawaiian programs may loosely practice a property of Hawaiian culture (*hula*), culture is the foundation of—but not an agglomeration of—beliefs and values. Therefore, despite the existence of shared properties of a culture, there is an intracultural diversity within Hawaiian society. Put differently, there is not a one-to-one correspondence between culture and behavior such as drug use (Dressler, Balieiro, & dos Santos, 2018). Thus, the assumption that changing excessive alcohol use patterns, for example, among Native Hawaiians, which came into place under European contact and Western influence, simply requires exposure to the properties of Native Hawaiian culture is unfounded (Williams, Makini, Rezentes, & Ehia, 2019).

Despite decades of preferential funding and legal clauses stipulating the financial support for the development of comprehensive treatment for Native Hawaiians, the treatment effects of Hawaiian culture-based substance use disorder remain unknown. A major reason for this is the uncritical acceptance of Native Hawaiian culture-based treatment by its funders, stakeholders, single state agency (ADAD), and proponents. In the absence of legitimate vocal concern, there has been little incentive to conduct relevant scientific assessments (Williams, 2018). As a direct consequence, there are no empirical data that would convincingly demonstrate that the addiction treatment offered by Native Hawaiian culturally-based programs provides more comprehensive, culturally appropriate, and effective treatment of the Hawaiian populations than treatment-as-usual (Williams, 2018). Since all medical treatment should produce evidence of its effectiveness, the current trends in Native Hawaiian culture-based treatment appear to be starkly at odds with

the 21st Century Cures Act of 2016, which mandates that substance and mental health prevention and treatment keep pace with science.

HSPs working in the addiction treatment field, interim students, and prospective professionals ascribing to the HSP discipline are bound to face the particular challenge of finding opportunities to implement and carve out new directions in line with expected health reform for culture-based addiction treatment systems (Alle-Corliss & Alle-Corliss, 2015). Given the current trend towards broader treatment systems, the stand-alone Native Hawaiian culture-based addiction treatment model is currently at odds with existing policy efforts, embodied, for instance, in the American Recovery and Reinvestment Act (ARRA) of 2009, Patient Protection and Affordable Care Act [PL 111-148] of 2010, state-specific equal-coverage laws for SUD treatment (so-called parity laws), and the 21st Cures Act. What is needed, then, are changes in the overall structure and delivery of behavioral health operations and a compelling system transformation (Clark, 2017). Legislative health reform is meant to phase out parochial and ossified treatment models (e.g., non-adoption of medication-assisted treatment, off-site health related services, short-term and non-transdisciplinary health care delivery for addiction disorders co-occurring with psychiatric complications and medical diseases) and create a more comprehensive and collaborative marketplace where multiple disciplines and agencies work together for the good of Native Hawaiians impacted by substance use. Agencies and treatment systems that meet higher quality standards for the increasing number of newly insured with comorbidities (Campbell, Parthasarathy, Altschuler, Young-Wolff, & Satre, 2018), will be better off positioned to compete for the increasing CMS funds from Medicaid enrollment (Aletraris et al., 2017; Smith, 2018), with continually projected upticks in Medicaid spending on addiction treatment as the largest payer of such services (Antonisse, Garfield, Rudowitz, & Artiga, 2017; Levit et al., 2013). Native Hawaiian culture-based programs, then, must find ways to structurally and philosophically adapt in order to better align with the goals and objectives of health care reform (Aletraris et al., 2017).

In light of current policy reforms and trends in the treatment industry, HSPs must reconsider the current stand-alone culture-based addiction treatment model (CSAT, 2000; 2019). While these free-standing programs meet a need that has not been catered to by mainstream treatment programs, they will need to evolve by remedying its separation from the (Native Hawaiian) health care system and pursuing solid evidence obtained in progress monitoring. This is an organizational challenge that human services professionals can play a crucial role in facilitating, both as support staff within the treating agencies able to relay information, and as a administrators with more direct influence over their organizations (Austin, Brody, & Packard, 2009; Woodside & McClam, 2015). Ideally, this would be followed by investments in quantifying data via progress monitoring to either integrate practice within a local community healthcare clinic or to form a consortium in which multiple providers partner to create a transdisciplinary team of medical and health practitioners to deliver optimal care.

References

American Psychiatric Association [APA]. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Antonisse, L., Garfield, R., Rudowitz, R., & Artiga, S. (2017). *The effects of Medicaid expansion under the ACA: Updated findings from a literature review.* Retrieved from https://pdfs.semanticscholar.org/a263/5d0fe9bfe6e8883877206a18865f36f83a35.pdf

Akau, M., Akutagawa, W., Birnie, K., Change, M., Kinney, E. S., & Nissanka, S. (1998). Ke ala ola pono: The Native Hawaiian community's effort to heal itself. *Pacific Health Dialog*, *5*, 232-238.

Aletraris, L., Roman, P. M., & Pruett, J. (2017). Integration of care in the implementation of the Affordable Care Act: Changes in treatment services in a national sample of centers treating substance use disorders. *Journal of Psychoactive Drugs*, *49*, 132-140. doi:10.1080/02791072.2017.1299263

Alle-Corliss, L. A., & Alle-Corliss, R. M. (2015). *Advanced practice in human service agencies: Issues, trends, and treatment perspectives*. Boston, MA: Cengage Learning.

Andrews, C., Abraham, A., Grogan, C. M., Pollack, H. A., Bersamira, C., Humphreys, K., & Friedmann, P. (2015). Despite resources from the ACA, most states do little to help addiction treatment programs implement health care reform. *Health Affairs*, *34*, 828- 835. doi:10.1377/hlthaff.2014.1330

Andrews, C., Grogan, C. M., Brennan, M., & Pollack, H. A. (2015). Lessons from Medicaid's divergent paths on mental health and addiction services. *Health Affairs*, *34*, 1131-1138. doi:10.1377/hlthaff.2015.0151

Austin, M. J., Brody, R., & Packard, T. (2009). *Managing the challenges in human service organizations: A casebook*. Thousand Oaks, CA: Sage.

Bernal, G., & Adames, C. (2017). Cultural adaptations: Conceptual, ethical, contextual, and methodological issues for working with ethnocultural and majority-world populations. *Prevention Science*, *18*, 681-688. doi:10.1007/s11121-017-0806-0

Blaisdell, R. K. (1983). Health section of Native Hawaiians Study Commission Report. In Native Hawaiian Study Commission (Ed.), *Report on the culture, needs and concerns of Native Hawaiians: Pursuant to public law 96-565, title III* (pp. 99-122). Honolulu, HI: Native Hawaiians Study Commission.

Blase, K., & Fixsen, D. (2013). Core intervention components: Identifying and operationalizing what makes programs work. Retrieved from https://aspe.hhs.gov/report/core-intervention-components-identifying-and-operationalizing-what-makes-programs-work

Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2015). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research*, *25*, 6-19. doi:10.1080/10503307.2013.817696

Brolin, M., Quinn, A., Sirkin, J. T., Horgan, C. M., Parks, J., Easterday, J., & Levit, K. (2012). *Financing of behavioral health services within federally qualified health centers.* Washington, DC: Truven Health Analytics, Brandeis University.

Bureau of Labor Statistics. (2011). *Helping those in need: Human service workers*. Retrieved from https://www.bls.gov/careeroutlook/2011/fall/art03.pdf

Burkhardt, J. T., Schröter, D. C., Magura, S., Means, S. N., & Coryn, C. L. (2015). An overview of evidence-based program registers (EBPRs) for behavioral health. *Evaluation and Program Planning*, *48*, 92-99. doi:10.1016/j.evalprogplan.2014.09.006

Campbell, C. I., Parthasarathy, S., Altschuler, A., Young-Wolff, K. C., & Satre, D. D. (2018). Characteristics of patients with substance use disorder before and after the Affordable Care Act. *Drug and Alcohol Dependence*, *193*, 124-130. doi:10.1016/j.drugalcdep.2018.08.028

Castro, F. G., Barrera,M., Jr., & Holleran Steiker, L. K. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology*, *6*, 213-239. doi:10.1146/annurev-clinpsy-033109-132032

Castro, F. G., & Yasui, M. (2017). Advances in EBI development for diverse populations:

Towards a science of intervention adaptation. *Prevention Science*, *18*, 623-629. doi:10.1007/s11121-017-0809-x

Center for Substance Abuse Treatment [CSAT]. (2000). *Funding and policy issues (Integrating substance abuse treatment and vocational services: Treatment improvement protocols (TIP 38). Substance Abuse and Mental Health Services Administration*. Retrieved from from: https://www.ncbi.nlm.nih.gov/books/NBK64279/

Center for Substance Abuse Treatment [CSAT]. (2019). *Behavioral health services for American Indians and Alaska Natives: For behavioral health service providers, administrators, supervisors (TIP 61).* Retrieved from https://store.samhsa.gov/system/files/tip_61_aian_full_document_020419_0.pdf

Chu, J., & Leino, A. (2017). Advancement in the maturing science of cultural adaptations of evidence-based interventions. *Journal of Consulting and Clinical Psychology*, *85*, 45-57. doi:10.1037/ccp0000145

Chun, M. N. (2011). *No na mamo: Traditional and contemporary Hawaiian beliefs and practices*. Honolulu, HI: University of Hawai'i Press.

Clark, H. W. (2017). Health reform and the substance use disorder treatment system: a time of change. *Journal of Psychoactive Drugs*, *49*, 91-94. doi:10.1080/02791072.2017.1315471

Committee on Indian Affairs, United States Senate. (1992a). *Reauthorization of the Native Hawaiian Health Care Improvement Act* [P.L. 100-579]. Washington, DC: U.S. Government Printing Office.

Committee on Indian Affairs, United States Senate. (1992b). *Acknowledging the 100th anniversary of the January 17, 1893 overthrow of the Kingdom of Hawai'i, and to offer an apology to Native Hawaiians on behalf of the United States for the overthrow of the Kingdom of Hawai'i*. Washington, DC: U.S. Government Printing Office.

Cousins, L. H. (Ed.). (2014). *Encyclopedia of human services and diversity*. Thousand Oaks, CA: SAGE Publishing.

Dice, T. F., & Rehfuss, M. C. (2017). Human services students' preferences for master's level training. *Journal of Human Services*, *37*(1), 41-53.

Dressler, W. W. (2017). *Culture and the individual: Theory and method of cultural consonance*. New York, NY: Routledge.

Dressler, W. W., Balieiro, M. C., & dos Santos, J. E. (2018). What you know, what you do, And how you feel: Cultural competence, cultural consonance, and psychological distress. *Frontiers in Psychology*. Advance online publication. doi:10.3389/fpsyg.2017.02355

Duncan, B. L. (2014). *On becoming a better therapist: Evidence-based practice one client at a time* (2nd ed.). Washington, DC: American Psychological Association.

Duncan, B. L., & Sparks, J. A. (2018). *The partners for change outcome management system: An integrated learning manual for everything PCOMS.* Jensen Beach, FL: Better Outcomes Now.

Durand, Z., Cook, A., Konishi, M., & Nigg, C. (2016). Alcohol and substance use prevention programs for youth in Hawaii and Pacific Islands: A literature review. *Journal of Ethnicity in Substance Abuse*, *15*, 240-251. doi:10.1080/15332640.2015.1024811

Edwards, C., Giroux, D., & Okamoto, S. K. (2010). A review of the literature on Native Hawaiian youth and drug use: implications for research and practice. *Journal of Ethnicity in Substance Abuse*, *9*, 153-172. doi:10.1080/15332640.2010.500580

Fujikane, C., & Okamura, J. Y. (Eds.). (2008). *Asian settler colonialism: From local governance to the habits of everyday life in Hawai'i.* Honolulu, HI: University of Hawai'i Press.

Gorman, D. M. (2017). Has the National Registry of Evidence-based Programs and Practices (NREPP) lost its way? *International Journal of Drug Policy*, *45*, 40-41. doi:10.1016/j.drugpo.2017.05.010

Green-Hennessy, S. (2018). Suspension of the National Registry of Evidence-Based Programs and Practices: the importance of adhering to the evidence. *Substance Abuse Treatment, Prevention, and Policy, 13*(26), 1-4. doi:10.1186/s13011-018-0162-5

Kincaid, S. O. (2009). Defining human services: A discourse analysis. *Human Service Education*, *29*(1), 14-24.

Henry, D., Tolan, P., Gorman-Smith, D., & Schoeny, M. (2017). Alternatives to randomized control trial designs for community-based prevention evaluation. *Prevention Science*, *18*, 671-680. doi:10.1007/s11121-016-0706-8.

Hoffmann N. G. (2016, February). *An assessment and outcomes based treatment process*. Paper presented at the Addiction Executives Industry Summit, Naples, FL.

Johnson, K. F., Sparkman-Key, N., & Kalkbrenner, M. T. (2017). Human service students' and professionals' knowledge and experiences of interprofessionalism: Implications for education. *Journal of Human Services, 37*(1), 5-13.

Kaholokula, J. K. A., Ing, C. T., Look, M. A., Delafield, R., & Sinclair, K. I. (2018). Culturally responsive approaches to health promotion for Native Hawaiians and Pacific Islanders. *Annals of Human Biology*, *45*, 249-263. doi:10.1080/03014460.2018.1465593

Kamaka, M. L. (2010). Designing a cultural competency curriculum: asking the stakeholders. *Hawaii Medical Journal*, *69*(Suppl. 3), 31-34.

Kapulani, N. L., & Judd, M. (1998). Laau lapaau: herbal healing among contemporary Hawaiian healers. *Pacific Health Dialog*, *5*, 239-245.

Kelly, J. F., & Mee-Lee, D. (2019). Quality, accountability, and effectiveness in addiction treatment: The measurement-based practice model. In I. Danovitch & L. Mooney (Eds.), *The assessment and treatment of addiction: Best practices and new frontiers* (pp. 207-218). St. Louis, MO: Elsevier.

Kiluk, B. D., Fitzmaurice, G. M., Strain, E. C., & Weiss, R. D. (2019). What defines a clinically meaningful outcome in the treatment of substance use disorders: reductions in direct consequences of drug use or improvement in overall functioning? *Addiction*, *114*, 9-15. doi:10.1111/add.14289

Kim, R. J., & Jackson, D. S. (2009). Outcome evaluation findings of a Hawaiian culture-based adolescent substance abuse treatment program. *Psychological Services, 6,* 43-55. doi:10.1037/a0014750

Knudsen, H. K., & Studts, J. L. (2017). Perceived impacts of the Affordable Care Act: perspectives of buprenorphine prescribers. *Journal of Psychoactive Drugs*, *49*, 111-121. doi:10.1080/02791072.2017.1295335

Lambert, M. J., Whipple, J. L., & Kleinstäuber, M. (2018). Collecting and delivering progress feedback: A meta-analysis of routine outcome monitoring. *Psychotherapy*, *55*, 520-537. doi:10.1037/pst0000167

Levit, K. R., Stranges, E., Coffey, R. M., Kassed, C., Mark, T. L., Buck, J. A., & Vandivort-Warren, R. (2013). Current and future funding sources for specialty mental health and substance abuse treatment providers. *Psychiatric Services*, *64*, 512-519. doi:10.1176/appi.ps.201200298

Maclean, J. C., & Saloner, B. (2018). Substance use treatment provider behavior and healthcare reform: Evidence from Massachusetts. *Health Economics*, *27*, 76-101. doi:10.1002/hec.3484

Maniss, S., & Pruit, A. G. (2018). Collaborative documentation for behavioral healthcare providers: an emerging practice. *Journal of Human Services: Training, Research, and Practice*, *3*(1), 1-23.

Martin, M. (2014). *Introduction to human services: Through the eyes of practice settings* (3rd ed.). Upper Saddle River, NJ: Pearson Education.

McCabe, H. A., & Wahler, E. A. (2016). The affordable care act, substance use disorders, and low-income clients: Implications for social work. *Social Work*, *61*, 227-233. doi:10.1093/sw/sww030

Mee-Lee D., Shulman, G. D., Fishman, M. J., Gastfriend, D., Miller, M. M., & Provence, S. M. (2013). *The ASAM criteria: treatment criteria for addictive, substance-related, and co-occurring conditions* (3rd ed.). Carson City, NV: The Change Companies.

Mokuau, N., DeLeon, P. H., Kaholokula, J. K., Soares, S., Tsark, J. U., & Haia, C.-L. (2017). Challenges and promise of health equity for Native Hawaiians. In K. Bogard, V. M. Murry, & C. Alexander (Eds.), *Perspectives on health equity and social determinants of health* (pp. 169-183). Washington, DC: National Academy of Medicine.

Murphy, J. J., & Sparks, J. A. (2018). *Strengths-based therapy: Distinctive features*. New York, NY: Routledge.

National Organization for Human Services [NOHS]. (2015a). *Ethical standards for human services professionals.* Retrieved from https://www.nationalhumanservices.org.

National Organization for Human Services [NOHS]. (2015b). *What is human services?* Retrieved from https://www.nationalhumanservices.org/what-is-human-services

Neukrug, E. S. (2017). *Theory, practice, and trends in human services: An introduction* (6th ed.). Belmont, CA: Cengage Learning.

Nigg, C. R., Wagner, A., Garza, C. M., & Goya, D. (2017). *State epidemiological profile—2011-2015: Selected youth and adult drug indicators*. Honolulu, HI: Office of Public Health Studies, University of Hawai'i at Manoa.

Office of Hawaiian Affairs, Justice Policy Institute, University of Hawai'i, & Georgetown University. (2010). *The disparate treatment of Native Hawaiians in the criminal justice system*. Honolulu, HI: Office of Hawaiian Affairs. Retrieved from http://www.oha.org/page/native-hawaiians-criminal-justice-system

Office of the Surgeon General. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. Washington, DC: United States Department of Health and Human Services.

Overington, L., & Ionita, G. (2012). Progress monitoring measures: A brief guide. *Canadian* Canadian Psychology/Psychologie Canadienne, *53*, 82-92. doi:10.1037/a0028017

Papa Ola Lokahi. (2016). *Nana i ka pono na ma*. Honolulu, HI: Author.

Prescott, D. S., Maeschalck, C. L., & Miller, S. D. (Eds.). (2017). *Feedback-informed treatment in clinical practice: Reaching for excellence*. Washington, DC: American Psychological Association.

Proehl, R. A. (2001). *Organizational change in the human services*. Thousand, Oaks, CA: Sage.

Quinn, A. E., Stewart, M. T., Brolin, M., Horgan, C. M., & Lane, N. E. (2017). Massachusetts substance use disorder treatment organizations' perspectives on the Affordable Care Act: Changes in payment, services, and system design. *Journal of Psychoactive Drugs*, *49*, 151-159. doi:10.1080/02791072.2017.1301600.

She, Z., Duncan, B. L., Reese, R. J., Sun, Q., Shi, Y., Jiang, G., & Clements, A. L. (2018). Client feedback in China: A randomized clinical trial in a college counseling center. *Journal of Counseling Psychology*, *65,* 727-737. doi:10.1037/cou0000300

Smith, S. R. (2018). The future of nonprofit human services. *Nonprofit Policy Forum, 8*, 369-389. doi:10.1515/npf-2017-0019

Sparkman, N. M., & Lott, T. (2014). The human services—board certified practitioner: A review of the current state. *Journal of Human Services*, *34*, 184-189.

Sparks, J. A., & Duncan, B. L. (2018). The Partners for Change outcome management system: A both/and system for collaborative practice. *Family Process*, *57*, 800-816. doi:10.1111/famp.12345

Substance Abuse and Mental Health Services Administration [SAMHSA]. (n.d.). National Registry of Evidence-based Programs and Practices [NREPP]. Retrieved from https://newsletter.samhsa.gov/2016/08/23/hawaiian-substance-abuse-treatment-program/

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2017, September 15). Block grants laws and regulations: Laws and regulations that impact block grants. Retrieved from https://www.samhsa.gov/grants/block-grants/laws-regulation

Szalay, L. B., Strohl, J. B., & Doherty, K. T. (Eds.). (1999). *Psychoenvironmental forces in substance abuse prevention*. New York, NY: Kluwer Academic/Plenum.

The Anti-Drug Abuse Act of 1986, referred to in par. (21), is Pub. L. 99–570, Oct. 27, 1986, 100 Stat. 3207, as amended. 21st Century Cures Act (2016), Pub. L. No. 114–225, § [section 7002], 130 Stat 1033.

Weiner, A. (2014). Education for diversity in human services. In L. H. Cousins (Ed.), *Encyclopedia of human services and diversity* (Vol. 1., pp. 432-332). Thousand Oaks, CA: Sage.

Wendt, D. C., & Gone, J. P. (2012). Rethinking cultural competence: Insights from indigenous community treatment settings. *Transcultural Psychiatry*, *49*, 206-222. doi:10.1177/1363461511425622

Weng, S. S. (2014). Culturally specific services. In L. H. Cousins (Ed.), *Encyclopedia of human services and diversity* (Vol. 1., pp. 330-332). Thousand Oaks, CA: Sage.

White, W. L. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America* (2nd ed.). Bloomington, IL: Chestnut Health Systems/Lighthouse Institute

Williams, I. L. (2019). Does Native Hawaiian culture-based treatment deserve more funding than treatment-as-usual? *Journal of Ethnic and Cultural Diversity in Social Work*, *28*, 246-261. doi:10.1080/15313204.2018.1555500

Williams, I. L., Makini, G. K., Jr., Rezentes, W. C., III., & Ehia, A. W. (2019). *Indigenous Hawaiian healing to treat psychoactive drug use: A view through the historical looking glass, before European contact and after 1778.* Manuscript submitted for publication.

Winfield, C., Cole, R., & Craigen, L. (2016). The affordable care act and addiction treatment: Preparing the undergraduate human services professional. *Journal of Human Services*, *36*(1), 37-45.

Woodside, M. R., & McClam, T. (2015). *An introduction to the human services* (8th ed.). Stamford, CT: Cengage Learning.

Using an Attachment Lens to Conceptualize Grief: Practical Implications for Human Services Professionals

Jillian M. Blueford, *University of Denver and Charmayne* and R. Adams, *University of Nebraska Omaha*

Abstract

We explore grief and attachment literature to provide empirically informed suggestions for human services professionals to support individuals in the grieving process. We first present foundational literature on two attachment theories and the parallels to grief literature, specifically Stroebe and Schut's Dual Process Model. The Dual Process Model provides a framework for human services professionals to conceptualize grieving individuals' attachments and grieving processes. Practical implications are provided to human services professionals through brief client-counselor dialogues depicting strategies for one to validate grief as an adaptive process, explore the client's relationship with the deceased, and integrate the grieving individual's loss with an adapted internal working model. Human services professionals can implement the contents of this article to support grieving clients with navigating their loss and reframing their attachments.

Keywords: grief; attachment; dual process model; human services professional

Introduction

Human services professionals (HSPs) work in a variety of capacities including direct care services, advocacy, and administration (Bayne, Pusateri, & Dean-Nganga, 2012; National Organization for Human Services [NOHS], 2015; Neukrug, 2017). They work with a wide range of people including but not limited to individuals recovering from substance use disorder in group homes or halfway houses, individuals with intellectual disabilities, and individuals receiving services in community mental health agencies. The common factor in all human services positions is that they are helping to support "individuals and communities to function as effectively as possible in the major domains of living" (NOHS, 2015, para. 14). Due to the broad range of roles HSPs fill (Neukrug, 2017) and settings they work in, it is imperative that they have the skills to support clients experiencing distress caused by death-related loss, a universal experience encountered by many every year. This article will introduce the process of integrating Attachment Theory and the Dual Process Model as one way for HSPs to conceptualize, guide treatment planning, and inform referrals when working with individuals experiencing grief.

Foundations of Attachment Theory

Since Bowlby first introduced Attachment Theory, this theory has become a reputable lens to conceptualize loss (1969, 1982). Even though most individuals think of Attachment Theory as a conceptualization of human bonding, this theory helps scholars and practitioners understand separation as much as it does attachment (Bowlby, 1969, 1982). Attachment Theory does not apply to all human relationships, but only those Bowlby classified as attachment relationships. There are three defining features of an attachment relationship that distinguish it from other relationships: (a) *proximity seeking*: when an individual is in distress they seek proximity (mentally or physically) to the attachment figure; (b) *safe haven/secure base*: the attachment figure can provide support and soothe the distressed individual which allows for them to step out and explore; and (c) *separation anxiety*: loss of an attachment figure causes

significant and sustained distress (Bowlby, 1969, 1982; Mikulincer & Shaver, 2009). Each of these classifications impact the way an individual grieves and are essential for HSPs to take into consideration when working with a client navigating issues on grief and loss. In addition to their confirmatory contribution to the literature on separation anxiety, Ainsworth and colleagues (1978) also discovered three distinct categories of attachment style several practitioners and educators used today: secure, anxious, and avoidant attachment. The researchers were able to see distinctions in proximity seeking behavior explicit to each style. Secure attachment is characterized by experiences of consistent and responsive support from a primary caregiver, which in turn creates a flexible internal working model (Lopez & Brennan, 2000). Individuals exhibiting this attachment style tend to function with a generous amount of autonomy and possess the ability to self-soothe in the majority of situations. However, individuals with a secure attachment still easily rely on attachment figures to provide support when they are overwhelmed or unable to cope (Ainsworth et al., 1978; Lopez & Brennan, 2000). HSPs may recognize these grieving clients or patients as those that tend to follow through with referrals, are generally open to feedback on how to progress toward more effective levels of functioning, and seem to display relatively effective coping skills in times of distress.

An individual utilizing anxious attachment strategies in times of distress may engage in hyper-activating approaches to increase the likelihood of remaining close to the attachment figure (Brown, Rodgers, & Kapadia, 2008). The foundation of these behaviors is the result of experiencing inconsistent care from a primary caregiver and mixed messages, which have led the individual to hyper-activate in an attempt to bring the primary caregiver closer during periods of stress (Brown et al., 2008). These behaviors may look like over-dramatization, exaggeration, and hypervigilance in settings where HSPs provide direct care services such as community mental health agencies, half-way houses, or group homes (Bartholomew & Thompson, 1995). In contrast to the hyper-activating strategies of individuals that employ anxious strategies, individuals that engage in avoidant strategies tend to use deactivating methods such as withdrawal and becoming unavailable emotionally or physically to the attachment figure (Brown et al., 2008). The root of these strategies in an avoidant relationship stems from the individual experiencing non-responsive or mismatched-responses to their needs, which has led to internalized thoughts of *I can take care of myself better than my caregiver can take care of me* (Shaver, Collins, & Clark, 1996). In the helping relationship, this may appear like a client underutilizing resources or avoiding following through with referral suggestions. An understanding of attachment styles and how they impact behavior can help HSPs view client behavior in context, and support better treatment planning, referral services, and advocacy efforts (Bayne et al., 2012).

Through the years, additional scholars have contributed to the attachment literature (e.g., Cassidy & Shaver, 2018; Schore, 2000), and despite changes, the constructs of *proximity seeking*, *secure base*, *safe haven*, and *separation anxiety* have remained (Bowlby, 1969, 1982, 1988). These central aspects of Attachment Theory emphasize that physical and psychological proximity to primary attachment figures is imperative to promote a sense of safety, competency, and psychological well-being (Ainsworth et al., 1978; Cassidy & Shaver, 2018; Field, Gao, & Paderna, 2005). As we mature, physical proximity becomes less critical as we increase our capacity to self-soothe in times of distress and we replace physical closeness with mental images of those we trust, a concept defined as our internal working model of the world (Mikulincer & Shaver, 2016). Our internal working model is our road map of how we anticipate reacting to others, and others reacting to us, especially in times of distress. Even though this model becomes more complicated as we increase our ability to self-soothe in a variety of stressful situations, the

reassurance that those we care about are accessible if we need them is as an aspect that allows us to accept psychological closeness, complete tasks independently, and take more risks (Ainsworth, 1990; Kobak, 1999). The foundations of Attachment Theory help set a basic understanding of how individuals form relationships and the impact of figurative relationships have on development. Next, we build upon this foundation and use Attachment Theory to explain the grieving process.

Grief through an Attachment Lens

The research on human attachment and development parallels the literature focused on grief and loss. When individuals are grieving a death, various thoughts and emotions about their relationship and connections with the now deceased arise (Kosminsky & Jordan, 2016). Their relationship with the individual before death is crucial and influences their ongoing grieving process and responses to this significant loss (Burke & Neimeyer, 2013). Several studies have shown the correlation between individuals with anxious-attachment strategies and their grief process post-death (Delespaux, Ryckebosc-Dayez, Heeren, & Zech, 2013; Wayment & Vierthaler, 2002; Wijngaards-de Meij et al., 2007). These studies highlighted that individuals engaging in anxious-attachment strategies were more likely to experience intense grief and depression than individuals with a secure attachment who were more likely to express their grief authentically, but employ healthy responses to cope with their losses (Wayment & Vierthaler, 2002). Furthermore, Wijngaards-de Meij and colleagues (2007) found that individuals grieving the loss of an anxiously-attached figure tended to exhibit more negative coping skills and had a stronger grief response.

On the other hand, individuals grieving the loss of an avoidant attachment is scarce within the literature. Although researchers believe that grieving the loss of an avoidant attachment figure may look similar to the nature of that avoidant attachment, they are still unclear about other coping strategies used in the grieving process. To look at the holistic grieving process, scholars have developed models to help clinicians and researchers conceptualize the transformation of attachment after a loss (Buglass, 2010). These models are important for HSPs to understand, as they work in a variety of settings that focus on supporting optimal functioning for clients across their life domains (Neukrug, 2017).

One such model was developed by Bowlby (1973), who believed that grief was a strong reaction due to separation, beginning once the attachment was disconnected. To depict his perspective on grief, Bowlby introduced four flexible overlapping phases of grief that are not sequential, but are distinct: a) disbelief, denial, avoidance, and failure to register the loss; (b) yearning, protest, anger, frustration, and anxiety; (c) despair, depression, sadness, and emptiness; and (d) cognitive restructuring of the internal working model and a renewed interest in exploration (Bowlby, 1973, 1980). Individuals fluidly move through each of these phases as they wrestle with reorienting to the loss and incorporating this new information into their internal working model.

Dual Process Model

Stemming from Bowlby's work, Stroebe and Schut (1999, 2010) developed a grief model with an attachment lens. The Dual Process Model complements Bowlby's belief in an adaptable and flexible approach towards one's loss and the ability for individuals to reframe their attachment (Stroebe, Schut, & Stroebe, 2005). This model frames the grieving process as two types of stressors grieving individuals have towards their bereavement: loss-orientation and restoration-orientation. Loss-orientation focuses on grief work and the impact present grief

symptoms have on daily functioning, while restoration-orientation is looking to one's new normal, including new roles, relationships, and behaviors that shift the focus away from grief (Stroebe & Schut, 1999, 2010; Stroebe et al., 2005). Furthermore, this model aligns with Ainsworth and colleague's (1978) categories of attachment style, as the relationships grieving individuals have with their loved ones prior to death influence how grieving individuals will process their loss and reframe relationship with the deceased. Although HSPs can depict the nature of one's attachment by determining which orientation is the most challenging for their clients, Strobe and Schut (2010) believed that individuals go back and forth between both orientations for the duration of the grieving process, as well as have short periods of time where they may not engage in either of the orientations. Mikulincer and Shaver (2008) showed support for this perspective on grief and attachment and stressed the importance of HSPs recognizing which orientation their clients naturally gravitated towards, and which orientation caused the most difficulties. Beyond HSPs providing direct care, this is also important for individuals working in administration and advocacy capacities. By understanding which orientation clients gravitate towards, HSPs can ensure that care systems and treatment plans attend to the areas clients are experiencing the most difficulties in and target services to support them.

The integration between the explained attachment theories and the Dual Process Model highlights the integral role attachment plays in the grieving process. The ongoing oscillation grieving individuals experience captures the complexity of maintaining daily functioning while interpreting their new relationship with their deceased loved one (Stroebe & Schut, 1999, 2010). Furthermore, the categories of attachment styles (Ainsworth et al., 1978) can highly influence this oscillation process as grieving individuals reflect on the emotional and physical needs their deceased loved ones provided, or the connections they desired to have with their deceased loved ones but were unable. Also, the type of attachment style the grieving individual had with the deceased loved one can predict potential attachment styles they have with others (Ainsworth et al., 1978), which could be a support or barrier in the grief process. The Dual Process Model highlights the transparent grieving process that disrupts one's internal working model and provides considerations for professionals to discuss with grieving individuals to better understand their grief and attachment to the deceased. The following section takes a look into implications for HSPs and utilizes short pieces of dialogue between a hypothetical client and clinician to explain application of this content in a therapeutic session.

Implications for Human Services Professionals

Just as Bayne and colleagues (2012) explained the importance of integrating empathy in into the diverse roles of human service professionals, understanding the complex nature of grief can ensure professionals are providing the best care in the variety of roles they fill. By integrating concepts behind a couple of attachment theories (Bowlby, 1973, 1980; Ainsworth et al., 1978) and the Dual Process Model (Strobe & Schut, 1999, 2010), we explain three practical implications for HSPs: conceptualization of adaptive grief, exploration of attachment with the deceased, and integration. Although we discuss these as distinct strategies, they are most likely happening throughout the entire helping relationship and in tandem, depending on the needs of the individuals seeking services. We have added brief client-counselor dialogues under each implication to demonstrate further. Each dialogue will follow the case of Xavier, a 24-year-old male grieving the death of his father. Xavier had sought out counseling services from Tyler, a licensed professional counselor, at a local community college after his mentors and supervisors noticed a shift in Xavier's behavior and relationships with others. Even though this example depicts a counseling relationship, these skills can be applied across human services professions

(e.g., family support worker, group home worker, social work assistant, mental health aide, halfway house counselor) to support clients in a variety of settings as they navigate the complex thoughts and emotions associated with loss.

Conceptualization of Adaptive Grief

HSPs working with a grieving client can employ basic counseling skills, such as reflection, active listening, and empathy (Bayne et al., 2012) to support the client in understanding their grief response as adaptive. Bowlby's (1973) phases of grief depicted alternating feelings individuals can have throughout the process, therefore it can be normal for feelings like shock, relief, and anger to occur simultaneously. Reflections should focus on phrases that support self-awareness around their cognitions, feelings, and actions as normative and adaptable. The responses to the loss can mimic the thoughts and feelings the individual had towards their loved one prior to death and can show a reflection of their attachment (Ainsworth et al., 1978). Neimeyer and Jordan (2013) stated that the therapeutic presence of a practitioner along with their attunement to the client's honest response to the loss is not only necessary but fundamental in the client-counselor relationship. The grieving process is unique and complex, so HSPs must take the time to build the client's trust and validate each facet of the client's grief as well as their vulnerability to share their loss (Holmes, 2013; Kosminsky & Jordan, 2016). The tenderness of an individual's grief should not be taken lightly and should be seen as an opportunity to form a strong therapeutic alliance. If the direct care worker is in a position in which they are unable to provide therapeutic services themselves, they can still validate the client's feelings and offer support through active listening. It is important to understand the client and their presenting issue in order to make the most appropriate referral to therapeutic services, if necessary.

Along with clinical practitioners, it is foundational for all HSPs to create a strong relationship with any grieving individual seeking services. Even if individuals do not identify grief as a presenting concern, it is crucial for HSPs to be attune to any mention of a recent loss or a change in behavior or physical symptoms after a loss. The loss-orientation stressor of the Dual Process Model (Stroebe & Schut, 1999, 2010) emphasized that grief symptoms, which affect daily functioning such as sleep, appetite, and interpersonal functioning, can occur at any time. Meaning, individuals can express their grief during their medical appointments, at case management meetings, family services appointments, or any number of social service appointments at agencies where HSPs tend to work (Bureau of Labor Statistics, 2019). Further, children and adolescents are not immune to grief (Doka, 2002) and can often bring up their losses in passing with trusted teachers, day care workers, or school nurses.

In these moments, HSPs are not expected to immediately resolve the individual's grief, but rather acknowledge the loss of their attachment as significant and convey empathy by listening, reflecting, and paraphrasing (Bayne et al., 2012; Neimeyer & Jordan, 2013). This can occur in any human services setting and could be initiated by an HSP inquiring about their clients and providing a therapeutic space for the grieving individual to share their loss. The key moment in this engagement with a grieving individual is to recognize and not overlook the relationship they had with that person, but rather see grief as an experience that is prominent and life changing.

A barrier to HSPs building a strong alliance with individuals is attempting to pathologize responses to a loss. Social media, pop culture, and family norms often impact the ways that individuals believe they should be grieving, and feelings outside of those norms can cause discomfort, shame, or isolation. It is vital for all HSPs to explore cultural backgrounds for insight

into their normative grief reactions (Doughty Horn, Crews, & Harrawood, 2013). It is not a matter of a right or wrong way to grieve, but rather the client's exposure to others' grieving processes and their internalization of how they believe they should be responding to a loss. By focusing on increasing self-awareness around the strategies the individual is utilizing to cope and supporting an understanding of those as adaptive reactions to a significant life event, practitioners can help clients better understand and manage their experience and choose the best coping strategies for them.

Conceptualization of adaptive grief case illustration. In the following dialogue, Xavier meets with his counselor Tyler and begins to explain his relationship with his father and how that is impacting the grieving process.

> *Xavier:* All my life, I wanted to have my father around. After he and my mom divorced, he stopped showing up to my games, birthday parties, and Thanksgiving at my grandmother's. It just seemed like he did not care about me or my family. After I moved out of the house, I contacted him, and we started to rebuild our relationship. We spent hours and hours catching up, and I finally felt that I had a dad. Then he told me he was sick, and my heart just dropped. After that, the relationship disappeared. I felt that I was going to lose him again, so I stopped talking to him. When he eventually died, I did not know what to do or think. I just felt numb.

This statement begins to explain the background of the relationship Xavier had with his father, and how that may be impacting the way he is processing the loss. Tyler, his counselor, responds,

> *Tyler (counselor):* People have a variety of feelings when they experience a loss, and it sounds like numbness is the one that is most notable for you. It seems like the relationship between you and your father has changed drastically in your life, and right when you felt that you two were making a secure connection, something else interjected and caused you two to drift apart again.

This statement includes a summary of what the counselor hears, in addition to psychoeducation on how people generally feel when there is a loss. The counselor helps Xavier unpack his feelings by restating what seems notable and the themes he hears. Xavier goes on to say,

> *Xavier:* I feel that this is my fault. I should have never reached out to him again. I felt so angry at him the first time he left...and now I am angry at him all over again.
>
> *Tyler:* So, the anger is reappearing, because you feel that your dad has left you again. I would like to hear more about feeling like it is your fault.

Again, the counselor uses reflections of feeling to highlight the anger that Tyler is feeling and also reiterate that the client is feeling at fault, prompting Xavier to explore that further. Xavier continues by stating,

> *Xavier:* It is just... I put myself in this situation. I would not be angry again or be missing him this much if I had not tried to establish this relationship. I have a lot going on in my head.

Tyler again responds with a reflection of feeling and a plan for how they will move forward in their work.

> *Tyler:* It seems like you are frustrated with yourself for initiating contact with your father only to be hurt by his death. Grief can manifest itself in several ways, including being angry at ourselves and the individuals who died. As we move forward, I want us to continue to explore the entire spectrum of emotional response you are having and make this a safe space where we can untangle each of those emotions.

This dialogue provides an example of how an HSP in a direct care position could begin the conversation with a new client about their grief. In this example, Tyler allows Xavier to provide background information about his father, and primarily uses reflection, summarization, and active listening to show that he is tracking with the client. He ends with a clear roadmap and where they will pick up next time. This next section introduces the concept of exploring the attachment to the deceased, and again has a short illustration of how this could be done.

Exploration of Attachment with the Deceased

When helping clients to explore their attachment with the deceased, the practitioner works to support the client in understanding their relationship with the deceased person, alongside comprehending the impact of that relationship on the client's grieving process (Cassidy & Shaver, 2018). Additionally, HSPs can use the foundational aspects of Attachment Theory to explore the types of needs the deceased fulfilled or neglected for the client, how the deceased functioned as a secure base or safe haven for the client in times of need, and the ways that the client *protested* when separated from the deceased in the past (Mikulincer & Shaver, 2008). This can also be helpful if HSPs, such as case managers, practitioners, or psychologists need to gather family background information for an assessment or intake or assistance with identifying a potential support system for the grieving individual for after care services. Having a stable support system can be instrumental for grieving individuals to express their grief authentically and confide in others (Jakoby, 2012). This support can be disrupted severely if individuals are not only grieving a physical loss of a loved one, but someone who was a strong supporter for them. Therefore, it is crucial for HSPs to assess for and work with the individual to grow their support system.

This exploration process aligns with the restoration-orientation stressor of the Dual Process Model (Stroebe & Schut, 1999, 2010) by giving individuals the chance to conceptualize the relationship they once had and the opportunity to restructure the new relationship going forward. While this exploration does not have to be in-depth or prolonged, it can spark meaningful conversations and self-awareness. By exploring the relationship with the deceased, HSPs can begin to comprehend the context and nuances of the loss in addition to the intricacies of the relationship. They can help grieving individuals understand that the loss is much more than the physical person, but also the role that the person served in helping the client navigate distress. This exploration will begin to help create self-awareness for the grieving individual as the HSP takes the time to carefully and empathically untangle the past relationship and present feelings of the client.

In the process of making sense of the grieving individual's relationship with the deceased, HSPs can work alongside their clients or patients to explore and identify their emotional responses in order to build their capacity to process these heavy emotions (Kosminsky & Jordan, 2016). This process will be influenced by the attachment style the individual had with the deceased (Ainsworth et al., 1978). For example, grieving individuals with a secure attachment may acknowledge the loss and change in the relationship while expressing their authentic reactions. Individuals who had an insecure attachment to the deceased can have stronger and more unstable reactions to the loss (Wijngaards-de Meij et al., 2007). Therefore, HSPs have to be mindful of when they engage in conversations about the clients' emotional responses to their losses (Odgen, 2009). Finally, grieving individuals who had an avoidant attachment to the deceased individual can depict a reluctance or hesitation to discuss the loss in great detail. HSPs should be cautious in assuming that individuals not discussing their grief as them handling the loss well, but instead a potential representation of the avoidance they

experienced with the now deceased individual. Having an intentional balance between exploring the client's attachment to the deceased and the heaviness of their emotional response can help adaptively foster their grieving process.

Exploration of attachment with the deceased case illustration. This case illustration begins in the second session with the client, Xavier. Tyler now has some background information about Xavier's relationship with his now deceased father.

Tyler: I'd like to start where we left off, talking about the feelings that come up when you think about your father.

Xavier: It is confusing. I miss seeing my dad, but I miss more of him being a dad to me as a kid.

Tyler: What I hear you saying is, you miss the role of a father more than your physical, biological father?

Tyler responses to Xavier by clarifying the role his father played for him. This allows Xavier to begin becoming aware of how his relationship with his dad while he was alive may be impacting the grieving process.

Xavier: Yeah, I guess so. Of course, I want my father back, but I want what a real father is supposed to be.

Tyler: What does it mean for you to have a "real father?"

Tyler uses an intentional question to understand the meaning that Xavier has assigned to the role a father is supposed to play in a son's life.

Xavier: Just a man that never leaves you. Is there for the good and bad... provide advice. It is hard to describe, just someone who will be there when you need them.

Tyler: Consistent, available, and attuned.

Xavier: Yeah...It started like that. When I had trouble in school, I could talk to him. He would play baseball with me and go to basketball games with me. You know, he was just around.

With a simple reflection, Tyler is able to hone in on the characteristics that Xavier was looking for in his dad. Tyler is aiming to help Xavier explore the past relationship and recall the broad range of emotions that Xavier had toward his father when he was alive.

Tyler: What comes up for you when you remember him being around and available?

Xavier: It was great. I knew I had someone in my corner that I could trust. It did not matter what the world could throw at me, because I knew my dad would be there. Until he up and left my family and me. After that, I felt like it was easier to take care of myself instead of relying on others.

Tyler will wrap up this part of the session by trying to capture everything he has heard in a summary statement to see if he understood the content, and to help Xavier create connections he may not be aware of yet.

Tyler: It was essential to have someone you could count on regardless of the challenges you faced, but it hurt when you felt you could not rely on him. It seemed that you had that relationship with your father, and it was lost when your father left the household. Years later you took a chance and tried to rely emotionally on your father again, but then were faced with his health diagnosis and eventual death. Now you are grieving the absence of your father both physically and emotionally because you cannot have that father role from him again.

This last statement from Tyler is a summative statement, which lays the foundation to start integrating what this *new normal* could look like for Xavier. For HSPs, once grieving

individuals have reached a point where they can see the impact their past relationship is having on their present state of grieving, practitioners can support them in integrating this information in their internal working model.

Integration

The integration aspect of counseling focuses on grieving individuals beginning to conceptualize and integrate their new understanding of the loved one as deceased into their worldview and internal working model. Building from the development of his phases of grief model, Bowlby believed that people had an internal working model for the world that changed throughout the lifetime and helped us understand ourselves and others (1980). This perspective is utilized to guide interactions and becomes especially important in times of distress. We view our internal working model as *the script*, or the amount of distress we believe we can handle, and the coping skills we utilize to navigate the distress. It also includes *the script* of the way others react to us when we are in distress. When we lose an individual that was a part of our internal working model, we need to *re-write* their role to reflect the change in how accessible or responsive they will be in future moments of anguish. When we are children, often this soothing comes with physical proximity and physical touch. As we grow older, we use mental representations, like memories, songs, phrases, phone calls, and pictures to elicit feelings of being soothed (Cassidy & Shaver, 2018).

Re-writing the script involves the oscillation component of the Dual Process Model (Stroebe & Schut, 1999, 2010), which is reflected during this integration phase. Grief is alternating between the loss- and restoration- orientations as individuals are learning how to adjust their daily functioning while conceptualizing the changes in their relationship with loved ones after death. That process involves reframing their internal working model and changing their perspectives on distress. During the integration phase, HSPs should work with grieving individuals to *re-write* the deceased's place into a new understanding of the world. Special consideration should be taken to help clients integrate instead of cast-aside or forget the individual whom they lost in an attempt to soothe distress more quickly. This grief response can be more noticeable in individuals who had an avoidant attachment with the deceased individual and are pushing their grief away for a prolonged period (Ainsworth et al., 1978). The integration phase can take time, so this strategy is more suitable for HSPs who are engaged in long-term services with the grieving individual. Over time, as the therapeutic trust and safety is established, discussing how to re-write one's internal model can appear organically as HSPs give space and openness for the grieving process to occur.

Integration case illustration. There is no prescribed amount of time for helping professionals and grieving clients to spend in the two implications explained above. However, only after grief has been established as normative and adaptive, and the past relationship with the deceased has been explored, can integrating the information begin. Tyler and Xavier have met now for four sessions, spending the last couple sessions creating a firm therapeutic bond and exploring Xavier's past relationship this his father.

Tyler: So, we have spent quite a bit of time talking about the past. I was wondering if we could shift slightly and begin to talk about what happens next?

Xavier: Now that I have no choice but to move on from my dad?

Tyler: Xavier, it seems like you think you are looking at two options: keep thinking about your dad and the hopes for a relationship that will not happen or move on from him.

Tyler uses reflection to draw attention to Xavier's black and white thinking about his father. He wants to clarify and create a space to explore a more nuanced option later in session.

Xavier: Pretty much. I need to let go.

Tyler: Let go of what?

Xavier: Let go of my father...our memories...of what could be.

Tyler: So, letting go of your father physically, also means letting go of the memories.

Again, Tyler presses into the absolute thinking that Xavier is displaying. Tyler wants to clarify and help bring awareness that just because his father died it does not necessarily mean he cannot find a way to integrate the memories. Next, we will begin to suggest ways that they could work together to try and soften this concrete thinking.

Xavier: Yeah

Tyler: I wonder if we could reframe the black and white idea you have of letting go in order to move on. I am curious if there is a middle ground where you can hold all of the emotions you had for your father and integrate them into the last memory that does not involve forgetting him.

Xavier: I am unsure how to do that

Confusion about how to proceed is normal and allows for the counselor to step in and support the client as they work toward a new normal together. Next, Tyler can introduce some psychoeducation on Attachment Theory and Dual Process Model to help lay the foundation for how they will spend the next couple sessions.

Tyler: That is entirely normal, and I am here to help. Each of us has expectations of how we should react in situations and how others will react to us. These expectations start when we are children and change as we get older. I am wondering if you would like to try an exercise with me where you write out "what a father should be", "what my father was like", "the needs my father filled or did not fill", and "how I get those needs met now that my father is physically gone"?

Xavier: Sure, I am willing to give it a try

Tyler: This may take us a couple of sessions, but I think once you have a better understanding of what this loss has meant to you holistically, we can find a way for you to maintain a continuing bond with your father if that is what you would like.

This sample of dialogue shows the practitioner beginning to support the client in softening his view on maintaining a connection with the deceased and offering an avenue to maintain the relationship in a way that does not cause as much distress. Tyler will continue to work with Xavier as he explores his relationship with his father and the meaning he holds towards that relationship presently and in the future. As Tyler continues through the integration aspect, he may circle back to increasing awareness and exploration. As we mentioned before, none of these strategies are used in isolation, and the support needed from the client mainly drives it. It is essential that HSPs remain attuned and open to the needs of the grieving individual through this process.

Future Directions

Looking forward, the understanding of grief has shifted over time and will continue to alter as scholars press into the nuances of the grieving process. At the time that Attachment Theory (Ainsworth et al., 1978; Bowlby, 1962, 1982) and the Dual Process Model (Stroebe & Schut, 1999, 2010) were introduced as frameworks to conceptualize grief, the concept of ambiguous losses, or losses that are unclear (Boss, 1999) was not commonly discussed. Examples of ambiguous losses include family separation as a result of military deployment,

caring for a loved one diagnosed with Alzheimer's, or changes in a family dynamic after an individual identifies as a member of the LGBTQIA+ community (Boss, 1999, 2006, 2007). Although Attachment Theory (Ainsworth et al., 1978; Bowlby, 1962, 1982) began and primarily remains a theory to aid in the understanding of human bonds, Bowlby's development of his phases of grief model (1973) was focused on death-related losses. Further, the Dual Process Model (Stroebe & Schut, 1999) was also originally designed to conceptualize death-related loss, adding to other solid grief literature at that time that focused on grieving a death.

Regardless of the intentions behind the development of these theories and models, literature confirms that individuals do grieve ambiguous losses and can often face prolonged, negative grief symptoms as they navigate a muddy grieving process (Boss, 1999, 2006, 2007). It is imperative that HSPs recognize that individuals have the capacity to grieve any type of loss and need the same support to validate their grief as adaptive, explore the relationship they once had with the individual, and integrate this loss into their internal working model. Further, ambiguous losses may not involve another individual, but rather a shift in one's life experiences (e.g. change in health status) that can evoke grief (Boss, 1999, 2006, 2007). As researchers continue to explore ambiguous losses, HSPs can still offer a therapeutic space for ambiguous loss and extra time to process the uncertainty often associated with this type of loss.

In addition to broadening how HSPs conceptualize loss, considering culture is crucial for providing services to others. From a cultural perspective, it was in Uganda that Ainsworth began to create her famous attachment categories that were later validated through the replication of her initial study in the Strange Situation procedure (Ainsworth et al., 1978). This study was the first of its kind to lay the foundation for the cross-cultural implications of attachment and this classification system. Since this initial study, Attachment Theory and the attachment classifications have been studied in numerous countries including several in Africa (Kermoian & Leiderman, 1986; Peterson, Drotar, Olness, Guay, Kitiri-Mayengo, 2001; Tomlinson, Cooper, & Murray, 2005), China (Hu & Meng, 1996), Japan (Nakagawa, Lamb, & Miyake, 1992), and Indonesia (Zevalikink, 1997; Zevalikink, Riken-Walraven, & Van Lieshount, 1999). These studies showed that the foundation of Attachment Theory as a concept to describe relationships is relatively stable across cultures, but the strategies that we use to engage in the attachment process tend to be specific to an individual's culture.

These findings mimic the culturally competent approaches helping professionals should take when providing services to grieving clients. Scholars have stressed the need for cultural awareness when understanding one's grieving process, especially for individuals with non-Western cultural backgrounds, along with cultural sensitivity when developing appropriate interventions and treatment modalities (Doughty Horn et al., 2013; Waldrop, 2012). Stroebe and Schut (2010) emphasized the need to be culturally competent when using the Dual Process Model in order to understand cultural responses to a loss and normative expression to others. For HSPs, this means that it is essential to use active listening skills, rely on the grieving individuals to describe their relationships with the individual they lost, and remain open to the way culture may be impacting the grief response. The underlying concepts described in this article may remain constant across cultures, but the expression of attachment and grief shifts based on past experiences, cultural expectations, and societal norms (Cassidy & Shaver, 2018). Further, as researchers and helping professionals engage more with diverse clients, patients, families, and communities, more insight can be gained and culturally competency in grief and attachment can be maintained.

Conclusion

Our attachments to other individuals are both a fundamental piece of our development and a model for the way we engage in future relationships. When a loss occurs and disrupts that attachment, the grieving process can be painful and life-altering as individuals reflect on their attachment to the now deceased, and work to integrate this new information into their working model without that individual. HSPs can normalize grief as adaptive and flexible, engage in dialogue concerning the individual's disrupted attachment, and support them in their process to determine their new world without the deceased. Intentional efforts to conceptualize grief through an attachment lens can bring forth healing and self-awareness for grieving individuals during this significant event in their lives. As helpers, we have the privilege of sitting with individuals as they work through some of their most painful experiences, and by utilizing these models to conceptualizing grief, HSPs can walk alongside grieving individuals in a therapeutic environment where they can explore, feel safe, and re-engage in relationships in a meaningful way after a loss.

References

Ainsworth, M. D. S. (1990). Some considerations regarding theory and assessment relevant to attachments beyond infancy. In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years,* (pp. 463–488). Chicago, IL: University of Chicago Press.

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.

Bartholomew, K., Thompson, J. M. (1995). The application of attachment theory to counseling psychology. *The Counseling Psychologist*, 23, 484-490. doi:10.1177/0011000095233006

Bayne, H. B., Pusateri, C., & Dean-Nganga, L. (2012). The use of empathy in human services: Strategies for diverse professional roles. *Journal of Human Services*, 32(1), 72-88.

Boss, P. (1999). *Ambiguous loss*. Cambridge, MA: Harvard University Press.

Boss, P. (2006). *Loss, trauma, and resilience: Therapeutic work with ambiguous loss*. New York, NY: W.W. Norton & Co.

Boss, P. (2007). Ambiguous loss theory: Challenges for scholars and practitioners. *Family Relations: An Interdisciplinary Journal of Applied Family Studies, 56*(2), 105–111. doi:10.1111/j.1741-3729.2007.00444.x

Bowlby, J. (1969/1982). *Attachment and loss: Vol. 1. Attachment.* New York, NY: Basic Books.

Bowlby, J. (1973). *Attachment and loss: Vol 2. Separation: Anxiety and anger.* New York, NY: Basic Books.

Bowlby, J. (1980). *Attachment and loss: Vol 3. Loss: Sadness and depression*. New York, NY: Basic Books.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* New York, NY: Basic Books.

Brown, D., Rodgers, Y. H., & Kapadia, K. (2008). Multicultural considerations for attachment theory. *American Journal of Psychotherapy*, *62*(4), 353–363. doi:10.1176/appi.psychotherapy.2008.62.4.353

Buglass, E. (2010). Grief and bereavement theories. *Nursing Standard, 24*(41), 44-47. doi:10.7748/ns.24.41.44.s46

Bureau of Labor Statistics. (2019). *Occupational outlook handbook, social and human service assistants.* Retrieved from https://222.bls.gov/oob/community-and-social-service/social-and-human-service-assistant.htm

Burke, L. A., & Neimeyer, R. A. (2013). Prospective risk factors for complicated grief: A review of the empirical literature. In M. S. Strobe, H. Schut, & J. van den Bout (Eds.), *Complicated grief: Scientific foundations for health care professionals* (pp. 145-161). New York, NY: Routledge/Taylor & Francis Group.

Cassidy, J., & Shaver, P. R. (2018). *Handbook of attachment: Theory, research, and clinical applications* (3rd ed.). New York, NY: Guilford Press.

Delespaux, E., Ryckebosc-Dayez, A. S., Heeren, A., & Zech, E. (2013). Attachment and severity of grief: The mediating role of negative appraisal and inflexible coping. O*mega: Journal of Death and Dying, 67*(3), 269-289. doi:10.2190/OM.67.3.b

Doka, K. (2002). *Disenfranchised grief: New directions, challenges, and strategies for practice.* Champaign, IL: Research Press.

Doughty Horn, E. A., Crews, J. A., & Harrawood, L. K. (2013). Grief and loss education: Recommendations for curricular inclusion. *Counselor Education & Supervision, 52*, 70-80. doi:10.1002/j.1556-6978.2013.00029.x

Field, N. P., Gao, B., & Paderna, L. (2005). Continuing bonds in bereavement: An attachment theory-based perspective. *Death Studies*, *29*(4), 277–299. doi:10.1080/07481180590923689

Holmes, J. (2013). Attachment theory in therapeutic practice. In A. N. Danquah & K. Berry (Eds.), *Attachment theory in adult mental health* (pp. 16-32). New York, NY: Routledge/Taylor & Francis Group.

Hu, P., & Meng, Z. (1996). *An examination of infant mother attachment in china*. Poster presented at the meeting of the International Society for the Study of Behavioral Development, Quebec, QB, Canada.

Jakoby, N. R. (2012). Grief as a social emotion: Theoretical perspectives. *Death Studies, 36*(8), 679-711. doi:10.1080/07481187.2011.584013

Kermoian, R., & Leiderman, P. H. (1986). Infant attachment to mother and child caretaker in an East African community. *International Journal of Behavioral Development, 9*, 455-469. doi:10.1177/016502548600900404

Kobak, R. (1999). The emotional dynamics of disruptions in attachment relationships. In J. Cassidy & R. R. Shaver (Eds.), *Handbook of attachment theory and research* (pp. 21–43). New York, NY: Guilford Press.

Kosminsky, P. S., & Jordan, J. R. (2016). *Attachment-informed grief therapy: The clinician's guide to foundations and applications*. New York, NY: Routledge.

Lopez, F., & Brennan K. A. (2000). Dynamic processes underlying adult attachment organization: Towards an attachment theoretical perspective on the healthy and effective self. *Journal of Counseling Psychology*, 47, 283-300. doi:10.1037/0022-0167.47.3.283

Mikulincer, M., & Shaver, P. R. (2008). An attachment perspective on bereavement. In J. Cassidy and P. R. Shaver (Eds.), *Handbook of bereavement research and practice: Advances in theory and intervention* (pp. 87-112). Washington, DC: American Psychological Association.

Mikulincer, M., & Shaver, P. R. (2009). An attachment and behavioral systems perspective on social support. *Journal of Social and Personal Relationships, 26*(1), 7-19. doi:10.1177/0265407509105518

Mikulincer, M., & Shaver, P. (2016). *Attachment in adulthood: Structure, dynamics, and change* (2nd Ed.). New York, NY: Guilford Publications.

Nakagawa, M., Lamb, M. E., & Miyake, K. (1992). Antecedents and correlates of the Strange Situation behavior of Japanese infants. *Journal of Cross-Cultural Psychology, 23*, 300-310. doi:10.1177/0022022192233002

National Organization of Human Services [NOHS]. (2015). *What is human services?* Retrieved from https://www.nationalhumanservices.org/what-is-human-services

Neimeyer, R. A., & Jordan, J. R. (2013). Historical and contemporary perspectives on assessment and intervention. In D. Meager & D. Balk (Eds.), *Handbook of thanatology* (2nd ed.) (pp. 219-237). New York, NY: Routledge/Taylor & Francis Group.

Neukrug, E. S. (2017). *Theory, practice, and trends in human services: An introduction* (6th ed.). Belmont, CA: Books/Cole, Cengage Learning.

Odgen, P. (2009). Emotion, mindfulness, and movement: Expanding the regulatory boundaries of the window of affect tolerance. In D. Fosha, D. J. Siegel, & M. F. Solomon (Eds.), *The healing power of emotion: Affective neuroscience, development & clinical practice (Norton Series on Interpersonal Neurobiology)* (pp. 204-231). New York, NY: W. W. Norton & Company.

Peterson, N. J., Dortar, D., Olness, K., Guay, L., & Kiziri-Mayengo, R. (2001). The relationship of maternal and child HIV infection to security of attachment among Ugandan infants. *Child psychiatry and Human Development, 32*, 3-17. doi:10.1023/A:1017581412328

Schore, A. (2000). Attachment and the regulation of the right brain. *Attachment & Human Development*, 2(1), 23–47. doi:10.1080/146167300361309

Shaver, P. R., Collins, N., & Clark, C. L. (1996). Attachment styles and internal working models of self and relationship partners. In G. J. O. Fletcher & J. Fitness (Eds.), *Knowledge structures in close relationships: A social psychological approach* (pp. 25-61). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Stroebe, M. S., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies, 23*(3), 197-224. doi:10.1080/074811899201046

Stroebe, M. S., & Schut, H. (2010). The dual process model of coping with bereavement: A decade on. *Omega: Journal of Death and Dying, 61*(4), 273-289. doi:10.2190/OM.61.4.b

Stroebe, M. S., & Schut, H., & Stroebe, W. (2005). Attachment in coping with bereavement: A theoretical integration. *Review of General Psychology,* 9(1), 48-66. doi:10.1037/1089-2680.9.1.48

Tomlinson, M., Cooper, P., & Murrau, L. (2005). The mother-infant relationship and infant attachment in South-African peri-urban settlement. *Child Development, 76*, 1044- 1054. doi:10.1111/j.1467-8624.2005.00896.x

Waldrop, D. P. (2011). Denying and defying death: The culture of dying in 21st century America. *The Gerontologist, 51*, 571–576. doi:10.1093/geront/gnr076

Wayment, H. A., & Vierthaler, J. (2002). Attachment style and bereavement reactions. J*ournal of Loss and Trauma, 7*(2), 129-149. doi:10.1080/153250202753472291

Wijngaards-de Meij, L., Stroebe, M. S., & Schut, H., & Stroebe, W., van den Bout, J., van der Heijden, P., & Dijkstra, I. (2007). Neuroticism and attachment insecurity as predictors of bereavement outcome. *Journal of Research in Personality*, 41(2), 498-505. doi:10.1016/j.jrp.2006.06.001

Zevalkink, J. (1997). *Attachment in Indonesia: The mother-child relationship in context*. Ridderkerk, Netherlands: Ridderprint.

Zevalkink, J., Riksen-Walraven, J. M., Van Lieshount. (1999). Attachment in the Indonesian caregiving context. *Social Development, 8*, 21-40. doi:10.1111/1467-9507.00078

Ethics Education in Human Services: Course Context and Teaching Activities

Linda Wark, *Purdue University Fort Wayne;* Tammi Dice, *Old Dominion University;* Shoshana Kerewsky, *University of Oregon; and* Tricia Hudson, *Metropolitan State University of Denver*

Abstract

Ethical choices are a cornerstone of effective human services practice. Human services professionals are expected to adhere to ethical standards, but little is written on the teaching strategies that ready students for ethical practice with clients. This article meets the need for such literature by addressing the teaching context that influences student learning in human services courses and presenting four teaching activities. Future directions and suggestions for research to examine the effectiveness of these activities are offered.

Keywords: ethics education, human services, teaching ethics, ethics activities, ethical decision-making

Introduction

Like other service-oriented professions, human services is embedded in a culture of ethics (Anderson & Handelsman, 2011). Standard 44 of the Ethical Standards for Human Services Professionals (NOHS, 2015) indicates that educators of human services students should provide the means to familiarize, inform, and hold them accountable to the Standards. To promote ethical competence, human services training programs are tasked with including comprehensive ethics education in their curricula (CSHSE, 2018).

An essential component of an ethics education includes teaching a professional ethical code (Corey, Corey, & Callanan, 2005; Lambie, Ieva, Mullen, & Hayes, 2011; Vanlaere & Gastmans, 2007) as it promotes a grasp of foundational ideals in the profession. However, the acquisition of knowledge of ethical code content falls short because it does not prepare students for the complications of everyday professional practice, including the gray areas in ethics and having no single *right answer* to dilemmas (Dudani, 2014; Levitt, Farry, & Mazzarella, 2015; Shallcross, 2011). As such, ethics education focused only on teaching the mechanics of an ethical code is necessary but not sufficient (Kinsella, Phelan, Lala & Mom, 2015; Shallcross, 2011).

We teach ethics in human services degree programs for numerous reasons. Ethics preparation is important to the effectiveness of human services agencies because they will benefit from the good judgment of human services graduates, since ethics education increases the capacity for ethical reasoning (Svanberg, 2008). Ethics education also decreases tolerance for unethical behavior in the workplace (Lopez, Rechner, Sudaramurthy, & Olson-Buchanan, 2005). Didactic education in ethics gives opportunities to develop critical thinking, reflection, and self-examination (Smith, 2011). Students who are sensitized to morals in ethics education (Park, Kjervik, Crandell, & Oermann, 2012) are more likely to positively affect society through their work with clients, which is less likely to be uncompromised when forged from principled service. Finally, there are tangled moral, legal, and ethical issues that face our graduates, and ethics education assists in sorting out these issues (Barsky, 2019; Reamer, 2005).

Consequently, inherent in the process of ethics education is an understanding that ethical decision-making is a developmental process that necessitates compartmentalization of one's personal morals (Monin, in Dudani, 2014; Neukrug, Lovell, & Parker, 1996; Toffler, 2002). The

Ethical Standards for Human Services Professionals (NOHS, 2015) addresses the necessity of compartmentalization in Standard 7, stating, "Human service professionals ensure that their values or biases are not imposed on clients" (p. 3). Values imposition occurs in human services when professional helpers use their personal values actively or inadvertently to influence a client against his/her/their own values and judgment in the context of the professional relationship.

Francis and Dugger (2014) explain several means of imposing values in counseling including the manner in which the counselor uses micro-skills or selectively highlights only part of what the clients says. They may also impose their values by not helping the client explore his/her/their own values and selecting interventions and homework assignments without client input. In human services, similar values impositions can occur through remarks and nonverbal communication that oppose clients' beliefs, positions, or choices or through a helper's failure to show interest in the clients' priorities. Values impositions can occur through disapproval of different but common practices such as childrearing, when there is a poor fit between the clients' expressed values and the professional's choice of interventions, through favoring approaches to services that are not consonant with the clients' culture and/or ethnicity (Palladino-Schultheiss & Stead, 2008), or through not including what is meaningful to clients in service plans. The power differential between the client and the professional in the helping relationship and potential abuses of power can also open the door for values imposition (Francis & Dugger, 2014; Valutis & Rubin, 2016). The agency of the client can be diminished when a client wishes to please the professional or worries that the professional will report them to an authority if the client challenges the perspective of the professional.

To undergird the seriousness of not imposing personal values on clients, values imposition has been tested in the legal arena. Two court cases in particular (Keeton v. Anderson-Wiley, 2010; Ward v. Wilbanks, 2009, cited in Francis & Dugger, 2014) focused on counselors who, based on their personal values, refused to serve clients who identified as gay, which was in direct contradiction to the values of the American Counseling Association. In Ward v. Wilbanks (2009) the counselor was dismissed from an academic degree program, and the courts upheld the decision. As values imposition continues to be taught and discussed in human services, it is clear for both legal and ethical reasons that it is necessary for students to examine their personal values in formal, deliberate means in human services degree programs.

Taught successfully, students may learn to guard against imposing values that may result in ethical decisions that may not be appropriate for the client being served (Comartin & Gonzalaz-Prendes, 2011; Hancock, 2014). Thus, comprehensive ethics education has the potential to reduce the development of problematic responses stemming from decisions based in rote application of ethical codes or inappropriate application of personal morals (Neukrug, 1996; Oramas, 2017; Sanders & Hoffman, 2010). Supporting this perspective, Dalton & Crosby (2012) emphasize the responsibility of higher education to promote ethical development as a means to prepare graduates for successful and responsible professional lives.

Definition and Goals of Ethics Education

Although there are a number of human services' textbooks that discuss ethics (Kiser, 2016; Mandell & Schram, 2020; Neukrug, 2017; Woodside & McClam, 2009) no formal definition of ethics education in human services exists in the literature, but components of a definition can be detected in a variety of related disciplines. Social work defines ethics education as including the development of analytic skills to explore moral responsibilities and the decision-making skills to respond to ethical ambiguity (Reamer, 2001; Sanders & Hoffman, 2010; Hugman, 2005). Similarly, counseling defines ethics education as including the teaching of

ethical codes and their application, raising an awareness of legal issues, clarifying of students' values, and promoting students' ability to engage in sound ethical judgments and actions (Ametrano, 2014; Corey et al., 2005; Kitchener, 1986; Remley & Herlihy, 2010).

Earlier writings in human services addressed the need for human services education to promote cognitive development among trainees to provide them with the complexity to make sound ethical decisions (Neukrug, 1996) and modeled an integration of ethics in all program aspects (Lichtenstein, Lindstrom, & Kerewsky, 2005). More recent human services textbooks have added direction for ethics education, including Kiser's (2016) use of case examples to assist students in recognizing the intersection of ethical, legal and personal value issues. Mandell and Schram (2020) help students dissect the means to maximize self-determination of clients in discussion questions. Neukrug (2017) offers vignettes to which the Ethical Standards for Human Services Professionals can be applied. Woodside and McClam (2009) provide case studies to help students recognize the subtle ways that confidentiality can be violated.

Drawing from the definitions of ethics education found in related fields and the literature offering theoretical approaches to ethical decision-making for human services students, the authors propose that ethics education for human services trainees is the provision of a context in which students can learn the standards of professional behavior and professional responsibility (Corey et al., 2005), develop a sensitivity to morals (Kitchener, 1986; Park, Kjervik, Crandell, & Oermann, 2012), know themselves in relation to ethical behavior (Boon, 2011; Hugman, 2005), and acquire thinking skills for real-life ethical decisions (Hope & Fulford, 1994; Neukrug, 1996). To achieve these goals, intentional pedagogy for ethics education is necessary to meet the standards of the profession and promote competent professional conduct in the field (Lichtenstein, Lindstrom, & Kerewsky, 2005). An appropriate context for ethics education includes a classroom environment that invites higher-level thinking and provides opportunities through course activities to contemplate real-world experiences that require complex decision-making processes (Honderich & Lloyd-Hazlett, 2016). Presented next is a discussion of the context for ethics education, an explanation of the procedures and pedagogy of four course activities, and a conclusion, which provides perspectives on limitations and future directions of the present work.

Classroom and Course Context for Ethics Education

Classrooms may be one of the best places for people to discuss ethics. However, it is the faculty who set the pace for learning and acquiring aspects of professional behavior and attitude change (Barretti, 2007). Classroom efforts are not likely to succeed without high-quality teachers (Boon, 2011). Wescombe-Down (2009) states: "A pedagogically fit teacher is able to maintain a positive, inclusive, and safe learning environment" (p. 20). This is particularly important in classes where challenging ethical dilemmas are discussed, and students are asked to share personal reactions, moral conflicts, and potentially unpopular ethical decisions (Hatipkarasulu & Gunhan, 2012). To create a learning environment appropriate for ethics education, instructors are encouraged to establish ground rules for engagement among students, similar to those used in multicultural education courses (Gorski, 2004; Miller, Donner, & Fraser, 2004). These include the use of active listening and respecting others when they are talking, being aware of body language and non-verbals, sharing one's own experience rather than invalidating someone else's story, striving for open-mindedness, respectfully challenging one another while refraining from personal attacks, and maintaining privacy among peers in the class (Gorski, 2004; Miller, Donner, & Fraser, 2004).

Finally, the modeling of ongoing investment in ethics by faculty can serve to demonstrate a life-long commitment to self-examination pertaining to personal values, continuing ethics education, and meaningful dialogue around ethical dilemmas to aid in thoughtful and appropriate ethical decision-making (Hugman, 2005). The authors suggest that this modeling in conjunction with deliberate application of skills applied through course activities may assist in promoting ethically competent human services professionals.

Course Activities

Intentionally designed activities have been found to promote learning among students (American College Personnel Association, 2008). When activities aim to provide role-taking experiences with opportunity for reflection and feedback in a supportive yet challenging manner, growth and development are possible (Brendel, Kolbert, & Foster, 2002; Hawley, 2006). Also key in moving students to higher order cognitive skills that are necessary for ethical decision-making are experiential activities and class discussions (Kaczmarek, 2001).

Several human services textbooks are a source of teaching materials for ethics education such as discussion questions, case studies or vignettes, and decision-making guides (Kiser, 2016; Mandell, Schram, Dann, & Peterson, 2020; Neukrug, 2017; Woodside & McClam, 2009). These examples are a laudable start, but there is a need for additional classroom and course activities to assist growth in ethical understanding and behavior in the field of human services. Instead of borrowing from other professions, the activities presented below help fill this gap with the aim to promote human services students' ability to apply the human services ethical standards, process difficult ethical dilemmas, and make ethically competent decisions. Each activity supplies a rationale and purpose for the activity, a practical description or how-to for the activity, contraindications and tips, additional relevant information, and a summary. All the activities can be used as graded assignments.

Activity 1: Writing and Responding to Ethics Vignettes

Rationale and purpose. This activity provides two opportunities for students to apply their knowledge of the Ethical Standards for Human Service Professionals (NOHS, 2015) and practice higher-order cognitive skills such as analysis and synthesis (Bloom, Engelhart, Furst, Hill, & Krathwohl, 1956). Most professional ethics textbooks include vignettes to illustrate ethical dilemmas or allow students to answer questions in order to apply their learning (e.g., Kenyon, 1998; Parsons & Dickenson, 2016). However, adding a component in which students write the vignettes serves several important functions that lead to greater learning (Lincoln, 2006; cf. Bailey, Sass, Swiercz, Seal, & Kayes, 2005). It increases active student engagement with the NOHS ethical standards (2015), requiring them to consider ethical problems and dilemmas that may arise in their current or anticipated practices. Grounding this activity in student-generated vignettes permits them to learn how other students respond to challenging scenarios that reflect the writers' concerns and fears. Peer discussions in the writing and response phases help students become more aware of their personal assumptions that may not be consistent with NOHS ethical standards (2015), decreasing their risk of later facing remedial action (Kincaid & Andresen, 2016). Importantly, students report that they value vignettes written by other students (Levesque, 2018). Students are more invested in other groups' potential solutions when they are made in response to their own scenarios, rather than impersonal vignettes created by textbook authors or instructors, thus promoting active learning.

To foster these higher order skills, student groups create ethics vignettes based on problematic situations that human services workers might encounter. The group then responds to

a vignette written by a different group, which allows them to practice responses to difficult situations by applying the Standards. This activity may be completed in two in-class hours separated by a week so that the instructor has time to review and prepare the vignettes for the second part of the activity.

Activity description.

Part I: In small groups, students review the Standards and discuss their experiences and fears. Each group writes a vignette that presents a short, ethically complex situation for a human services student or worker. No questions, instructions about what to focus on, or identified Standards may be included. The vignette must be understandable by someone who cannot ask the group questions. Groups email their vignettes to the instructor, who reviews them for a portion of the grade and removes any guidance provided to readers (e.g., Angelo's dilemma is…; Is confidentiality an issue?). The instructor anonymizes each vignette and makes it available to a different student group.

Part II: Each group discusses the vignette it has received and writes a professional, consultative response. This should cite the relevant Standards and explain their decision-making process. Other material to report may include emotions experienced when first reading the vignette, legal considerations, advice for the human services provider(s) in the vignette, diversity and cultural considerations, and points of disagreement within the responding group. Groups email their responses to the instructor, who reviews them for the remainder of the grade and creates an anonymized master document with all vignettes and responses. This anthology may be discussed in class or form the basis for additional activities.

Contraindications and tips. Students should have exposure to the Standards before engaging in this activity. Ideally, they will have had opportunities to ask questions and discuss the Standards. Emphasize to students that if they use aspects of a real situation, they must disguise it sufficiently to provide confidentiality. Students also should be aware of the potential for stereotyping and microaggressions as they write and respond. The instructor should review vignettes carefully and request revisions if they are needed prior to distributing them for Part II.

Other information. This activity can be modified to require that specific components be included in the vignette (e.g., diversity factors, specific settings, specific human services roles, etc.). The response can be modified to require the use of specific ethical decision-making models. The instructor can model this activity by responding to a vignette provided by students or from another source.

Students enjoy the opportunity to try to stump their peers with difficult ethics scenarios. In responding to complex vignettes, they typically discover that applying the Standards helps the human services professional to simplify the problem and respond appropriately.

Summary. This activity allows students to create professional vignettes that reflect their own ethical concerns, and to gain experience analyzing ethical dilemmas and responding as a consulting peer.

Activity 2: Ethical Decision-Making Project

Rationale and purpose. This activity is designed to assist students in developing their ethical decision-making skills. It is aligned with Neukrug, Lovell, and Parker's (1996) theoretical

approach to promoting ethical processing in counselors through inviting complex thinking with regard to difficult ethical dilemmas. Such a decision-making process would reflect a developmentally advanced, relativistic perspective based on William Perry's (1999) Developmental Model of Intellectual and Ethical Development. This model states that ethical decision-making follows a continuum from dualistic to relativistic processing. As compared to a dualistic processor, in which black and white/right and wrong thinking occurs, students are encouraged to think as a relativist, using flexible, complex, and non-dogmatic approaches when faced with ethical dilemmas. The aim of the activity is to demonstrate the importance of engaging in thoughtful ethical decision-making as opposed to focusing on determining the "right" answer based on one's own personal values. Students are challenged to decide upon a plan of action that results in the greatest amount of good for as many of the individuals involved in the dilemma as possible, while also recognizing that any action may also have some negative consequences for those involved. Since becoming an ethical professional has been described as a developmental process (Neukrug, Lovell, & Parker, 1996), providing students with the opportunity to move from dogmatic to relativistic approaches to ethical decision-making through this activity may promote the developmental process (Ametrano, 2014).

Activity description.

Directions: Student groups of three to four process one ethical dilemma assigned to the class utilizing the Corey, Corey, and Callanan (2011) eight-step ethical decision-making model. The model includes the following steps: (1) identify the problem, (2) identify the potential issues involved, (3) review the relevant ethical guidelines, (4) review the relevant laws, (5) obtain consultation, (6) consider possible courses of action, (7) enumerate the consequences of the various decisions, and (8) decide on the best course of action. In addition to the course text, students are encouraged to refer to the NOHS ethical standards (2015), as well as supplementary resources, particularly current refereed professional journal articles to support their responses to each step. A case example appears below.

Producible: Groups are expected to submit a report detailing their responses at each of the steps in the Corey et al. (2011) model accompanied by a one-page reflective commentary on her/his role in the project, and opinions about the process. During a class session, groups give brief presentations on their decision-making process and outcome. Each group can be encouraged to share their experiences working together to reach a decision about the case. The instructor can highlight similarities and differences in the groups, allowing for the opportunity to emphasize that the actual outcome is less important than the deliberate, complex, and comprehensive process of getting there.

Contraindications and tips. The assignment is given at the beginning of the term with a due date after the concepts addressed in the assignment have been taught in class, including a review of the NOHS ethical code, Corey et al.'s (2011) decision-making model, and Perry's (1999) model of ethical development. The instructor models the activity by presenting a different vignette and responding at each decision-making step to demonstrate what is expected from the group assignment.

Other information. The assigned dilemma in the activity can be structured as the instructor sees fit. For example, different populations could be addressed or a greater focus on diversity could be included. Issues that address different ethical codes and laws could be

incorporated. Another alternative is to have the group develop their own dilemma as part of the assignment.

Summary. Ethical decision-making is a complex process (Neukrug, 1996; Oramas, 2017). This activity allows students to see that there is not just one ethical standard that applies to a given dilemma and not just one right answer to solve a problem. The goals are to help students refrain from making knee-jerk decisions based on their own personal values when faced with an ethical issue, to review the Ethical Standards of Human Service Professionals (NOHS, 2015) for multiple Standards that may apply to a given situation, and to be open to consulting with those who will challenge their perspectives and help prevent values imposition. Ultimately, students should complete this activity with an awareness that every course of action in an ethical dilemma has both positive and negative consequences; therefore, the best response is the one that results in the greatest amount of good and least amount of harm for the most amount of people involved.

Ethical Dilemma: Case Example.

Cecil, 82, is seriously depressed and feels that he has no reason to continue living after recently having been diagnosed with pancreatic cancer and given less than one year to live. As his case worker at the VA Hospital, you have been working with him for several years assuring his health benefits and pension are appropriately utilized. Lately, you have noticed a change in his affect. He expresses to you that he is determined to end what he considers to be an "empty existence" before death overtakes him. Cecil's partner of 45 years, Jude, died two years ago, and he now believes that the reality of his own mortality has become apparent. Cecil lives in a retirement complex but has few close friends. He and Jude had isolated themselves from others, and in order to safeguard their privacy, severed all social ties years ago. Cecil has no support system and is not interested in trying to develop one now. He tells you that he has lived long enough and has accomplished most of what he wished to do in life. He is now ready to die and wants only "to get it over with as quickly and painlessly as possible." He asks you to help him decide upon the most efficient means of achieving this goal. As his human services provider, what should you do?

Activity 3: Ethical Issues Case Study: Case Conceptualization

Rationale and purpose. This activity gives students the opportunity to process ethical decision-making skills (Drumwright, Prentice, & Biasucci, 2015) and to increase awareness of the complexities in the human services field. Codes of ethics, legal considerations, standards of practice, certification, licensure, and role identity of counselors are components that spark complex thinking when using the case studies. Students are given a case study with no identifying information on the first day of class. Students receive three case studies to complete over the term. Each case study includes three or four questions as a guide to help students apply critical thinking skills of analyzing, applying ethical standards, and supporting the reasons for their decisions. Two case studies are presented below.

Activity description.

Part 1: Groups of four to five students each receive copies of the Ethical Standards of Human Service Professionals (NOHS, 2015) and relevant mental health statutes to review, discuss, and apply to the case study. They may receive other ethical codes as well (for example,

NAADAC, 2016). The students have two weeks to write a paper on the case study with three focus areas: ethics, legality, and morals.

Part 2: Each student asks a professional consultant, external to the university, to review his/her paper. The consultant's responses are integrated into the body of the paper. The required subtitles are *Ethics, Legal Issues,* and *Moral Issues.* Students may choose to add additional subtitles such as *Possible Outcome* or *Summary.* A page should describe why the consultant was chosen as well as their experience and education in the field and contact information so that a networking list may be available for subsequent case studies. Finally, students share the most important thing they learned from their consultant and whether they would choose the same consultant again. Grading and feedback are based on students' application of the Standards and other materials as well as the reasons for their decisions.

Contraindications and tips: Students should have opportunities to explore the Standards, other codes, and state mental health statutes before engaging in this activity. These materials are discussed in-depth early in the term. Students are responsible for finding an outside consultant who is willing to assist them in reviewing the case study.

Other information. The case studies can be modified to include diversity factors and address a range of human service roles. Case studies can reference actual situations provided that identifying information is removed and disguised.

Summary. This activity allows students to develop and use their critical thinking skills and gives them practice in identifying and supporting a response to the legal and ethical aspects of human services-related situations (Preston-Shoot, 2011).

Case study I. Use the following directions. In your group of three or four students, discuss the ethical considerations in this case study. Use the Ethical Standards, other materials, and these questions to guide you in writing your paper. Answer these questions: (a) Do you agree or disagree with the service decisions described in the case study, (b) Cite two or more ethical standard(s) related to each violation you see in this situation and discuss why those Standards apply, and (c) Discuss the moral issues or concerns present in this case study.

Brianna has worked for three years as the clinical director of a human services agency. She has begun to hear rumors that staff member Angela, a licensed professional counselor and certified addiction counselor II, has been socializing with an ex-client of the agency. The client had completed the program less than four weeks before this relationship began.

Hearing this rumor, Brianna confronts Angela about her association with the client, who has now been out of the program for about three months. Angela replies that they live in the same apartment building. They have been grocery shopping, attending Alcoholics Anonymous (AA) meetings, and attending Angela's son's events. Angela has loaned her car to the ex-client. Angela states that they are friends who spend time together and are not in a sexual relationship. Six months after discharge, Angela and the ex-client are living together and engaged in sexual relationship.

Case study II.

Directions. In addition to the directions above, students should answer this question: what, if any, are Liliana's ethical obligations as the leader of this group, and which Ethical Standards support this?

Case study. Liliana, a certified addiction counselor III, facilitates an outpatient treatment group for adults with dual diagnoses of primary substance disorder with mental health concerns. The clients are generally compliant with their psychotropic medication, which is monitored by their primary care physicians and psychiatrists. Clients in the group have provided clean urinalysis and breathalyzer results to this agency for five months. The group consists of six male and six female clients.

During a recent session, the client Antonio said that he often drank to help him relax and have self-confidence when he first met a woman he was interested in dating. Upon hearing this, group member Sam joked that perhaps Antonio should consider "going gay" so that he wouldn't have this problem. Other members in the group laughed and made other homophobic jokes. Xavier, another client, said nothing. He had been struggling with issues around sexual identity and stigma. Xavier had not come out to the group, although he had confided privately in Liliana. He found the group conversation intimidating, frightening, and hateful, although he did not share this perception with Liliana or the group.

After the session ended, Liliana's supervisor asked why she had allowed the homophobic discussion to continue. Liliana maintained that since no one in the group seemed to be offended or verbalized concerns or opposition to the discussion, she felt it was appropriate to "let the group vent," adding, "no harm, no foul, no one got hurt."

Activity 4: Students' Reflections on the Standards of the NOHS Ethical Code

Rationale and purpose. Noted earlier in this article is the insufficiency of ethical codes, alone, as a basis for teaching and assuming ethical behavior. However, professional ethics and accompanying ethical codes must be known by students, and they have numerous purposes. For example, codes of ethics promote high standards of conduct and guidance when working with clients and colleagues (Weckart & Lucas, 2013). They assist in modulating personal values in practice (Spano & Koenig, 2007). They can influence the processing of ethical dilemmas (Lawton, 2004). They signify an organization's advancement in its development (Wilcoxon, Remley, Gladding, & Huber, 2008). Finally, they elicit respect from the public for professional organizations and bring awareness of ethics to an organization's members (Joyce & Rankin, 2010).

No studies exist to demonstrate whether or not university or college graduates use their ethical codes after graduation. Without attention drawn to professional ethics, students will not have the awareness that precedes intent to use ethics in numerous situations (Noel & Hathorn, 2013). Further hampering the use of an ethical code is that many traditional-age college students are not ready for self-directed learning (Cercone, 2008; Lowry, 1989). Wotruba, Chonko, and Loe (2001) suggest that the perceived usefulness of an ethical code is related to the degree of familiarity with it. This teaching activity increases familiarity through examination of the NOHS ethical code (NOHS, 2015), self-reflexive responses (Desautal, 2009) to questions on how to grow ethically, and attention to the student's reasoning on how to comply with the ethical code.

Directions. Students receive a copy of the Ethical Standards for Human Services Professionals (NOHS, 2015). To prepare for the written assignment, the instructor provides an

overview of the format of the code, locating the document on the NOHS website and pointing out that it is organized into sub-sections and standards. Students are asked to find terms they do not know or standards that do not make sense to them, and the instructor answers questions to provide clarity. The instructor also reviews several terms related to ethics such as decision-making, ethical dilemmas, ethical code, ethical conduct, and at-risk behavior (Brock, 1997).

The instructor also tours students through the three sections of the assignment. In the first section, *Growing Ethically with the NOHS Ethical Code*, students select three of the Standards in the ethical code in which they believe they need to grow. Students cut and paste or type the Standard number and paragraph that goes with it. Below the Standard, the students critically examine themselves and describe why they need to grow in relation to this standard (Siles-Gonzalez & Solana-Ruiz, 2016).

In the second section of the paper, *Reactions to the NOHS Ethical Code*, students write about two topics they are surprised not to find in the Standards. This is useful because students express concern that ethical codes do not address every challenging issue they might encounter. In addition, they bring their own views about what is ethical or not (Koerber et al., 2005). In a new paragraph, they write about their disagreements with one or more Standards. Pedagogically, allowing the articulation of different viewpoints may open students to a new perspective or synthesis (Higgins, 2011).

In the third section, *Ability to Comply with Ethical Codes*, students are given the opportunity to creatively construct three ways that they could develop the ability to adhere to the Standards. This part of the assignment projects students into the future with the intent to use ethical thinking. It also contributes to students becoming knowledge generators, an aspect of critical thinking (Brookfield, 2012), while examining their need for a plan. If students state that they do not know how to proceed, common ideas such as memorizing or flash cards are offered with the expectation that neither of these will be used by the students in their papers.

Contraindications and tips. This teaching activity is designed for undergraduates in lower-level courses. It works well whether it is the students' first exposure to the Standards or not. Some students question whether they can disagree with the NOHS ethical code (2015) due to a lack of familiarity with ethics and the profession. The instructor can address this by explaining that the current ethical code came about, in part, through disagreement as well as consensus. Further protests from students can be managed by allowing students to select three Standards not used elsewhere in the paper with which they agree and why.

Other information. After the assignment has been graded, the returned papers are used as the stimulus for a final discussion. Students share their responses and ask further questions about the Standards.

Summary. This activity promotes students' self-examination and provides an opportunity to plan for using the Ethical Standards for Human Services Professionals (NOHS, 2015). In addition, it exposes and corrects naïve views of the breadth and depth of professional ethical codes.

Conclusion

The teaching activities presented here include the review and application of the Ethical Standards for Human Services Professionals (NOHS, 2015) as well as opportunities for self-reflection and critical thinking. When combined with a classroom context designed to promote

learning in a safe and supportive, yet challenging, environment in which an investment in learning ethics is modeled, students may have the opportunity to cultivate their ability to engage as ethical professionals. Similar classroom activities implemented in master's counseling programs have shown an increase in students' ability to engage effectively in ethical decision-making and an increase in their ability to reconcile personal and professional values (Ametrano, 2014). Further, human services textbooks are important sources for growth in ethics education, and their suggested activities supplement well the teaching activities presented in this article (Kiser, 2016; Mandell, Schram, Dann, & Peterson, 2020; Neukrug, 2017; Woodside & McClam, 2009).

Promoting the development of ethical professionals takes more than exposing them to the standards of an ethics code without analysis or debate (Boon, 2011; Dudani, 2014). Even with established means of analyzing the ethical code, people continue to change their decision priorities with additional education and experience (Kohlberg, 1981). Thus, it would be erroneous to assume that continued development of the professional in ethics is not necessary. It is recommended that ethics education continue throughout one's career (Oramas, 2017).

Limitations and Future Directions

We conclude that orienting students to the human services culture of ethics requires exposure, immersion, and an examination of self in relation to this culture. However, the effectiveness of the activities presented in this article has not been evaluated specific to human services professionals. Research is needed to assess the impact of the classroom context and activities proposed in this article including sound ethical decision-making, the appraisal of ethical sensitivity, and complexity in the ability to take differing perspectives. In addition, follow-up studies to examine whether or not the activities proposed in this article translate to professional practice are also needed. Further, members of the profession of human services may wish to work on a collaborative definition of ethics education. The development and the scholarly investigation of additional teaching activities to enhance ethics education for human services students is also recommended. Research has been conducted in the related fields of counseling and social work, however there is a dearth of information pertaining to ethics education specific to human services. The present article aimed to present a model for shaping ethics education specific to human services, and research must follow.

References

American College Personnel Association (2008). *The student learning imperative: Implications for student affairs.* Retrieved from https://co.myacpa.org/wp-content/uploads/2015/01/acpas_student_learning_imperative.pdf

Ametrano, I.M. (2014). Teaching ethical decision making: Helping students reconcile personal and professional values. *Journal of Counseling & Development, 92*(2), 154-161. doi:10.1002/j.15566676.2014.00143.x

Bailey, J., Sass, M., Swiercz, P.M. Seal, C., & Kayes, D.C. (2005). Teaching with and through teams: Student-written, instructor-facilitated case writing and the signatory code. *Journal of Management Education*, *29*(1), 39-59. doi:10.1177/105262904269641

Barsky, A.E. (2019). *Ethics and values in social work: An integrated approach for a comprehensive curriculum*. New York, NY: Oxford University Press.

Barretti, M. A. (2007). Teachers and field instructors as student role models: A neglected dimension in social work education. *Journal of Teaching in Social Work*, *27*(3/4), 215-239. doi:10.1300/J067v27n03_14

Bloom, B.S., Engelhart, M.D., Furst, E.J., Hill, W.H., & Krathwohl, D.R. (1956). *Taxonomy of educational objectives: The classification of educational goals. Handbook I: Cognitive domain.* New York, NY: David McKay.

Boon, H. (2011). Raising the bar: Ethics education for quality teachers. *Australian Journal of Teacher Education*, *36*(7), 76-93. doi:10.14221/ajte.2011v36n7.2

Brendel, J.M., Kolbert, J.B., & Foster, V.A. (2002). Promoting student cognitive development. *Journal of Adult Development, 9*(3), 217-227. doi:10.1023/A:1016056227344

Brock, G. (1997). Reducing vulnerabilities to ethics codes violations: An at-risk test for marriage and family therapists. *Journal of Marital and Family Therapy*, *23*(1), 87-89. doi:10.1111/j.1752-0606.1997.tb00233.x

Brookfield, S.D. (2012). *Teaching for critical thinking: Tools and techniques to help students question their assumptions.* San Francisco, CA: Jossey Bass.

Cercone, K. (2008). Characteristics of adult learners with implications for online learning design, *AACE Journal*, *16*(2), 137-159.

Comartin, E.B., & Gonzalo-Prendes, A.A. (2011). Dissonance between personal and professional values: Resolution of an ethical dilemma. *Journal of Social Work Values and Ethics*, *8*(2), 5-14.

Corey, G., Corey, M.S., & Callanan, P. (2005). An approach to teaching ethics courses in human services and counseling. *Counseling and Values, 49*(3), 193-207. doi:10.1002/j.2161-007X.2005.tb01022.x

Corey, G., Corey, J.S., & Callanan, P. (2011). *Issues and ethics in the helping professions*. Belmont, CA: Brooks/Cole.

Council for Standards in Human Service Education [CSHSE]. (2018). *CSHSE national standards.* Retrieved from https://www.cshse.org

Dalton, J. C., & Crosby, P.C. (2012). Reinventing the extra-curriculum: The educational and moral purposes of college student activities and experiences. *Journal of College and Character, 13*(3), 1-7. doi:10.1515/jcc-2012-1927

Desautal, D. (2009). Becoming a thinking thinker: Metacognition, self-reflection and classroom practice. *Teacher's College Record*, *111*(8), 1997-2020.

Drumwright, M., Prentice, R., & Biasucci, C. (2015). Behavioral ethics and teaching ethical decision making. *Decision Sciences: Journal of Innovative Education*, *13*(3), 431-458. doi:10.1111/dsji.12071

Dudani, S. (2014). *Stanford panel debates: Does teaching ethics do any good*? Retrieved from https://news.stanford.edu/news/2014/may/ethics-in-society-051314.html

Francis, P.C., & Dugger, S.M. (Eds.). (2014). Professionalism, ethics, and value-based conflicts in counseling. *Journal of Counseling & Development*, *92*(2), 131-134. doi:10.1002/j.1556-6676.2014.00138.

Gorski, P.C. (2004). Multicultural education and progressive pedagogy in the online information age. *Journal of Multicultural Perspectives, 6*(4), 37-48. doi:10.1207/s15327892mcp0604_10

Hancock, K.S. (2014). Student beliefs, multiculturalism, and client welfare. Psychology of *Sexual Orientation and Gender Diversity*, *1*(1), 4-9. doi:10.1037/sgd0000021

Hawley, L.D. (2006). Reflecting teams in micro-counseling in beginning counselor training: Practice in collaboration. *Journal of Humanistic Counseling, Education, & Development, 45(2)*, 198-207. doi:10.1002/j.2161-1939.2006.tb00018.x

Hatipkarasulu, Y., & Gunhan, S. (2012). *A classroom discussion of applied ethics*. American Society for Engineering Educators 2012 Annual Conference, Engineering Ethics Division *25*, 1-8. Retrieved from: www.asee.org/public/conferences/8/papers/3849/download

Higgins, D. (2011). Why reflect? Recognising the link between learning and reflection. *Reflective Practice: International and Multi-Disciplinary Perspectives*, *12*(5), 583-584. doi:10.1080/14623943.2011.606693

Honderich, E.M., & Lloyd-Hazlett, J. (2016). Content analysis of counseling ethics and decision-making. *VISTAS Online*, *32*, 1-12.

Hope, T., & Fulford, K.W.M. (1994). The Oxford Practice Skills Project: Teaching ethics, law, and communication skills to clinical medical students. *Journal of Medical Ethics*, *20*(4), 229-234. doi:10.1136/jme.20.4.229

Hugman, R. (2005). Exploring the paradox of teaching ethics for social work practice. *Social Work Education 24*(5), 535-545. doi:10.1080/02615470500132772

Joyce, N.R., & Rankin, T.J. (2010). The lessons of the development of the first APA ethics code: Blending science, practice, and politics. *Ethics and Behavior*, *20*(6), 466-481. doi:10.1080/10508422.2010.521448

Kaczmarek, P. (2001). *Experiential teaching strategies applied to an ethics and professional issues course*. San Francisco, CA: American Psychological Association.

Kenyon, P. (1998). *What would you do? An ethical case workbook for human service professionals.* Boston, MA: Pearson.

Kincaid, S., & Andresen, S.A. (2016). A standards-based approach to human services professional fit: Curriculum, policy, and social justice. In S.D. Kerewsky (Ed.), *Fitness for the human services profession: Preliminary explorations* (pp. 13-31). Alexandria, VA: Council for Standards in Human Services Education.

Kinsella, E.A., Phelan, S.K., Lala, A.P., & Mom, V. (2015). An investigation of students' perceptions of ethical practice: Engaging a reflective dialogue about ethics education in the health professionals. *Advances in Health Sciences Education*, *20*(3), 781-801. doi:10.1007/s10459-014-9566-9

Kiser, P.M. (2016). *The human services internship: Getting the most from your experience*. Belmont, CA: Cengage Learning.

Kitchener, K.S. (1986). Teaching applied ethics in counselor education: An integration of psychological processes and philosophical analysis. *Journal of Counseling and Development, 64(5)*, 306-310. doi:10.1002/j.1556-6676.1986.tb01117.x

Koerber, A, Botto, W.W., Pendleton, D.D., Albazzaz, M.B., Doshi, B.S., & Rinando, V.A. (2005). Enhancing ethical behavior: Views of students, administrators, and faculty. *Journal of Dental Education*, *69*(2), 213-224.

Kohlberg, L. (1981). *The philosophy of moral development: Moral stages and the ideas of justice*. San Francisco, CA: Harper & Row.

Lambie, G.W., Ieva, K.P., Mullen, P.R., & Hayes, B.G. (2011). Ego development, ethical decision-making, and legal and ethical knowledge in counselors. *Journal of Adult Development, 18(1)*, 50-59. doi:10.1007/s10804-010.

Lawton, A. (2004). Developing and implementing codes of ethics. *Viesoji Politika ir Administravimas, 7,* 94-101.

Levitt, D.H., Farry, T.J., & Mazzarella, J.R. (2015). Counselor ethical reasoning: Decision-making practice versus theory. *Counseling & Values*, *60*(1), 84-99. doi:10.1002/j.2161-007X.2015.00062.x

Levesque, L.L. (2018). Student-authored ethics vignettes: Giving voice to values all semester.

Management and Teaching Review, *3*(4), 331-245. doi:10.1177/2379298118781771
Lichtenstein, D.P., Lindstrom, L.E., & Kerewsky, S.D. (2005). A delicate balance: An integrated model for the preparation of competent human services professionals. *Human Service Education*, *25*(1), 27-39.
Lincoln, D.J. (2006). Student authored cases: Combining benefits of traditional and live case methods of instruction. *Marketing Education Review*, *16*(1), 1-7. doi:10.1080/10528008.2006.11488930
Lopez, Y. P., Rechner, P., Sundaramurthy, C., & Olson-Buchanan, J. B. (2005). Enhancing ethical perceptions: Impact of integrated ethics curriculum vs. a stand-alone ethics course. In *Management Education & Development Paper Abstracts*, Academy of Management Proceedings, 1-34.
Lowry, C.M. (1989). *Supporting and facilitating self-directed learning.* (ERIC Document Reproduction Service No. ED312 457). Retrieved from https://www.ntlf.com/html/lib/bib/89dig.htm.
Mandell, B.R., Schram, B., Dann, P., & Peterson, L. (2020). *An introduction to human services: Policy and practice.* Boston, MA: Pearson.
Miller, J., Donner, S., & Fraser, E. (2004). Talking when talking is tough: Taking on conversations about race, sexual orientation, gender, class, and other aspects of social identity. *Smith College Studies in Social Work, 74*(2), 377–392. doi:10.1080/00377310409517722
NAADAC: The Association for Addiction Professionals. (2016). *The National Certification Commission for Addiction Professionals code of ethics.* Retrieved from https://www.naadac.org/assets/2416/naadac-code-of-ethics-033117.pdf
National Organization for Human Services [NOHS]. (2015). *Ethical standards for human services professionals*. Retrieved from http://www.nationalhumanservices.org/ethical-standards-for-hs-professionals
Neukrug, E. (2017). *Theory, practice, and trends in human services: An introduction* (6th ed.). Belmont, CA: Cengage Learning.
Neukrug, E. (1996). A developmental approach to the teaching of ethical decision-making. *Human Service Education, 16(1)*, 19-36.
Neukrug, E.S., Lovell, C., & Parker, R.J. (1996). Employing ethical codes and decision-making models: A developmental process. *Counseling and Values*, *40*(2), 98-106. doi:10.1002/j.2161-007X.1996.tb00843.x
Noel, C.Z.J., & Hathorn, L.G. (2014). Teaching ethics makes a difference. *Journal of Academic and Business Ethics*, *8*(1), 1-38.
Oramas, J.E. (2017). Counseling ethics: Overview of challenges, responsibilities and recommendations practices. *Journal of Multidisciplinary Research 9*(3), 47-58.
Palladino-Schultheiss, D.E. & Stead, G. (2008). Ethical issues in testing and assessment. In J. A. Athanasou & R. V. Esbroeck (Eds.), *International Handbook of Career Guidance* (pp. 603-623). New York, NY: Springer.
Park, M., Kjervik, D., Crandel, J., & Oermann, M.H. (2012). The relationship of ethics education to moral sensitivity and moral reasoning skills of nursing students. *Nursing Ethics*, *19*(4), 568-580. doi:10.1177/0969733011433922
Parsons, R.D., & Dickinson, K. L. (2016). *Ethical practice in the human services: From knowing to being.* Thousand Oaks, CA: SAGE.
Perry, W.G. (1999). *Forms of intellectual and ethical development in the college years: A scheme*. San Francisco, CA: Jossey-Bass.

Preston-Shoot, M. (2011). On administrative evil-doing within social work policy and services: Law, ethics, and practice. *European Journal of Social Work*, *14*(2), 177-194. doi:10.1080/13691450903471229

Reamer, F.G. (2001). *Ethics education in social work*. Boston, MA: Routledge & Kegan Paul.

Reamer, F.G. (2005). Ethical and legal standards in social work: Consistency and conflict. *Families in Society: The Journal of Contemporary Social Services, 86*(2), 163-169. doi:10.1606/1044-3894.2237

Remley, T.P., & Herlihy, B. (2010). *Ethical, legal, and professional issues in counseling* (3rd ed.). Upper Saddle River, NJ: Pearson Education.

Sanders, S., & Hoffman, K. (2010). Ethics education in social work: Comparing outcomes of graduate social work students. *Journal of Social Work Education, 46*(1), 7-22. doi:10.5175/JSWE.2010.200800112

Shallcross, L. (2011). Do the right thing. *Counseling Today*, 1-7.

Siles-Gonzalez, J., & Solano-Ruiz, C. (2016). Self-assessment, reflection on practice, critical thinking in nursing students. *Nurse Education Today*, *45*(1), 132-137. doi:10.1016/j.nedt.2016.07.005

Smith, E. (2011). Teaching critical reflection. *Teaching in Higher Education*, *16*(2), 211-223.

Spano & Koenig (2007). What is sacred when personal and professional values collide? *Journal of Social Work Values and Ethics, 4(3)*.

Svanberg, J. (2008). Educating for accounting ethics: Abilities and identities? The case for a model of moral motivation development. *International Journal of Business Research*, *8*(1), 158-175.

Toffler, B. (2002). Money and ethics. *PBS Newshour* (video). Retrieved from https://www.pbs.org/hewshour/bb/business/jan-june02/ethics/6-26.html

Valutis, S., & Rubin, D. (2016). Value conflicts in social work: Categories and correlates. *Journal of Social Work Values and Ethics*, *13*(1), 11-24.

Vanlaere, L., & Gastmans, C. (2007). Ethics in nursing education. *Nursing Ethics*, *14*(6), 758-766. doi:10.1177/0969733007082116

Ward v. Wilbanks, No. 09-CV-11237, Doc. 1 (E.D. Mich., Apr. 2, 2009).

Weckart, J., & Lucas, R. (2013). Are codes of ethics useful? In J. Weckart & R. Lucas (Eds.), *Professionalism in the information and communication technology industry* (261-314), Canberra, Australia: Griffin Press.

Wilcoxon, A., Remley, T.P., Gladding, S.T., & Huber, C.H. (2007). *Ethical, legal, and professional issues in the practice of marriage and family therapy*. Upper Saddle River, NJ: Pearson.

Woodside, M.R., & McClam, T. (2014). *An introduction to human services*. Belmont, MA: Cengage Learning.

Wotruba, T.R., Chonko, L.B., & Loe, T.W. (2001). The impact of ethics code familiarity on manager behavior. *Journal of Business Ethics, 33*(1), 59–69. doi:10.1023/A:1011925009588 (https://doi.org/10.5840/bpej1981114)

Designing Program Evaluation Outcomes to Mirror Council for Human Services Education (CSHSE) Standards at the Baccalaureate Degree Level

Kristy L. Carlisle, Shuntay Z. Tarver, and Mark C. Rehfuss, *Old Dominion University*

Introduction

The Council of Standards for Human Services Education (CSHSE) requires all accredited human services programs to articulate strategies for improving their programs (2019). Although such improvement is an essential aspect of the accreditation process, it can end after the accreditation is received if the university or program does not require annual evaluations of program performance. Fortunately, many universities and colleges require annual outcome evaluations. Regular program evaluation aids the accreditation process while enhancing and ensuring the goals of the program are addressed and accomplished annually (Walvoord, 2010). By designing program evaluation outcomes to mirror the CSHSE's Standards, human services programs provide a ready infrastructure for continual improvement that will strengthen and enhance programs overtime. This brief note provides a description of one accredited Baccalaureate Degree program's attempt to integrate the CSHSE professional standards into its formal programmatic evaluation process.

The Importance of Program Evaluation

Program evaluation is an important tool for enhancing the quality of higher education programs through assessment of student performance (Walser, 2015; Walvoord, 2010), serving students' evolving needs (Mizikaci, 2006; Walvoord, 2010), meeting accountability demands (Mizikaci, 2006; Murray, 2009; Walser, 2015), and ensuring programs are meeting the standards for respective accreditation bodies (Mizikaci, 2006; Murray, 2009; Walvoord, 2010). CSHSE (2019) publishes the agreed upon standards that human services programs must meet in order to receive the only programmatic accreditation available within the human services field. However, when programs fail to illustrate programmatic alignment with the professional standards of CSHSE, the authors believe it threatens the legitimacy of human services programs and consistency in the process of educating human services professionals. This is particularly alarming when considering that out of more than 300 existing human services programs in the United States, only 51 currently hold the accreditation (CSHSE, 2019). CSHSE Standards have been used to accredit human services program for 35 years since 1983 (CSHSE, 2018a), and this rate of accreditation is notably low. When programs apply for the CSHSE accreditation, their understanding of how to incorporate program evaluation into the accreditation process is critical to their potential success in obtaining accreditation. Designing program evaluation outcomes that mirror the CSHSE standards may enhance the likelihood that human services programs are successfully accredited. The authors contend that increasing the number of programs securing CSHSE accreditation contributes to the legitimacy of the human services profession and improves professional consistency within the field of human services.

Operationalizing Professional Standards into Program Evaluation Outcomes

There are four important steps for operationalizing professional standards into measurable program evaluation outcomes (i.e., using the phrasing of the standards to write outcomes that are readily quantifiable). The first component of the program evaluation process is establishing program learning outcomes (Walvoord, 2010). Second, programs must align courses and assignments to each of the learning outcomes and should include identifying both indirect

and direct measures of how well students are achieving each outcome (Murray, 2009; Walvoord, 2010). For example, the program illustrated in the current paper uses several indirect outcomes measures such as an evaluation completed by internship site supervisors who observe students in their fieldwork, as well as the collection of a self-reported evaluation of the human services program from each graduating student during their last course. Examples of direct measures include students' grades in coursework and on individual assignments.

The third step for operationalizing professional standards into measurable program evaluation outcomes is to secure representative stakeholder involvement in the assessment process (Rossi, Lipsey, & Freeman, 2004). Therefore, measures should incorporate input from faculty, community partners engaged with the program (e.g., site supervisors), and students (Mizikaci, 2006; Walser, 2015). The fourth and final step in operationalizing professional standards into measurable program evaluation outcomes is disseminating findings and recommendations in order to implement changes and improvements in the program (Pasovic, 2011; Walser, 2015; Walvoord, 2010). Collectively, these four steps will strengthen the probability of any human services program earning CSHSE accreditation.

Writing outcomes that mirror the CSHSE standards in this way characterizes many of the human services programs that are currently accredited. For example, the curriculum standards outlined by CSHSE are articulated in standards 11 through 21. Each of these standards refers to the knowledge, theory, skills, and values that human services students should obtain through completion of coursework at the baccalaureate level (CSHSE, 2018b). Table 1 illustrates how one baccalaureate program operationalized the CSHSE curriculum standards into program evaluation outcomes. Each of the operationalized program evaluation outcomes incorporate the four steps described above, thus mirroring the CSHSE curriculum standards.

Table 1

	Council for Standards on Human Services Education Standards (CSHSE, 2018b)	***Operationalized Program Evaluation Outcomes***
Standard 11	History	Students will be able to evaluate how the human services profession has developed historically.
Standard 12	Human Systems	Students will be able to determine the appropriate responses to human needs: individual, interpersonal, group, family, organizational, community, and societal.
Standard 13	Human Service Delivery Systems	Students will be able to appraise the scope of conditions that promote or inhibit human functioning, including aging, delinquency, crime, poverty, mental illness, physical illness, addiction, and developmental disabilities.
Standard 14	Information Literacy	Students will be able to evaluate and disseminate information related to client data and records.
Standard 15	Program Planning and Evaluation	Students will be able to analyze service needs, plan strategies and interventions, and evaluate outcomes.
Standard 16	Client Interventions and Strategies	Students will be able to demonstrate clinical intervention skills such as case management, group facilitation, and use of consultation for providing direct services to clients.

Standard 17	Interpersonal Communication	Students will be able to develop genuine and empathic relationships with others in ways that a) clarify expectations, b) deal effectively with conflict, c) establish rapport with clients, and d) develop and sustain behaviors that are congruent with the values and ethics of the profession.
Standard 18	Administrative	Students will be able to demonstrate skills for indirect service as related to the administrative aspects of the human services delivery system by demonstrating skills in a) leadership and management, b) human resources, c) grant writing and fundraising, d) risk management, and e) budget/financial management.
Standard 19	Client-Related Values	Students will be able to critically analyze and apply values and attitudes that reflect human services ethical practice.
Standard 20	Self-Development	Students will be able to develop awareness of their own values, personalities, reaction patterns, interpersonal styles, and limitations as part of producing effective interactions with clients.
Standard 21	Field Experience	Students will be able to integrate knowledge, theory, skills, and professional behaviors in a human services field experience.

Conclusion

Pursuing accreditation takes time, energy, and concerted effort, but it provides a strong foundation of accountability and excellence which students, colleges, and accreditation bodies are increasingly demanding. CSHSE accreditation provides human services programs with professional legitimacy, and thus contributes to the legitimacy of the human services profession, the practitioners working in the field, and the faculty educating them. Furthermore, it offers consistency across programs for agreed upon standards human services students, practitioners, and programs should all be meeting. This brief example of clearly linking program evaluation outcomes both direct and indirect to CSHSE standards can provide insight for programs seeking CSHSE accreditation. By operationalizing the standards into a program's formal evaluation processes, programs will be strengthened and enhanced, while also simplifying some of steps needed to pursue CSHSE accreditation.

References

Council for Standards in Human Services Education [CSHSE]. (2018a). The CSHSE history. Retrieved from https://cshse.org/about-us/our-history/

Council for Standards in Human Services Education [CSHSE]. (2018b). National standards: Baccalaureate degree inhuman services. Retrieved from https://cshse.org/wp-content/uploads/2018/06/CSHSE-National-Standards-Baccalaureate-Degree-2018-1.pdf

Council for Standards in Human Services Education [CSHSE]. (2019). CSHSE accredited program. Retrieved from https://cshse.org/members-and-accredited-programs/cshse-accredited-programs/

Mizikaci, F. (2006). A systems approach to program evaluation model for quality in higher education. *Quality Assurance in Education, 14*(1), 37-53.

Murray, R. B. (2009). An accreditation dilemma: The tension between program accountability and program improvement in programmatic accreditation. *New Directions for Higher Education, 145*, 59-68.

Pasovic, E. J. (2011). Evaluation reports: Interpreting and communicating findings. In *Program evaluation: Methods and case studies* (8th Edition, Chapter 13, pp. 242-258). Upper Saddle River, NJ: Pearson.

Rossi, P. H., Lipsey, M.W., & Freeman, H. E. (2004). *Evaluation: A systematic approach* (7th ed.). Thousand Oaks, CA: SAGE Publishing.

Walser, T. M. (2015). Evaluability assessment in higher education: Supporting continuous improvement, accountability, and a culture of assessment. *Journal of Assessment and Institutional Effectiveness, 5*(1), 58-77.

Walvoord, B. E. (2010). *Assessment clear and simple: A practical guide for institutions, departments, and general education*. (2nd ed.). San Francisco, CA: Jossey-Bass.

Guidelines for Authors

The *Journal of Human Services* (JHS) is a national refereed journal. Manuscripts judged by the editors to fall within the range of interest of the journal will be submitted to reviewers without the names and identifying information of the authors. The principal audiences of JHS are human service faculty members, administrators, practitioners, and undergraduate and graduate students. Sample areas of interest include teaching methods, models of internships, faculty development, career paths of graduates, credentialing, accreditation, models of undergraduate and graduate study, clinical issues in human service treatment, and supervision of human service practitioners.

JHS publishes three types of submissions: 1) articles, 2) brief notes, and 3) critical reviews of instructional materials and scholarly books of interest to human service educators.

Directions for each type of submission include the following:

1. **Articles.** Manuscripts for articles should not exceed eighteen (18) typed pages. The page limit includes all pages of the manuscript excluding the title page (i.e., abstract, reference pages, tables, and graphs). **Manuscripts may not exceed this page limit.** Following the title page include an abstract of not more than 100 words. This statement should express the central idea of the article in non-technical language and should appear on a page separate from the text.

2. **Brief Notes**. Submissions appropriate for this format include brief reports of research projects or program innovations. Manuscripts should not exceed four (4) double-spaced typed pages; it is recommended that the results and implications occupy at least half of the brief note. A 50- word capsule statement should accompany the note.

3. **Critical Reviews.** JHS accepts reviews of textbooks, other instructional materials, and scholarly books of interest to human service educators and practitioners. Manuscripts should not exceed three (3) typed pages unless two or more related books are included in one review in which case manuscripts should not exceed five (5) typed pages.

The following instructions apply to all three types of submissions:

1. Manuscripts should be well organized and present the idea in a clear and concise manner. Use headings and subheadings to guide the reader. Avoid the use of jargon and sexist terminology.

2. Manuscripts should be typed in 12-point type with margins of at least one inch on all four sides. All materials should be double spaced including references, all lines of tables, and extensive quotations.

3. All material should conform to the style of the sixth edition of the Publication Manual of the American Psychological Association.

4. Avoid footnotes wherever possible.

5. Tables should be kept to a minimum. Include only essential data and combine tables whenever possible. Each table should be on a separate sheet of paper following the reference section of the article. Final placement of tables is at the discretion of the editors.

6. Figures (graphs, illustrations) must be supplied in electronic format and must be in black and white with a minimum of gray shading. Use of submitted figures or a re-rendering of the figures for clarity is at the discretion of the editors.

7. Two (2) copies of the manuscript must be electronically submitted (Microsoft Word or text file versions only).The first version should include, on a separate page, the title of the article, the names of the authors, their professional titles, and their institutional affiliations. The second version must be free of any identifying information. Articles' titles and headings should be as short as possible.

8. Check all references for completeness; make sure all references mentioned in the text are listed in the reference section and vice versa. *Please include doi numbers when relevant.*

9. Manuscripts are edited for consistency of grammar, spelling, and punctuation. In some cases, portions of manuscripts may be reworded for conciseness or clarity of expression.

10. Manuscripts are accepted for review with the understanding that they represent original work and are not under review by another publication.

NOTE: All manuscripts must meet the specifications detailed above or they will be returned to the authors before review for publication.

Send two (2) electronic Microsoft Word or text file versions of the manuscript, one with and one without identifying information, as well as inquiries concerning the publication via e-mail to:

Editor
Journal of Human Services (JHS)
editorhse@yahoo.com