Counselor Preparation and Adolescent Youth: A Study of Clinical Mental Health Counselors

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COUNSELOR PREPARATION AND ADOLESCENT YOUTH: A STUDY OF CLINICAL MENTAL HEALTH COUNSELORS

by

Brian R. Russ

A dissertation submitted to the Graduate College in partial fulfillment of the requirements for the degree of Doctor of Philosophy Counselor Education and Counseling Psychology Western Michigan University December 2016

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Prevalence data have raised concerns that child and adolescent mental health issues are at an epidemic level. For example, Knopf, Park, and Mulye (2008) suggested that 20-25% of all youth experience symptoms of distress. Researchers have also estimated that one in five adolescents in the United States have a diagnosable mental health disorder, and one in ten with a disorder that would be considered severe (Kessler, Berglund, Demler, et al., 2005; Knopf, Park, & Mulye, 2008). Yet, the training of clinical mental health counselors who work with adolescent populations has received limited attention in the counselor education literature. Although the 2016 CACREP clinical mental health counseling standards require students to be knowledgeable and skilled in the diagnosis and the treatment of mental and emotional disorders, there are no specific guidelines for working with adolescent populations. Without such training, counselors may run the risk of being ineffective with, or even doing unintended harm to adolescent clients. Adolescents who do not receive adequate care may experience negative effects in school performance, juvenile delinquency, substance use, and potentially pose harm to other people, as evidenced by the recent murder of 20 first graders and six educators at Sandy Hook Elementary School by a young gunman who had experienced mental health problems in his youth.
The purpose of the present study was to establish baseline data on the training that clinical mental health counselors receive before working with adolescent populations. Specifically, members of the American Mental Health Counselor Association (AMHCA) were surveyed about their preparation to work with adolescents. A total of 188 clinical members of AMHCA completed the survey, and data were analyzed through covariate adjusted comparisons, using analysis of covariance. The results showed that the majority of the sample reported having expertise related to adolescent populations in domains of traditional individual counseling. However, the participants reported less expertise in the specialized skills necessary to operate within a system of care to address clinical mental health concerns in adolescents. It was additionally determined that taking a specific course in counseling children and/or adolescents had the most influence on key training areas, while program accreditation had minimal impact. These findings suggest that clinical mental health counselor programs should offer specific coursework that addresses the more specialized skills necessary to successfully treat adolescents with more complex mental health needs.
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Brian R. Russ
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CHAPTER 1
INTRODUCTION

As a youth, Adam Lanza struggled with a mental health disorder; in 2012, he killed 20 first graders and six educators at Sandy Hook Elementary School. Megan Meier and Rebecca Sedwick both committed suicide following encounters with cyberbullying. They were ages 13 and 12, respectively. Though all three individuals received mental health services, the treatments were not ultimately successful in preventing these tragedies. The media extensively covered these events and their aftermaths (Bauman, 2014; Schildkraut & Muschert, 2014), making the current state of adolescent mental health in the United States a relevant national topic.

Prevalence data have raised concerns about the status of adolescent mental health at a time when child and adolescent mental health concerns are at an epidemic level. For example, Knopf, Park, and Mulye (2008) suggested that 20-25% of all youth experience symptoms of distress. Researchers have also estimated that 1 in 5 adolescents in the United States have a diagnosable mental health disorder and that 1 in 10 have a disorder that would be considered severe if diagnosed (Burns et al., 1995; Kessler, Berglund, Demler, et al., 2005; Knopf, Park, & Mulye, 2008; U.S. Department of Health and Human Services [USDHHS], 1999). Moreover, the President’s New Freedom Commission on Mental Health (The President’s Commission, 2003) estimated that 4.5 to 6.3 million children and adolescents in the United States have been diagnosed with a mental disorder.

In 2010, Merikangas et al. estimated that among individuals between the ages of 12 and 18, 31% experienced an anxiety disorder (e.g., generalized anxiety disorder, social phobia), 14% exhibited a behavior disorder (e.g., attention-deficit/hyperactivity disorder [ADHD], oppositional defiant disorder, conduct disorder), and 14% experienced a mood disorder (e.g., bipolar disorder,
major depression) (Merikangas et al., 2010). Indeed, as Kessler, Berglund, Demler, et al. (2005) projected, half of all lifetime mental health cases begin before age 14.

Historically, the psychology profession has been committed to meeting the mental health needs of the adolescent population. Through professional organizations, research, and specialized training programs, psychologists have already begun addressing the mental health needs of children and adolescents. For instance, the American Psychological Association (APA) first recognized the treatment of child and adolescent mental health concerns as a distinct subfield in 1962, with the creation of Section 1 (Clinical Child Psychology) of APA Division 12 (Clinical Psychology) (Routh, 1994). Clinical Child Psychology was expanded further in 1999 with its change from a section to APA Divisions 53 and 54 (the Society for Clinical Child and Adolescent Psychology and the Society of Pediatric Psychology, respectively) (Erickson, 2013). Within these divisions, the APA has established scholarly journals – *The Journal of Clinical Child and Adolescent Psychology* (APA Division 53) and *The Journal of Pediatric Psychology*; and *Clinical Practice in Pediatric Psychology* (APA Division 54) – to review and disseminate empirical research related to child and adolescent psychology.

Additionally, researchers within the APA have specifically discussed how to train clinical psychologists to work with children and adolescents (e.g., Fisher, 1978; La Greca & Hughes, 1999; Mannarino & Fischer, 1982; Roberts, 1982; Roberts, Erickson, & Tuma, 1985; Roberts & Sobel, 1999; Tuma & Pratt, 1982; Wohlford, 1978). Likewise, the American Board of Clinical Child and Adolescent Psychology (ABCCAP, 2013) has established guidelines for certifications in Clinical Child Psychology. To maintain due diligence on the subject, clinical child psychologists have continually reassessed the state of their training programs (Pidano, Kurowski, & McEvoy, 2010; Pidano & Whitcomb, 2012).
Similarly, researchers and practitioners in social work have demonstrated a devotion to serving child and adolescent populations. To provide professional development for its discipline, the National Association of Social Workers (NASW, 2014b) designated a specialty practice section for Children, Adolescents, and Young Adults. NASW also publishes *Children and Schools*, a scholarly journal focused on social work services for children (NASW, 2013). In addition, NASW has made a Certified Advanced Children, Youth, and Family Social Worker credential accessible to MSW-level practitioners with at least 20 contact hours of continuing education specific to the population and two years and 3,000 hours of paid, supervised, and post-MSW work experience with children, youth, and families (NASW, 2014a).

The counseling profession, also, has a tradition of meeting the developmental needs of children and adolescents. For example, the American School Counselor Association (ASCA, 2014), the school counseling affiliate of the American Counseling Association (ACA), has promoted professionalism and ethical practices. The Council for the Accreditation of Counseling and Related Education Programs (CACREP, 2015), further, has maintained formal standards for school counseling training that focus on the academic, career, personal, and social concerns of K-12 students in school settings. For example, the American School Counselor Association (2009) holds that, although professional school counselors should be prepared to address mental health crises, they should do so through short-term interventions and not through long-term therapy in a school setting. Additionally, Mellin and Pertuit (2009) argued that many professional school counselor programs do not require their students to be trained to work with acute mental health concerns, which could leave school counselors ill prepared to address complex presenting concerns or concerns that could result in harm to themselves or others.
In 2010, the ACA chartered the Association for Child and Adolescent Counseling (ACAC) with the mission to promote research and counseling services for child and adolescent populations (Shallcross, 2011). ACAC established its first journal in 2015 (Journal of Child and Adolescent Counseling, JACAC) with articles that focused primarily on play therapy (Armstrong, Brown, & Foster, 2015; Astramovich, Lyons, Hamilton, 2015; Blanco, Muro, Holliman, Stickley, & Carter, 2015; Schottelkorb, Swan, Jahn, Haas, & Hacker, 2015; Taylor & Meany-Walen, 2015). The JACAC also produced articles that focused on more clinical topics like adolescent anxiety (Lenz, 2015), trauma (Perron & Pender, 2015; Wheeler & Jones, 2015), crisis stabilization (Balkin & Schmit, 2016), evidenced based practices (Del Conte, Lenz, & Hollenbaugh, 2016), and substance abuse (Doumas, Hausheer, & Esp, 2015). The official publication of the ACA, The Journal of Counseling and Development (JCD), has also published articles related to counseling adolescents, including those with adolescent depression (Erford et al., 2011; Hazler & Mellin, 2004; Moilanen, 1995), adolescent suicide and self-harm (Everall, Altrows, & Paulson, 2006; MacAniff Zilla & Kiselica, 2001; Shreve & Kunkel, 1991), disruptive behavior disorders and adolescent violence (Aspy, Oman, Vesely, Mcleroy, Rodine, & Marshall, 2004; Granello & Hanna, 2003; Lancaster, Balkin, Garcia, & Valarezo, 2011), and adolescent substance use (Burrow-Sanchez, 2006; Coker & Borders, 2001; McGuire Parnell, Blau, & Abbott, 1994). These topics have also received attention in other ACA publications, such as the Journal of Mental Health Counseling, Journal of Multicultural Counseling and Development, Professional School Counseling, and The Family Journal. Yet, while there have been fewer than 20 articles published in these journals within the last 10 years that have "adolescent" in the title, none have examined counselor competencies related to working with adolescent populations. More troubling is the finding that only 5 articles have been published in the Counselor Education
and Supervision Journal since 1990 that focused on youth, adolescent, or children's issues. This lack of focus on how the counseling profession trains its graduates to work with adolescents is problematic because counselor educators do not know the degree to which their graduates are prepared to work with adolescents or the best practices that they should use to train their graduates to work with adolescents.

Statement of the Problem

With the prevalence of adolescents with clinical mental health concerns and shortages in qualified mental health clinicians, it is paramount to ensure that clinical mental health counselors are prepared to work with this population. Despite such need, there is little evidence that clinical mental health counseling programs are preparing their graduates to work with adolescents. According to CACREP (2015), clinical mental health counselors have been educated in the principles and practices of diagnosis, treatment, referral, and prevention, and their training has prepared them to work with clients across a spectrum of mental and emotional disorders. Still, the CACREP’s Education Standards (2015) for clinical mental health counseling do not specify standards for counselors who are working with adolescent populations in particular. By contrast, clinical psychologists and social workers do have established and maintained guidelines for preparing their graduates to work with adolescents (Mellin, 2009).

This lack of specialized training for clinical mental health counselors working with adolescent populations is problematic because mental health concerns manifest differently at different developmental stages. For example, depression in adolescents does not always present as sadness; instead, it may be characterized by irritability, boredom, or anhedonia (Brent & Birmaher, 2002). The symptoms of adolescent depression are also difficult to differentiate from the distress typical during this stage of development (Stanard, 2000). Given these
considerations, counselors should not provide treatment to adolescents as if they were adults. In fact, Lawrence and Kurpius (2000) persuasively argued that it is inappropriate and unethical to use adult-based interventions and knowledge with non-adult populations. Therefore, to work effectively with adolescents, clinical mental health counselors need specialized training.

The ACA Code of Ethics (2014) states that counselors are to practice within the scope of their training, yet CACREP (2015) does not maintain specific training requirements for clinical mental health counselors when working with adolescents. Without such training, counselors may be ineffective with, or even do unintended harm, to their adolescent clients. When adolescents do not receive adequate care, meanwhile, this is likely to have negative effects on their school performance, juvenile delinquency, and substance use; worse, it may pose harm to other people, as evidenced by Sandyhook, Virginia Tech, and other recent school shootings (Mellin, 2009).

Furthermore, given the aforementioned prevalence of clinical mental health concerns for the adolescent population (Commission, 2003; USDHHS, 1999) and the shortages of helping professionals trained to work with this group (Huang, Macbeth, Dodge, & Jacobstein, 2004), there is a demonstrated need for more clinical mental health counselors with specialized training in adolescent care. Although counselor educators value prevention and developmentally appropriate approaches to clients, the lack of training guidelines in the counselor education literature suggests that the counseling field may not be prepared to meet the increased demand.

Hence, the purpose of this study is to survey counselors who are members of AMHCA in order to determine the extent to which they have been trained to work with adolescent populations. By exploring the training that has been offered, a profile was produced to understand the current level of training in working with adolescents that counselors have, to
identify any deficiencies, and to determine better ways to train counselors in this area. Because there has been no study specifically looking at this area of training in CACREP-accredited programs, the present study is necessary to establish a baseline of information that may inform future educational practices and CACREP standards.

**Philosophical Framework**

The present study was framed by humanistic psychology; more specifically, by person-centered theory. Rogers (1959) stated that individuals have an innate tendency for growth and that this growth is stifled by the presence of incongruence in an individual. This tendency for growth or self-actualization is the foundation for learning; thus, by developing an understanding of the factors that promote the actualizing tendency, educators can adapt their environments to encourage lifetime learning. Furthermore, person-centered theory has roots in phenomenological theory (emphasizing the subjective experience of the individual) and perceptual theory (emphasizing how a change in perception can change one’s experience) (Wilkins, 2010). While this research specifically explored learning in relation to adolescent populations, the basic tenant of humanistic psychology – that all humans have the tendency for growth – was the underpinning of present study.

Human development, as conceptualized in person-centered theory, begins in infancy and continues throughout an individual’s life. Rogers (1959) postulated that infants experience reality through their own frames of reference and that the actualizing tendency is present from birth. Biermann-Ratjen (1996) added that the necessary conditions for development facilitate psychological growth starting in early childhood, which highlights the need for psychological contact, congruent relationships, unconditional positive regard, and empathic understanding. Furthermore, when the necessary conditions are not present in childhood, the tendency to
develop psychopathology in adulthood is present. For example, Mearns and Cooper (2005) linked difficulties in adult relationships to the failure to develop deep relationships in childhood, and Biermann-Ratjen (1996) linked a lack of positive regard to psychopathology. Therefore, the early treatment of psychopathy is paramount in order to prevent issues in adulthood.

**Research Questions**

The present study asks the following research questions:

**Research Question 1**

How are clinical mental health counselors prepared to work with adolescent populations in coursework and internship?

**Research Question 2**

How do attending a CACREP accredited program, taking a specific course on counseling children and/or adolescents, and the level of content about adolescent counseling that a graduate counseling program infuses into its coursework affect the degree to which a student feels prepared to work with adolescents at internship, the amount of direct contact a student has with adolescents during internship, and the variety of presenting concerns among adolescents encountered during the internship?

**Research Question 3**

To what extent are graduates providing counseling to adolescents and receiving postgraduate training to work with this population, and what factors of graduate training predict the postgraduate development of expertise in counseling adolescent populations?
Definitions of Terms

Adolescence. Adolescence is a unique phase of life that occurs between childhood and adulthood; it includes developmental transitions, which are affected by biological, psychological, and cultural influences (Berzonsky, 2000; Hall, 1904; Lerner & Steinberg, 2009).

Children. For the purpose of this student, the researcher identified children as individuals under the age of 18. The terms children and youth were used synonymously in this study.

Clinical Mental Health Concerns. Clinical mental health concerns are diagnosable disorders addressed by clinical mental health counselors, including emotional and disruptive behavior disorders.

Content Infusion. The manner in which a topic can be included across all courses in a counselor education curriculum (Pack-Brown, Thomas, &Seymour, 2008)

Core Coursework. Core coursework refers to the eight common core areas that CACREP has identified as being necessary for all entry level counselors, including professional counseling orientation and ethical practice, social and cultural diversity, human growth and development, career development, counseling and helping relationships, group counseling and group work, assessment and testing, and research and program evaluation (CACREP, 2015).

Disruptive Behavioral Disorders. Expressed externally, these disorders are categorized primarily by behavioral issues that are considered troublesome and antisocial (Geldard & Geldard, 2010).

Emotional Disorders. Emotional disorders generally include mental health conditions that have internalized symptoms, such as mood and anxiety disorders (Geldard & Geldard, 2010; Graber & Sontag, 2009).
Youth. In this study, the researcher considered individuals who were under the age of 18 as being a member of the youth population. The terms youth and children were used synonymously in this study.
CHAPTER 2
LITERATURE REVIEW

Counselors have served adolescent populations historically. The origins of the counseling field can be traced to the turn of the 20th century, with its foundation in the humanitarian efforts to better the lives of those affected by the Industrial Revolution (Aubrey, 1983). Those early efforts paved the way for counseling pioneers to begin working with children and adolescents. For example, Frank Parson’s and Jesse B. Davis’ work in school guidance and vocational development have been considered foundational in the field. From those early beginnings, the counseling field has expanded to include multiple specialty areas, including child and adolescent counseling, clinical mental health counseling, and counselor education. This chapter explores where these three specialty areas converge.

Chapter 2, specifically, provides a review of the relevant literature specific to adolescent development, adolescent mental health disorders, adolescent services, and counselor training to work with adolescent populations. First, the uniqueness of adolescence in the life cycle is discussed. Second, multiple factors of adolescent clinical mental health concerns are outlined. Third, adolescent help seeking, barriers to service utilization, and service delivery models are identified. Finally, the review confirms that the counselor education fields needs further information on how it trains its graduates to work with the adolescent population. This review of the literature establishes a gap in the research that the present study will fill.

Adolescent Development

Adolescence is a unique phase of life that occurs between childhood and adulthood; it includes developmental transitions that are affected by biological, psychological, and cultural
influences (Berzonsky, 2000; Hall, 1904; Lerner & Steinberg, 2009). As individuals move through adolescence, we encounter numerous developmental challenges that are unique to this stage. Adolescents experience biological, cognitive, psychological, social, moral, and spiritual developmental changes, and these changes vary from early to middle to late adolescence (Geldard & Geldard, 2010). Additionally, the development of an adolescent’s racial and ethnic and sexual identity warrants special consideration.

**Early Adolescence.** Early adolescence is the time when an individual transitions from childhood to adolescence. Taylor, Pooley, and Merrick (2014) identified the transition from preadolescent childhood to adolescence as the primary domain of early adolescence. The onset of puberty has been established as marking the beginning of early adolescence (Brooks-Gunn & Petersen, 1984), with a girl’s first menstruation and a boy’s first ejaculation being biological markers. However, the typical age of the onset of puberty varies between genders and among ethnicities. For example, girls can begin menstruating as early as age 8, with African American girls more likely to begin earlier than their White American counterparts (Herman-Giddens et al., 1997). First ejaculation in males has received considerably less attention, as Janssen (2007) has noted; but 13 is the mean estimated age of first ejaculation. Because of these variations in the onset of puberty, it is impossible to identify a specific age at which adolescence begins (Wagner, 1996). Instead, early adolescence may be defined better as the period of transition that includes the beginning of puberty but that is not defined singularly by its onset.

Prominent developmental psychologist Piaget (1948/1966) stated that cognitive development during early adolescence begins with a transition from a “concrete operations” stage, occurring between 7-8 to 11-12 years of age, to a “formal operations” stage, which continues to develop throughout adolescence (Piaget, 1948/1966). This evolution increases an
individual’s ability to use logic and critical thinking and to understand abstract concepts (Piaget, 1972). Furthermore, Flavell (1977) suggested that adolescents have a greater ability to use cognitive skills than children, including the ability to consider both the possible and impossible, to consider multiple outcomes, to predict ramifications, to implement new understandings, and to solve problems using multiple strategies. Still, cognitive development in early adolescence is premature, and these skills are not fully developed until later in life.

Additional challenges of early adolescence are found in psychological development. During this stage, young adolescents are finalizing their beliefs about whether they can survive in an institutionalized setting. Erikson (1968) deemed this stage, beginning at age 5 and ending by age 12, as defined by a struggle between one’s sense of industry, or one’s desire to produce in society, with one’s sense of inferiority, or one’s fears that he or she will be unsuccessful at tasks. Important to this stage is the development of self-confidence; early adolescents need to satisfy their sense of industry before they are able to transition to the development of identity in later stages of adolescence.

From childhood to early adolescence, changes in social roles occur primarily in an individual’s role within the family. Children are joined with their parents, but as they reach adolescence, they separate to become individuals. Steinberg and Sheffield-Morris (2001), in their synthesis of developmental research reported that adolescents experience increased conflict with their parents, leading to a decline in reported closeness and time spent together (Larson & Richards, 1991). This conflict can affect the mental health of early adolescents and their parents (Silverberg & Steinberg, 1990), but when the conflict is resolved, it leads to a more egalitarian relationship (Steinberg, 1990).
Moral development in early adolescence has been explained by Kohlberg (1966) as a transition from evaluating morality as it pertains to rewards and punishments to evaluation based on the approval of superiors. Kohlberg (1966) defined this as a conversion, one which begins at age 10, from a preconventional morality to a conventional morality. Gilligan (1983), adding to Kohlberg’s theory, argued that female adolescents engaged moral development differently from their male peers. Gilligan (1983) suggested that female adolescents moved from an initial motivation for survival to a stance of conformity and sacrifice during their moral development in early adolescence, whereas male adolescents have less pressure to conform or make sacrifices.

As adolescents develop intellectually and emotionally, their ability to develop spiritually increases as well. In fact, Good and Wiloughby (2008) identified adolescence as the most sensitive time for spiritual development and exploration. Fowler (1981) stated that as an individual moves from childhood to adolescence, his or her need to rely on figures of authority for the verification of spiritual beliefs decreases. In early adolescence, symbolism supersedes factual truth and, as an adolescent matures, personal experiences, symbols, and rituals begin to play a larger role in his or her spiritual development. Additionally, spirituality or religion has been indicated as a significant coping process used in adolescence (King, 2008; Roeser, Issac, Abo-Zena, Brittian, & Peck, 2008). Despite this, scholars have identified gaps in the mental health field on how to work with adolescents’ religious and spiritual identity (Magaldi-Dopman & Park-Taylor, 2013). Brawer, Handal, Fabricotore, Roberts, and Wajda-Johnson (2002) found that clinical psychologists do not receive adequate training in spiritual or religious issues affecting their practice. Furthermore, Mayers, Leavey, Vallianatou, and Barker (2007) noted differences between the spiritual beliefs of psychologists and those of the adolescents they were
treating. Indeed, Maher and Hunt (1993) found that counselors were unable to assist in spiritual development beyond their own understanding of the process.

Another significant aspect of development during adolescence is the advancement of one’s racial and ethnic identity. Racial and ethnic identity development has been considered a normal part of adolescence that youth of color experience as they attempt to understand how they relate to their racial or ethnic group (Phinney, 1989). Borrowing identity terminology from Marcia (1966), Phinney (1989) developed a four-stage model to illustrate what an individual may experience during the development of his or her ethnic identity. All four stages have been observed throughout the lifespan (Yip, Seaton, & Sellers, 2006), with the process beginning in adolescence. Furthermore, researchers have determined that typical adolescent’s ethnic identity development increases throughout adolescence (French, Seidman, Allen, & Abner 2006; Huang & Stormshak, 2011; Matsunaga, Hecht, Elek, & Ndiaye, 2010; Phinney, 1989).

The least mature stages of adolescent development have been identified as the **diffuse** status (having no commitment to or any exploration related to a particular identity) and **foreclosed** status (committing to an identity without exploration) stages. Those individuals who are transitioning from a less mature stage are considered to have **moratorium** status (a period of encounter and exploration). The successful completion of the **moratorium** status places an individual in the **achieved** stage, where he or she has a commitment to a particular identity through his or her self exploration.

Regarding racial identity, Cross (1971) developed the Nigrescence model in which an individual moves from self-hatred to self-love by navigating through five stages: (a) preencounter, (b) encounter, (c), immersion-emersion, (d) internalization, and (e) internalization-commitment. Cross (1991) suggested that race becomes salient when an individual has a
traumatic, racially prejudicical experience that allows for a critical reexamination of what it means to be “black.” This takes place in the immersion-emersion stage. When an individual establishes a positive view of his or her race, he or she moves to the internalization stage. The final stage is reached when an individual takes on the commitment to fight against racism and elevate the status of African Americans. However, while Worrell (2008) found that adolescents reported higher scores on pre-encounter attitudes than emerging adults or adults, he also found no significant between-group differences in immersion-emersion and internalization scores, limiting support for a developmental interpretation of racial identity.

Garcia Coll et al. (1996) proposed an integrative model of child development for youth of color. In this model, the researchers identified social position, race, social class, ethnicity, and gender as core variables in the development of the person. Further expressed is the interplay between social position variables, such as racism, prejudice, discrimination, and oppression; segregation; promoting or inhibiting environments; adaptive cultural factors; characteristics of the individual; characteristics of the family; and developmental competencies regarding an individual’s development. Garcia Coll and her colleagues did not describe the pathway of interaction as a linear relationship; instead, it was described as a complex relationship with multiple pathways of influence.

As an individual enters early adolescence, ethnic identity is influenced primarily by one’s family (Phinney, 2006; Phinney & Ong, 2006) in a process that has often been described as racial socialization. Stevenson (1995) defined racial socialization as “a concept that describes the process of communicating messages and behaviors to children to bolster their sense of identity given the possibility and reality that their life experience may include racially hostile encounters”
(p. 51), and he indicated that racial socialization has been associated with identity exploration for adolescents.

The development of sexual identity is another important developmental phase, one that increases in importance during early adolescence. Sexual identity models have described the process through which an individual seeks congruence between his or her sexual orientation, sexual behaviors, and sexual identity (Rosario, Schrimshaw, Hunter, & Braun, 2006). Initially, sexual identity models consisted of developmental stages that individuals navigated as they sought to understand, accept, and integrate their sexual orientations. For example, Cass’ (1979) model of sexual identity development stated that gay and lesbian individuals may experience six stages during their identify formation:

1. Identity confusion, in which the individual first struggles with their sexual identity as he or she becomes aware of his or her gay or lesbian thoughts, feelings, and attractions;

2. Identity comparison, which is the initial acceptance of the possibility that an individual may be gay or lesbian;

3. Identity tolerance, which consists of an individual’s search for other members of the gay and lesbian community;

4. Identity acceptance, in which an individual establishes a positive connotation to his or her sexual identity.

5. Identity pride, in which an individual separates from the heterosexual community.

6. Identity synthesis, the final stage, in which an individual integrates his or her sexual identity into all other aspects of the self.

Although Cass (1979) suggested that sexual identity begins during puberty, researchers have found evidence that same-sex feelings can begin in childhood. For example, Whitam,
Daskalos, Soboleswski, and Padilla (1998) reported that over 40% of American lesbian respondents to their questionnaire indicated feeling sexually attracted to the same sex before age 9.

More recently, these developmental stage models have been criticized for being too narrow in scope and failing to explain the complex, ongoing process of sexual identity development. Horowitz and Newcomb’s (2001) multidimensional approach to sexual identity development attempted to explain the process by deconstructing sexual orientation into sexual desires, behaviors, and identity. This model took a social constructionist perspective, emphasizing an individual’s unique meanings for the three constructs of sexual orientation, created through social interactions in multiple social contexts. Horowitz and Newcomb (2001) supported the idea that homosexual identity is a continuum, ranging from heterosexual to gay or lesbian and incorporating bisexuality, and that it is navigated fluidly throughout one’s life.

Although researchers have suggested that biological factors such as genetics or prenatal hormones determine one’s sexual orientation at birth (Mustanski, Chivers, & Bailey, 2002), sexual identity development itself begins when an individual experiences confusion following after feeling a sexual attraction to a member of the same sex (Cass, 1979; Troiden, 1989). These feelings may be experienced first in early adolescence, and they may lead individuals to question their sexuality. Sexual questioning is the precursor to the sexual experimentation that begins to occur as an individual transitions into middle adolescence (Rosario et al., 2006).

Scholarly focus on the topic of transgender identity has dramatically increased over the past few years, with a notable decrease in the conceptualization of cross-gender identity as a dysfunction (Boskey, 2014). At the same time, transgender youth have an increased risk of experiencing emotional disorders and trauma (Roberts, Rosario, Corliss, Koenen, & Austin,
2012). Although the expression of a cross-gender identity has been seen in individuals as young as age 2 (Diamond, Pardo, & Butterworth, 2011), not all individuals who are gender dysphoric before adolescence maintain this identity throughout their life. Wallien and Cohen-Kettenis (2008) found that 50% of girls and 20% of boys remained gender dysphoric after puberty. This supports the notion that gender identity can be fluid and non-binary across the lifespan. As puberty occurs in early adolescence, transgender youth experience more stress than cisgender youth, however (Edwasds-Leeper & Spack, 2012). The physical changes that occur during this time period include, physically, changes to the apparent characteristics of gender like breast development in girls and increased muscularity in boys. Because of this, medication that postpones puberty has been utilized as an option for transgender youth. The benefits of this treatment include the need for less extensive gender transition surgery (Kreukels & Cohen-Kettenis, 2011). However, researchers like Sisk and Zehr (2005) have questioned the ability of pubescent to make an informed decision at that stage of development about this treatment option. Furthermore, Steensma, Biemond, de Boer, and Cohen-Kettenis (2011) noted that gender dysphoria can resolve naturally after puberty, raising further questions about the appropriateness of postponing puberty into early adolescents.

**Middle Adolescence.** During the transition from early adolescence to middle adolescence, external biological growth and development continue to be visually apparent while less apparent changes are occurring within the individual. Middle adolescence includes marked increases in hormonal activity, both to facilitate the changes occurring in puberty and to develop neural pathways (Sisk & Zehr, 2005). One result of this is an increase of sexual feelings that leads to early sexual experimentation, especially noncoital sexual behaviors such as engaging in sexual fantasies, masturbation, and “making out.” A further product of amplified hormonal
activity is increased emotionality (Geldard & Geldard, 2010). This increase in emotionality may lead an adolescent to encounter mood swings, increased anxiety, and depressed moods.

Additional developmental changes in middle adolescence occur in the brain. With the use of updated technology like magnetic resonance imaging (MRI), new insights into adolescent development have been made in the field of neurobiology (Yurgelun-Todd, 2007). Noticeable developmental maturation is seen in the prefrontal cortex and limbic brain regions, with resultant, vital improvements in emotional and cognitive abilities for the developing adolescent (Spear, 2000). As the prefrontal cortex develops throughout adolescence, improvements in abstract reasoning, attentional shifting, response inhibition, processing speed, affective modulation, and discrimination between emotional cues are seen (Yurgelun-Todd, 2007). This continued brain development parallels the changes occurring in Piaget’s (1948/1966) “formal operations” stage of cognitive development.

Adolescence is also a period of egocentric thinking, when individuals may consider themselves both unique and invulnerable (Elkind, 1967). This increased belief in their own omnipotence may lead adolescents to increase their risk-taking behaviors, which Spear (2000) and Steinberg (2008) identified as a common occurrence in adolescence. Due to the escalation of risk-taking difficulties in regulating affect and behaviors, middle adolescence is a period of increased vulnerability (Steinberg, 2005). Steinberg’s research (2005) further indicated that adolescents engage in risk-taking despite having some understanding of the consequences involved, leading him to hypothesize that risk-taking is related more to affective and behavioral regulation than to cognitive development.

Psychological development for a middle adolescent is primarily expressed as the development of one’s personal identity. Erikson’s (1968) theory of psychosocial development
stated that the primary crisis in adolescence, which begins at age 13, lay between developing one’s identity and preventing role confusion. Kroger (2004) further noted that other major developmental theorists – including Blos, Kohlberg, Loevinger, and Kegan – also identified developing a personal identity as the central task of adolescence. According to Adams and Marshall’s (1996) synthesis of research from multiple identity theorists, personal identity has the following five prominent functions:

1. Providing the structure for understanding who one is.
2. Providing meaning and direction through personal commitments, values, and goals.
3. Providing a sense of personal control and free will.
4. Enabling consistency, coherence, and harmony between values, beliefs, and commitments.
5. Enabling the recognition of potential through a sense of future possibilities and alternative choices. (p. 433)

Although Adams and Marshall (1996) noted that identity development was not limited to adolescence, they did agree that adolescence was the stage in the life cycle where this task was most pronounced.

As adolescents work through this stage of development, the process of individuation occurs. During individuation, an individual formalizes his or her personal identity and separates from parents and family. Adolescents then shift their social focus to developing peer relationships. The need to form close connections with like-minded individuals is salient within these relationships, and adolescents have strong expectations that their peers will be trustworthy and loyal (Geldard & Geldard, 2010). Spirito, Stark, Grace, and Stamoulis (1991) identified difficulties with peer relationships as a primary concern of adolescence.
Moral developmental transitions continue to be a foundational component of adolescence as one enters the middle stage. According to Kohlberg’s (1964, 1984) model of moral development, adolescents move from a period of conventional morality (stage two, ages 10-13 years) to postconventional morality (stage three: 13+ years). During this transition, they move beyond their culture’s laws and values and begin to develop their own conscience regarding the rights of humanity. Again, Gilligan (1977) suggested that women developed differently from men, with middle female adolescents moving from self-sacrifice and social conformity to the management of one’s needs and the needs of others, whereas adolescent males do not experience as much pressure to manage the needs of others. Both Kohlberg (1984) and Gilligan (1983) identified these as the final stages of moral development.

Consistent with the other areas of development in adolescence, middle adolescents begin to establish their spiritual identity. Through their newly developed cognitive skills, they are able to think beyond the spiritual understandings of their authority figures and insert their own understandings of spirituality into their beliefs (Fowler, 1981). For those adolescents struggling with identity formation, the appeal of unorthodox religious practices may increase (Geldard & Geldard, 2010). Eagan (1998) identified adolescents as at risk for involvement with religious cults due to their increases in curiosity and openness. Magaldi-Dopman and Park-Taylor (2013) highlighted the need for mental health professionals to be aware of the possible traumatic impact that religious cults can have on adolescents.

Middle adolescence is a period of increased ethnic identity exploration as well (French et al., 2006). As ethnic identity development continues into middle adolescence, increases in cognitive development during this stage allow youth of color to conceptualize themselves both as individuals of color and as part of a racial or ethnic group. Furthermore, adolescents in this stage
spend more time with their peers, which has been demonstrated to increase one’s sense of ethnic identity (Phinney, 1989).

Racial discrimination is another primary factor that influences racial and ethnic identity development during middle adolescence. The Nigrescence model suggests that encounters with racial discrimination prompt individual's to explore their racial identities (Cross, 1991). Parents also have the task of preparing their children to live in a world where discrimination is commonplace, and middle adolescents who have been prepared for this have shown increased levels of ethnic identity and more advanced skills for coping with discrimination (Phinney & Chavira, 1992; Umana-Taylor, Vargas-Chanes, Gracia, & Gonzales-Backen, 2008; Wills et al., 2007).

Similar to other developmental processes, sexual identity development continues into middle adolescence. Following initial feelings of sexual attraction towards a member of the same sex, lesbian, gay, and bisexual (LGB) individuals continue to develop their sexual identity as their sexual attractions and fantasies turn toward sexual activity. This transition from heterosexual to homosexual behaviors has been described as an individual’s attempt to eliminate dissonance between their newly forming identity and their behaviors (Higgins, 2002). Through this conflict, adolescents begin to formalize their identity as LGB individuals. Once their identity has formalized, LGB individuals may experience additional cognitive dissonance as they decide to make their new identity public through “coming out.” Often, this decision is complicated by ongoing experiences with heterosexism.

Because sexual identity development often occurs in a community of individuals who are dissimilar in sexual orientation, LGBT individuals may lack support or reinforcement for their experiences (Rosario et al., 2006). This lack of support often appears in the form of
heterosexism or in the negative attitudes and beliefs held against the LGBT community, colloquially referred to as homophobia. Szymanski, Kashubeck-West, and Meyer (2008) wrote that experiences with heterosexism inevitably lead to internalized heterosexism. At a minimum, theorists have suggested, internalized heterosexism can affect an LGBT individual’s physical, emotional, and relational health (Szymanski et al., 2008). Cass (1979) and Troiden (1989) further postulated that the experience of heterosexism leads LGBT individuals, often as they transition from middle to late adolescence, to withdraw from heterosexual society and to explore the lesbian, gay, bisexual, and transgender (LGBT) community.

**Late Adolescence.** As individuals enter the later stages of adolescence, they finalize many developmental tasks and prepare for adulthood. During this stage, physical growth slows to a halt and sexual maturation is achieved. Colarusso (1992) suggested that, as sexual development concludes, many individuals are both physiologically and psychologically prepared to engage in sexual intercourse. An estimated 50% of 9th-12th graders have had sexual intercourse (Center for Disease Control and Prevention [CDC], 2000).

Although Piaget (1948/1966) suggested that cognitive development peaks during early to middle adolescence with the expansion of formal operations, contemporary researchers have concluded that brain development continues into the late teen years (Paus, 2005; Steinberg, 2005). As Paus (2005) highlighted, researchers agree that there are continuous increases in white matter in the brain throughout this period of adolescence. Steinberg (2005) further stated that although performance in laboratory-based cognitive tests stagnates in early to middle adolescence, further maturation in one’s ability to control new formal operations does not occur until late adolescence. This development in regulatory systems mitigates middle adolescent risk-taking.
Psychological development during late adolescence focuses on cementing a formalized identity during a time of identity crisis; adolescence ends when one has a firm sense of inner identity (Erikson, 1968). Erikson (1968) emphasized that trusting oneself and others, identifying others and ideas in which to have faith, establishing free will, and developing a sense of one’s occupational future are all issues that must be navigated during identity development. Following this stage, individuals shift their focus from identity development to issues of love and intimacy as they approach early adulthood (Erikson, 1950). Those who are unable to formulize their identity may struggle to develop healthy relationships in early adulthood.

In addition to Erikson’s work on identity development during adolescence, Havighurst (1951) outlined the following nine developmental tasks that one must resolve before the end of adolescence in order to be well-adjusted:

1. Accepting one’s physique and sexual role.
2. Establishing new peer relationships with both sexes.
3. Achieving emotional independence from parents.
4. Selecting and preparing for an occupation.
5. Developing intellectual skills and concepts necessary for civic competence.
6. Achieving assurance of economic independence.
7. Acquiring socially responsible behavior patterns.
8. Preparing for marriage and family life.
9. Building conscious values that are harmonious with one’s environment. (p. 33-71)

Havighurst (1951) further noted that issues of culture and class affect the outcome of each task, establishing that the successful completion of each task is not homogeneous. Instead, once these tasks are completed, an individual encounters new tasks in early adulthood.
Comparable to the other developmental processes in this stage, spiritual development in late adolescence concludes with the crystallization of one’s spiritual, religious, atheist, or agnostic identities. Although their families and communities can be strong influences, late adolescents can differ significantly from their family of origin in their beliefs and values. In fact, religious conversion has been identified as most likely to occur in adolescence (Spika, Hood, Hunsberger, & Gorsuch, 2003). On the other hand, spiritual identity development can also be static. For instance, Juang and Syed (2008) stated that spiritual or religious identity can be inherently connected with one’s ethnic identity. Magaldi-Dopman and Park Taylor (2013) further stressed that ethnicities connected with nonmajority religious groups have been subjected to discrimination, especially in post-9/11 America. This may be seen primarily in the increase in anti-Muslim discrimination (Sheridan, 2006), but it is also evident in modern anti-Semitic and anti-Israeli attitudes (Cohen, Jussim, Harber, & Bhasin, 2009).

Individuals of color entering later adolescence have had experiences with racial socialization and racial discrimination, making race a salient part of their self-concepts. Those individuals who have a more centralized ethnic sense of self report an increased exploration of their ethnic identities and stronger connections with their ethnic groups (Kiang, Witkow, Baldelowmar, & Fuligni, 2010). This connectivity has been shown to increase during the transition from middle school to high school (French et al., 2006). Furthermore, the transition from high school to college that occurs for many in late adolescence and young adulthood has been identified as a time of increased ethnic identity awareness due to new experiences with diversity, scholarly activities, and social spheres that promote consideration of one's ethnic identity (Azmitia, Syed, & Radmacher, 2008). As late adolescence comes to an end, the ethnic
identity formation process expands into multiple, relevant domains (Azmitia et al., 2008; Syed, 2010).

Sexual identity formation in late adolescence includes exploration of an LGBT identity. During this time, LGBT individuals seek further connection with the LGBT community. If individuals experience positive involvement with the LGBT community (through personal contacts and dating relationships, for example), then they may be able to integrate their sexual identity into their overall identity, completing the final stage of the process (Cass, 1979; Troiden, 1989). By accepting their identity, LGBT individuals can begin to transform their negative attitudes toward their identities, and ultimately, decrease their internalized heterosexism (Rosario, Hunter, Maguen, Gwadz, & Smith, 2001).

Although sexual identity development has been expressed and supported in the research as a linear process, development on an individual level includes high variability (Rosario et al., 2006). Researchers have suggested that gay men, lesbians, and bisexuals, meanwhile, may develop differently (Diamond, 2003; Kitzinger & Wilkinson, 1995). Furthermore, since members of the LGBT community from different ethnic groups experience both racism and heterosexism, researchers have suggested that racial or ethnic identity development and sexual development occur concurrently but independently of each other (Jamil, Harper, & Fernandez, 2009). This high level of complexity suggests that continued research on adolescent sexual identity development is warranted.

Furthermore, there has been a dearth of research focusing on transgender youth in the LGBT literature. The transition from male to female or female to male is complex and, like other members of the LGBT community, transgender youth often experience discrimination in multiple settings (Grossman & D’Augelli, 2006). Their experiences with harassment and
violence have been documented, with significant discrimination occurring in schools and the community (Ryans & Rivers, 2003). Grossman and D’Augelli (2007) noted additional concerns, reporting that nearly half of their sample of transgender youth had contemplated suicide, with a quarter of the sample having attempted suicide. Grossman and D’Augelli (2007) reported that transgender youth cope by seeking helping individuals like counselors; however, they noted, there has been a lack of mental health professionals qualified to meet the needs of transgender youth.

**Adolescent Mental Health**

Adolescents experience distress at alarming rates, with estimates suggesting that one in five adolescents feel excessive distress (Knopf, Park, & Mulye, 2008). Further estimates suggest that one in ten adolescents has a diagnosable mental health condition (Burns et al., 1995; Kessler, Berglund, Demler, et al., 2005; Knopf, Park, & Mulye, 2008; U.S. Department of Health and Human Services [USDHHS], 1999). The Diagnostic and Statistical Manual 5 (DSM-5; APA, 2013) defines a mental disorder as

…a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An acceptable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and
society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (p. 20)

Furthermore, an etiological understanding of the development of psychopathology has been discussed extensively. According to the Surgeon General’s 2001 report on mental health concerns in children,

psychopathology in childhood arises from the complex, multilayered interactions of specific characteristics of the child (including biological, psychological, and genetic factors), his or her environment (including parent, sibling, and family relations, peer and neighborhood factors, school and community factors, and the larger social-cultural context), and the specific manner in which these factors interact with and shape each other over the course of development. (USDHHS, 1999, p. 1270)

Each adolescent’s unique individual and environmental features contribute to psychopathology, while the influence of childhood experiences such as abuse and neglect serve as additional risk factors.

To date, however, the discussion of psychopathology among adolescents has been inconsistent in its terminology. The DSM-5 (APA, 2013) categorizes mental health concerns as mental disorders, while the broader mental health community and the U. S. government use the term Serious Emotional Disturbance (SED). Both terms have been used to cover multiple diagnostic categories, including mood disorders, anxiety disorders, disruptive disorders, psychotic disorders, trauma-related disorders, and neurodevelopmental disorders. For the purpose of this study, the general term clinical mental health concern will be used synonymously
with mental disorders and SED. This language was selected to relate specifically to the concerns of the population that clinical mental health counselors serve.

**Emotional Disorders.** Emotional disorders generally include mental health conditions that have internalized symptoms, such as mood and anxiety disorders (Geldard & Geldard, 2010; Graber & Sontag, 2009). Although depression and anxiety are most often experienced internally, their symptoms can be expressed externally, with suicide as an extreme example. While emotional concerns are experienced throughout the life cycle, the stress and upheaval of adolescence makes adolescents more prone to both mood and anxiety disorders (Garber & Sontag, 2009). Adolescents with emotional disorders, meanwhile, often express their symptoms differently than children or adults.

**Mood Disorders.** Mood disorders are the primary clinical mental health concern that affect adolescents. Characterized by disturbances in emotion regulation, the American Psychiatric Association (2013) has listed major depressive disorder and dysthmic disorder as mood disorders. Bipolar disorder was previously included in this category, but it has been categorized recently as its own class of disorder, and disruptive mood dysregulation disorder has been added to the roster to combat the misdiagnosing of bipolar disorder in youth who have not exhibited distinct mood episodes (Roy, Lopes, & Klein, 2014). Although such significant changes have been made in the DSM-5 regarding mood disorders, the relevant literature has not yet fully addressed these changes. Therefore, the present review is limited in its ability to incorporate a discussion of the changes in the DSM-5.

Major depressive disorder and persistent depressive disorder (dysthymia) are both categorized as depressive disorders, with major depression more severe and acute and dysthmic disorder more chronic. In any given year, 8% of adolescents experience major depression
disorder (SAMHSA, 2009), whereas the prevalence of persistent depressive disorder in adolescents is estimated at 3% (Garrison et al., 1997). The average duration of major depression ranges from seven to nine months (Birmaher, Ryan, Williamson, Brent, Kaufman 1996, Birmaher, Ryan, Williamson, Brent, Kaufman, Dahl, et al., 1996) while the average duration of dysthymic disorder lasts approximately four years (Kovacs, Obrosky, Gastonis, & Richards, 1997).

With a few significant exceptions, depressive symptoms in adolescents mirror those in adults. Most notably, adolescent depressive disorders frequently manifest as irritability rather than sadness, as seen in adults (Brent & Birmaher, 2002; Hammen & Rudolph, 2003; Stanard, 2000; USDHHS, 1999). Furthermore, expressions of boredom, decreases in academic performance, and changes in sleep patterns may signify the presence of depression in an adolescent (Stanard 2000). Depressive disorders have been linked to substance abuse and disordered eating during childhood (Fleming & Offord, 1990). The risk factors for adolescent depression, meanwhile, have been identified as genetic, cognitive, and psychosocial in nature, with family dynamics and stressful life events highlighted as key influencers (Fristad, Shaver, & Holderle, 2002; Stanard, 2000; USDHHS, 1999). Effective treatment recommendations for adolescent depression have included cognitive behavioral therapy and pharmacological interventions (Fristad et al., 2002; Stanard, 2000; Weisz & Kazdin, 2010; USDHHS, 1999). Additionally, interpersonal therapy, family therapy, and psychoeducational programs are recommended as treatment options (Fristad et al., 2002; Stanard, 2000; Weisz & Kazdin, 2010).

Alternating episodes of depression and mania, meanwhile, often signify the presence of bipolar disorder in an individual. The prevalence of this disorder has been estimated at 1% to 3% of the general population (Merikangas et al., 2010), with over 60% of the adult bipolar
population reporting the symptoms in childhood (Perlis et al., 2004). However, bipolar disorder in adolescence, or early onset bipolar disorder, has been especially difficult to diagnose due to the challenge of identifying a clinical presentation of mania in young people (Bernstein, 2011; Birmaher, 2013). For this reason, Birmaher (2013) encouraged counselors, when applying DSM criteria for mania to adolescents, to ensure that the elevated state is beyond what is typical for adolescent development, is episodic in nature, is not accounted for by other disorders, is not environmentally or culturally influenced, and negatively affects daily functioning. Psychotropic treatments of bipolar disorder in adolescence have been widely utilized, with mood stabilizers, atypical antipsychotics, and anticonvulsants the most commonly prescribed medications (Bernstein, 2011). Bernstein (2011) also recommended the maintenance of a consistent sleep cycle and lifestyle.

Responding to the misdiagnosis of bipolar disorder in adolescents when chronic irritability was present without episodic mood changes, the DSM-5 included disruptive mood dysregulation disorder (DMDD), a previously unidentified depressive disorder common in the pediatric population (Roy, Lopes, & Klein, 2014). DMDD manifests as a chronic, severe irritability with accompanying temper outbursts. This new disorder has been estimated to affect from 0.8% to 3.3% of individuals under 18 years of age, with higher rates in young children (Copeland, Angold, Costello, & Egger, 2013). Copeland et al. (2013) also reported that individuals with DMDD may have increased rates of social impairment, school suspension, service use, and poverty. Due to the newness of the diagnosis, the literature base has yet to identify appropriate treatment guidelines. Still, Roy et al. (2014) suggested that psychotropic stimulants and cognitive behavioral therapy can be recommended due to their success at treating the overlapping symptomology of DMDD present in other mental health disorders.
Ethnic and cultural variations in mood disorder prevalence and expression have received scholarly attention, although findings have often been contradictory. Some studies identified no or minimal difference in prevalence or symptom expression (Brooks, Harris, Thrall, & Woods, 2002; Costello et al., 1996), while others found higher variability in prevalence among adolescents of ethnic minority groups. For instance, Roberts, Roberts, and Chen (1997) found that adolescents of Mexican descent had higher rates of depressive symptoms, with no significant differences noted among other ethnic groups. Similarly, Merikanga et al. (2010) found higher rates of mood disorders in Hispanic adolescents than in non-Hispanic White American adolescents. Suluja et al. (2004) found that Hispanic and Native American youth had higher depressive symptoms than White American youth, and that African American and Asian youth had lower prevalence rates than White American youth. In regards to symptom expression, Stein et al. (2010) observed higher rates of severe behavioral symptoms of depression in Hispanic and African American youth, while finding no reported differences by interviewees of different ethnic groups. The researchers cautioned that the implicit biases held by the primarily White American evaluators and cultural factors, such as guardedness towards authority figures on the part of the interviewees, may have led to cultural misinterpretations that would explain the higher rates of severe behavioral symptoms. Finally, Kennard, Stewart, Hughes, Patel, and Emslie (2006) found that ethnic differences in cognitive errors and depressive symptoms diminished when they controlled for parent education level in their regression model. They claimed that group differences may be more attributed to socioeconomic variables than ethnic background.

**Anxiety Disorders.** Anxiety disorders manifest as excessive worry, fear, and/or panic with accompanying behavioral disturbances related to specific contexts (APA, 2013). For
example, excessive anxiety related to separation from a loved one (separation anxiety), a specific object or situation (simple phobia), or social situations (social anxiety disorder) are all considered anxiety disorders (APA, 2013; Velting, Setzer, & Albano, 2002). When the symptoms of anxiety are present in multiple contexts, an individual is often diagnosed with generalized anxiety disorder (APA, 2013). Furthermore, anxiety that manifests as an intense episode of distressful physiological symptoms (palpitations, sweating, trembling, etc.) is called a panic attack, and it may signify the presence of a panic disorder (APA, 2013).

Prevalence studies of anxiety disorders have yielded mixed results. Previously, Costello et al. (1996) estimated that adolescents were more likely to experience pathological anxiety than all other mental health disorders combined. However, it was later discovered that prevalence rates vary depending on the time criteria applied. For instance, studies using a three-month assessment period have demonstrated prevalence rates as low as 2.2% while studies using lifetime assessment periods can yield results running as high as 27.0% (Costello, Egger, & Angold, 2004). Costello, Foley, and Angold (2006) also found that social phobia and panic disorders are most often first presented in adolescence, while other anxiety disorders, such as separation anxiety disorders and specific phobias, occur earlier in life. Gender differences have also been noted as a factor, with women found twice as likely to experience anxiety disorders by late adolescence than men (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003).

Because adolescence is marked by numerous stressful psychosocial and developmental transitions, anxiety during this developmental is considered normal. However, excessive anxiety has been described as pathological due to the distress and internal conflict it causes (Nazeer & Calles, 2012). Often, adolescents with pathological anxiety express their concerns as vague and unexplained physical symptoms or through avoidant behaviors such as school refusal (Nazeer &
Calles, 2012). Although symptoms of pathological anxiety often dissipate as an adolescent approaches adulthood, some adolescents suffering from anxiety develop panic disorders and major depression later in life (Pine, Cohen, Gurley, Brook, & Ma, 1998).

Treatment options for adolescents with anxiety disorders often begin with psychotherapy. Nazeer and Calles (2012), stating that providing psychoeducational information to family can lead to a more supportive day-to-day existence for the client, noted the importance of collaborating with the client’s parents and school staff when treating adolescents with anxiety disorders. Additionally, cognitive behavioral therapy has demonstrated efficacy treating childhood anxiety (Manassis, Mendlowitz, Scapillato, Avery, Fiksenbaum, Freire, et al., 2002). Although the benefits of cognitive behavioral therapy have been considered stable over time, up to 50% of childhood participants with anxiety disorders continue to experience symptoms of anxiety after receiving this form of therapy (Nevo & Manassis, 2009). For those individuals with moderate to severe anxiety, the use of pharmocotherapies, such as selective serotonin reuptake inhibitors (SRIs), is recommended (Nazeer & Calles, 2012).

Research examining cultural or racial differences among adolescents with anxiety disorders has been limited. As Alano, Chorpita, and Barlow (2003) pointed out, many clinical samples in anxiety research have been predominately White American. Still, the limited research has reported that cultural differences are found among the subcategories of anxiety disorders. For instance, Compton, Nelsen, and March (2000) found that White American youths reported more symptoms of social anxiety disorder than black youths, but Burstein, Bessdo-Baum, He, and Merikangas (2014) found no racial differences among adolescents with generalized anxiety disorder. McLaughlin, Hilt, and Nolan-Hoeksema (2007) explored differences between internalizing and externalizing symptoms among adolescents of different
racial groups, claiming that Hispanic adolescents and African American males reported the highest levels of anxiety. In their study, African American males reported the highest levels of physiologic anxiety, while Hispanic youths reported higher levels of separation anxiety. Still, McLaughlin et al. (2007) noted limitations with their study, including the fact that their measures were normed on the basis of White American adolescents and that they were unable to control for socioeconomic status. Additionally, their sample was predominately Hispanic, limiting their power to detect group differences among the other racial groups.

**Adolescent Trauma.** Historically, post-traumatic stress disorder (PTSD) has been categorized as an anxiety disorder, but the DSM-5 (APA, 2013) classified it into a new category called "trauma related disorders." For a diagnosis of this disorder, an individual must have experienced a traumatic event before the onset of symptoms, which include distressing thoughts, nightmares, flashbacks, and intense reactions to experiences that remind an individual of the trauma. Like other disorders, PTSD manifests among adolescents in unique ways. Although PTSD among adolescents has been studied in the context of natural disasters, substantial accidents, or war, typical adolescents living in western society generally do not experience these events (Milan, Zona, Acker, & Turcois-Cotto, 2013). More likely, adolescents will experience sexual abuse or exposure to violence. According to Finkelhor, Ormorod, Turner, and Hamby’s (2005) sample of 2,030 youths, 1 in 8 youths reported having experienced child maltreatment, 1 in 12 reported having experienced sexual victimization, and 1 in 3 had witnessed some form of violence. Hanson et al. (2008) found similar prevalence rates, but they noted significant gender differences, finding that girls were more likely to be sexually abused than boys (13.2% of girls versus 3.5% of boys), whereas boys were more likely to be physically abused (26.1% versus 18.8%) or to witness violence (44% versus 35.2%). Additionally, Milan, Zona, Acker, and
Turcois-Cotto (2013) found that African American adolescents had the highest rates of exposure to violence, followed by Latinos and White Americans. However, African American adolescents who had such violence exposure developed PTSD at a slightly lower rate than their counterparts.

**Adolescent Suicide.** Suicide is the third leading cause of death in individuals between the ages of 10 to 24 in the United States (Centers for Disease Control and Prevention [CDC], 2014), with rates elevating post-puberty until leveling off in early adulthood, and suicide can result from emotional disorders. Furthermore, the national Youth Risk Behavior Survey (Kann et al., 2014) reported that in the 12 months before the survey, 17% of participants had considered suicide, 13.6% had created a plan to attempt suicide, 8% had attempted suicide, and 2.7% had made a suicide attempt that required medical intervention. While female adolescents generally attempted suicide at higher rates than males (Kann et al., 2014), male adolescents completed suicide at rates 5 times higher than their female peers (CDC, 2014). Adolescent females used overdosing as the preferred method of suicide, and this has a lower degree of lethality than other methods of suicide, like firearms and hanging (Spirito & Esposito-Smythers, 2006). In 2014, Native Americans had the highest rate of suicide completion, while Asians and Pacific Islanders had the lowest rate (CDC, 2014). Furthermore, White American adolescents completed suicide at a higher rates than African Americans and Latinos (CDC, 2014). Other high-risk groups were identified as gay, lesbian, and bisexual adolescents, incarcerated adolescents, and homeless or runaway teens (Spirito & Esposito-Smythers, 2006). Depression, disruptive behaviors disorders, and substance abuse were all found to be contributing factors to increased suicidality (Spirito & Esposito-Smythers, 2006).
Disruptive Behavior Disorders. Disruptive behavior disorders are common occurrences in adolescence. Expressed externally, these disorders are categorized primarily by behavioral issues that are considered troublesome and antisocial (Geldard & Geldard, 2010). Although some increases in behavioral issues have been considered normal, a result of the developmental changes that occur in adolescents, instances that are more chronic and pervasive have been classified as disruptive behavior disorders (APA, 2013). Included in this category are attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and conduct disorder (CD).

Attention-Deficit/Hyperactivity Disorder. Polanczyk, de Lima, Horta, Biderman, and Rohde (2007) stated that 5% of children globally have ADHD, making it the most prevalent youth psychiatric diagnosis. Although symptoms usually begin before age 7, 78% of children with ADHD continue to meet the diagnostic criteria into adolescence (Barkley, Fischer, Edelbrock, & Smallish, 1990; Biedderman et al., 1996; Hart, Lahey, Loeber, Applegate, & Frick, 1995). Attention-deficit/hyperactivity disorder has been identified as a neurobehavioral developmental disorder, with the core symptoms of inattention, hyperactivity/impulsive behaviors, or disinhibition (Barkely, 2003). Adolescent ADHD generally manifests as inattention and impulsivity, with a noted reduction in the hyperactivity that is more pronounced in childhood (Robin, 2002). Furthermore, adolescents with ADHD are more likely to have academic and/or behavioral issues in school (Barkley et al., 1990) and to engage in risk-taking behaviors (Robin, 2002) than adolescents without ADHD.

Treatment options for adolescents with ADHD have been discussed widely, with the pharmacological treatment of ADHD with psychostimulants has widely been considered an effective and efficient option for symptom reduction, with a response rate of between 75% and
90% (USDHHS, 1999). However, psychostimulant use has received harsh media criticism, leading to unease about this option among the general public. Safer and Krager (1992) reported circumstantial evidence that psychostimulant use resulted in a significant reduction in negative response due to negative media publicity. Researchers have found instances of ADHD misdiagnosis and psychostimulant prescriptions when alternate treatment options were available, but Goldman, Genel, Bezman, and Slanetz (1998), in their comprehensive report on the treatment and diagnosis of ADHD, stated that there was little evidence to support this widespread concern regarding diagnoses or prescribing practices.

Nonpharmacological treatment options have been highlighted in the relevant literature as well. Behavioral interventions emphasizing parent and school involvement have been widely recommended (Erk, 1999; Fabiano & Pelman Jr., 2002; USDHHS, 1999), and psychoeducational interventions have also been considered critical. Further, Robin (2002) highlighted the importance of educating adolescents with ADHD to correct others' misconceptions about the disorder. Finally, cognitive behavioral therapy has been discussed as an option for addressing the symptomology of commonly cooccurring disorders such as oppositional defiant disorder, anxiety, and depression (USDHHS, 1999).

Meanwhile, the amount of research on ADHD using diverse subjects is relatively small (Gingerich, Turnock, Litfin, & Rosen, 1998). Furthermore, ADHD research has emphasized using preadolescent samples, making comparisons between age groups difficult (because ADHD symptoms tend to decrease as an individual ages). In addition, the available ADHD research conducted on diverse children is now antiquated. Langsdorf, Anderson, Walchter, Madrigal, and Juarez (1979), for instance, found that nearly 25% of African American children and 8% of Hispanic American children met their criteria for ADHD. Scholars such as Gingerich et al.
(1998) later explained the higher ADHD prevalence rates among these populations as resulting from stressful environments, citing the fact that disproportionate numbers of subjects from certain racial groups live in highly stressful environments, and that clinicians should fully understand their social milieu before diagnosing or treating clients. Mattox and Harder (2007) also encouraged clinicians to consider cultural aspects before delivering empirically supported interventions, like parent training, to their clients with ADHD.

**Oppositional Defiant Disorder and Conduct Disorder.** Among the disruptive behavior disorders, oppositional defiant disorder (ODD) and conduct disorder (CD) have been categorized together often, primarily due to their overlapping symptomologies. Both disorders involve patterns of noncompliant behaviors and social deviancy that exceed the typical emergence of oppositional behaviors related to the individualization process in adolescence (American Psychiatric Association, 2013). Fraser and Wray (2008) stated that it can be difficult to diagnose ODD accurately because the behavioral qualifiers are typically seen in most children and adolescents. The relationship between the two disorders has been described as hierarchical, with CD considered a severe form of ODD (Kann & Hanna, 2000). Atkins, McKay, Talbott, and Arvanitis (1996) explained that adolescents with CD typically have had early histories of ODD. Still, ODD and CD are distinct diagnoses in the DSM (American Psychiatric Association, 2013), and discriminating between the two requires a thorough understanding of their diagnostic criteria and behavioral indicators (Kann & Hanna, 2000). The most salient difference between the two is the presence of socially deviant behaviors that violate basic human rights, which occurs in CD (Baker, 2008). CD, meanwhile, has been considered a precursor to antisocial personality disorder (ASPD), with almost all cases of ASPD having met the criteria for CD in adolescence (Hinshaw & Lee, 2002).
Both ODD and CD have been considered prominent disorders in adolescence, although prevalence estimates for them have varied. Prevalence rates for ODD have been estimated at between 5% and 10% among children ages 8 to 16 (Fraser & Wray, 2008), while the prevalence rates for CD have been estimated at between 1% and 4% among children ages 9 to 17 (Shaffer et al., 1996). Gender differences have also been explored. For example, ODD has been diagnosed at a higher rate in prepubescent boys than in prepubescent girls, but prevalence rates tend to equalize after puberty (USDHHS, 1999). Furthermore, CD has been found to be more common in urban than in rural settings (USDHHS, 1999).

The effects of ODD and CD on an individual, a family, and a community are extensive and costly (Gould, Beals-Erickson, & Roberts, 2012; Huang et al., 2005). Armstrong, Dedrick, and Greenbaum (2003) found that youth with disruptive disorders were more likely to drop out of school, use illegal drugs, and be arrested than their counterparts without such disorders. In addition, Finger et al. (2011) linked ODD to higher rates of aggression and antisocial behavior, with some individuals displaying a significant lack of guilt, empathy, and remorse. With CD, higher injury rates, school expulsion, removal from the home, and sexually transmitted diseases have been reported as common (USDHHS, 1999).

The treatment of ODD and CD has been widely explored. In their metaanalysis of clinical trials of treatments for oppositional behaviors, Erford, Paul, Oncken, Kress, and Erford (2014) found that psychotherapy was only moderately effective at changing behaviors. In general, effective treatments utilized a systemic approach that often included the parents, the family, the school, and community agencies in the treatment. Many evidenced-based treatments have been developed to treat disruptive and antisocial behaviors, although many of these are limited to preadolescence. Multisystemic therapy (Henggeler, Schoenwald, Borduin, Rowland,
& Cunningham, 2009) is one evidence-based therapy developed to address severe antisocial behaviors in children and adolescents. Overall, early intervention in disruptive behavior disorders was considered paramount to their treatment.

Researchers have also explored CD and ODD in the context of racial diversity. For example, Byck, Bolland, Dick, Ashbeck, and Mustanski (2013) found that 7.7% of their sample of low-income, urban African American adolescents met the diagnostic criteria for CD. Moreover, Bird, Canino, Davies, Zhang, Ramirez, and Lahey (2001) found CD prevalence rates of 4.1%, 5.8%, 9.9%, and 5.4% and ODD prevalence rates of 3%, 9.6%, 9.1%, and 8% for island Puerto Ricans, mainland Hispanics, African Americans, and mainland non-Hispanic/non-African Americans, respectively. The authors of this study explained the lower prevalence rates of antisocial behaviors among island Puerto Ricans as resulting from the better relationships between children and their families that occur in Puerto Rico. Although this correlated relationship was identified in their logistical regression, the authors failed to acknowledge the effect that living in an oppressive culture, such as the United States, can have on an individual’s mental health for immigrants and minorities. In contrast, Tobler, Maldonado-Molina, Staras, O’Mara, Livingston, and Komro (2013) provided evidence for a link between discrimination and antisocial behaviors in their study, finding that those adolescents who experienced at least occasional discrimination were more likely to report antisocial behaviors and physical aggression.

**Psychotic Disorders.** Generally, psychotic disorders consist of a combination of symptoms including delusions, hallucinations, and disorganized speech and behavior. As with most mental health conditions, the symptoms of psychotic disorders manifest differently among adolescent populations than among adult populations. For example, hallucinations have been
found to be much more common in youth populations than delusions (Sikich, 2013), with prevalence rates ranging from 5% to 11% of adolescents 13 to 18 years old (Kelleher, Connor, et al., 2012). Furthermore, youth hallucinations have been described as multimodal in nature, combining auditory, visual, and tactile experiences (Remschmidt & Theisen, 2005). With auditory hallucinations, comments and commands have been reported more often than conversing voices (Sikich, 2013). For their part, psychotic delusions in adolescents were, in general, vaguer than adult delusions, and youth under age 16 usually did not develop the extremely complex delusions expressed among psychotic adults (Remschmidt, Schulz, Martin, Warnke, & Trott, 1994).

Although individuals with a wide range of clinical mental health concerns experience psychotic symptoms, early onset schizophrenia has been the primary psychotic disorder among adolescents. Typically, schizophrenia first presents in late adolescence or early adulthood, while early onset schizophrenia has been considered an extremely rare disorder. The actual accepted prevalence rate of early onset schizophrenia has been estimated at 0.04% (Driver, Gogtay, & Rapoport, 2013). Misdiagnosis of the condition, however, has been common, with up to 5% of otherwise healthy children expressing psychotic symptoms (Keller & Cannon, 2011) and 30% to 50% of individuals with affective or atypical psychotic symptoms being diagnosed with early onset schizophrenia (Gordon, Frazier, McKenna, et al., 1994).

The recommended treatment of psychotic conditions in adolescents has been the use of psychotropic medication along with psychosocial interventions (Asarnow & Asarnow, 2003; Volkmar & Tsatsanis, 2002). Although prescription medication has been readily utilized by psychiatrists, there have been few randomized trials demonstrating the efficacy of psychotropic medication in adolescents with schizophrenia. Instead, studies of adult populations, case studies
of adolescent populations, and clinical experiences inform the prescribing practices for this population (McDonnell & McClellan, 2007). Furthermore, potentially dangerous, long-term side effects have been a significant concern, suggesting a need for informed consent and close monitoring of psychotropic treatments (McClellan & Werry, 1997). Specialized school interventions, social skills training, case management, rehabilitation counseling, and family therapy have been the recommended psychosocial interventions (Asarnow & Asarnow, 2003). Additionally, integrated multimodal treatment involving the close coordination of various professionals has been considered essential to the treatment of early onset schizophrenia (Volkmar & Tsatsanis, 2002).

Research related to psychotic disorders among racially and ethnically diverse groups, predominately using adult samples, have found that the expression of schizophrenia symptoms varies by ethnicity. For example, White Americans with schizophrenia scored higher on severe excitement, a risk factor for aggression (Barrio et al., 2003). Furthermore, White Americans with schizophrenia have demonstrated more behavioral issues than African Americans and Hispanics (Brekke & Barrio, 1997; Fabrega, Mezzich, & Ulrich, 1988). Additionally, Hispanics have expressed more somatic symptoms than White Americans (Weisman, Lopez, Ventura, Nuechterlein, Goldstein, & Hwang, 2000). Specific to the concerns of Patel, Crismon, Shafer, De Leon, Lopez, and Lane (2006) found that symptom presentation and responses to antipsychotic treatment among diverse youth with schizophrenia were consistent with those of their adult counterparts. However, as in other studies involving diverse populations, Patel et al. (2006) noted that ethnocentric clinician biases may cause cultural misunderstandings, leading to the inaccurate diagnoses of their participants before they became part of the study.
**Other Clinical Mental Health Concerns in Adolescence.** In addition to the previously described mental health concerns, there are other concerns that affect a significant number of adolescents. Included in this discussion are nonsuicidal self-injury and eating disorders.

**Nonsuicidal Self-Injury.** Nonsuicidal self-injury (NSSI) has gained considerable attention in the mental health field recently. Defined as the “deliberate, immediate destruction of one’s own body tissue in the absence of conscious suicidal intent” (Lewis & Heath, 2015, p. 1), lifetime prevalence rates for NSSI have been estimated at between 14 and 24% (Jacobson & Gould, 2007; Muehlenkamp & Gutierrez, 2004), with peak onset occurring during adolescence (Ross & Heath, 2002). Scratching, cutting, head banging, and burning have been the most commonly reported NSSI methods (Jacobson & Gould, 2007). Additionally, NSSI has often been considered more prevalent among female adolescents (Lloyd-Richardson, Perrine, Dierker, & Kelly, 2007; Ross & Heath, 2002), but some studies do not report any gender differences (Laye-Gindhu & Schonert-Reichl, 2005). Although research regarding differences between ethnic groups in NSSI prevalence has been sparse, no such significant differences have been found in the research that has been conducted (Hilt, Nock, Loyd-Richardson, & Prinstein, 2008). Treatment recommendations for NSSI have consisted of thorough assessments, motivational enhancement strategies, cognitive and behavioral interventions, and skills training (Washburn et al., 2012).

**Eating Disorders.** Eating disorders have been a prevalent clinical adolescent mental health concern because they generally begin in adolescence. Both anorexia nervosa (AN) and bulimia nervosa (BN) have been identified in the DSM-5 (APA, 2013) as the predominant eating disorders, with a diagnosis of partial criteria met for either AN or BN, which is categorized under “eating disorder not otherwise specified,” as the most common eating disorder diagnosed in
adolescence (Gonzalez, Kohn, & Clarke, 2007). Early adolescents generally exhibit more symptoms of AN, while AN and BN generally present equally in older adolescents; adolescent females experienced eating disorders more than males (Kohn & Golden, 2001). Historically, eating disorders have been believed to be more prevalent in White American women (Hsu, 1990), but researchers have demonstrated, instead, that ethnic minorities are less likely to seek treatment for or be diagnosed with an eating disorder (Sinha & Warfa, 2013). Service recommendations for adolescent eating disorders have encouraged family involvement in treatment (Gonzalez, Kohn, & Clarke, 2007), and evidence-based treatments have been developed, with behavioral family systems therapy (BFST) and family-based treatment identified as treatment options (Robin & Le Grange, 2010).

**Adolescent Services**

The ways in which adolescents who have clinical mental health concerns access and utilize mental health services has been an established topic in the relevant literature over the past 15 years. Interventions are imperative in the treatment and management of severe and persistent clinical mental health concerns in an individual. Therefore, understanding adolescent help-seeking is necessary to ensuring that this population receives the necessary care. The literature has focused primarily on how adolescents seek help and the potential barriers to help seeking that they face. Models of adolescent help-seeking have also been presented. Furthermore, specialized services for adolescents with clinical mental health concerns have been researched and developed to address the population’s unique challenges. Since adolescents often require approaches outside of traditional outpatient counseling, modalities such as home-based family counseling (HBFC) and outdoor behavioral healthcare (OBH) have been identified as effective treatment options for the population.
Adolescent Help-Seeking. With the high prevalence of adolescent mental health concerns, one would expect this population to use mental health services extensively. On the contrary, mental health services in the United States are underutilized, which has been identified as, in itself, an alarming public health concern (Dubow et al., 1990; Gould et al., 2006). Although research in this area has been limited (Del Mauro & Williams, 2013), valuable information relevant to adolescent help-seeking practices, barriers to services, and help-seeking models have been reviewed.

The relevant research exploring the extent to which adolescents seek help for mental health concerns found that, overall, help-seeking increases as an adolescent ages, with older adolescents seeking more help from both formal and informal resources than younger adolescents (Schonert-Reichl & Muller, 1996; Windle et. al., 1991). Researchers have also stated that adolescents prefer to seek help from informal sources such as friends and family over professional helping sources such as counselors (Cheung & Liu, 2005; Dubow et al., 1990; Ocampo, Shelley, & Jaycox, 2007). As an adolescent matures, he or she will rely less on family or school support (Dubow et al., 1990).

Researchers have also explored demographic differences in help-seeking behaviors. Female adolescents, for example, are more willing to seek help from sources such as teachers, parents, friends, social services, and mental health professionals than are their male counterparts (Cheung & Liu, 2005; Schonert-Reichl & Muller, 1996). Additionally, McMiller and Weisz (1996) found that two-thirds of the minority parents in their study utilized natural supports, such as family members and community contacts, instead of seeking services from a mental health professional.
The reasons given for help-seeking have provided information related to adolescent mental health service utilization. In their mixed-methods study, Garland and Besinger (1996) reported that among their 33 adolescent participants, the primary reasons given for seeking services were family problems, school problems, anger, sexual abuse, and depression or suicide attempts, while the most common goal was to improve self-esteem. Participants also indicated that personal growth facilitated by the therapeutic relationship and the specific problem-solving strategies gained were both benefits of counseling, and, in general, they reported a high level of satisfaction with their counseling experiences (Garland & Besinger, 1996).

**Barriers to Service Utilization.** Despite the positive findings in Garland and Besinger’s (1996) report, many adolescents have not received adequate mental health treatment. It is important, for this reason, to understand the barriers that prevent them from accessing and completing treatment. Researchers have established that adolescents often forego mental health services even when they have self-perceived needs (Elliot & Larson, 2004; Kelin, McNulty, & Flatau, 1998; Zimmer-Gembeck, Alexander, & Nystrom, 1997). More specifically, Samargia, Saewyc, and Elliot (2006) reported that 57% of their sample of 878 adolescents (primarily White American 16-year-olds who were living in Saint Louis County, Minnesota) reported that they had foregone services at least once. Additionally, Cummings (2014) reported that only 14% of adolescents with depression had sought mental health services within the previous year of her study. Regarding race and ethnicity, Kodjo and Auinger (2004) found that, among emotionally distressed adolescents, blacks were significantly less likely to receive psychological counseling than their White American and Hispanic counterparts. However, in Barker and Adelman’s (1994) sample, low service utilization was noted among adolescents of Hispanic ethnicity, despite an apparent need for help. Finally, Gutterman et al. (2002) reported that adolescents who
had experienced physical victimization did not receive services at a higher rates than those who had not experienced such victimization.

Of those individuals who do participate in mental health treatment, researchers have estimated that 40-60% of children drop out of services directly after an initial assessment (Baruch, Vrouva, & Fearon, 2009; Miller, South-Gerow, & Allin Jr., 2008). The reasons for these early dropouts have been explored in the literature, and it has been found that older adolescents, adolescents of ethnic minority status, and adolescents with externalizing behaviors were most likely to drop out of services (Baruch, Vrouva, & Fearon, 2009; Frairs & Mellor, 2007; Ganz & Tendulkar, 2006; Westin, Barksdale, & Stephan, 2013). Furthermore, in their review of treatments for eating disorders, Hoste, Zaitsoff, Hewell, and le Grange (2007) observed higher dropout rates in single-parent families, indicating that families with fewer resources encountered more barriers to service.

At the same time, researchers have established many of the obstacles and service barriers encountered by adolescent clients and their families. On a macro level, Cummings (2014) reported, the socioeconomic status of the county in which the adolescents live may be a key correlate in help-seeking among depressed adolescents. The researcher showed that adolescents who live in poor counties that have relatively few mental health providers were less likely to receive mental health care. Additionally, Samargia, Saewyc, and Elliot (2006) found that both nonstructural and structural barriers to access lead to foregone mental health care. The two most common nonstructural barriers were described as “thought or hoped the problem would go away” and “didn’t want parents to know,” and the two most common structural access barriers were “didn’t know where to go” and “couldn’t pay.” Additional studies have indicated that parental perceptions that treatment is poorly organized, costly, or ineffective may lead to
treatment dropouts (McKay et al., 2004; Thompson, Bender, Lantry, & Flynn, 2007). Finally, Oruche, Downs, Holloway, Draucker, and Aalsma (2014) found that adolescents and their parents identified agency obstacles, negative interactions with staff, staff turnover, and utilization of medication as barriers to effective services.

**Models of Service Utilization.** Cauce et al. (2002) established that youth engage in three steps in the help-seeking process: a) problem recognition, b) decision to seek treatment, and c) service selection. Within each step of this model, additional factors influenced the decision-making process. Cauce et al. (2002) differentiated between an epidemiologically defined need and a perceived need within the problem recognition step, and the authors also established that the decision to seek help can either be a coercive or a voluntary process. In the final step of the model, the authors identified three avenues of service selection: informal supports (e.g., family, friends, etc.); collateral services (e.g., school counselors, juvenile justice, etc.); and formal mental health services (e.g., clinical mental counselors, psychiatrists, psychologists, and social workers).

In addition to Cauce et al.’s (2002) model, French, Reardon, and Smith (2003) created another model specific to how at-risk youth engaged in help-seeking. In their qualitative study, these researchers identified four themes that they used to develop their model, which explained the engagement of at-risk youth with mental health services. Making the individual the focal point of the process, this model especially highlighted the first theme: the uniqueness of each participant’s decision making and engagement process. French, Reardon, and Smith (2003) identified service attractiveness, accessibility, and follow up as three additional themes relevant to how at-risk youth engage in help-seeking.
For adolescent mental health service utilization, both the youth and his or her caregiver can be identified as the consumer of the service, with both having a role in determination of treatment. Macdonald, Lee, Geraghty, McCann, Mohay, & Brien (2007) created a developmental model that distinguished between the role of the young client and that of his or her caregiver, explaining that a young client’s role in the determination of services will increase as he or she develops. This model explained that young people between the ages of 12 and 17 have an increasing responsibility for their own treatment, and that the role of the parent, although paramount in childhood, decreases throughout adolescence and into young adulthood (Macdonald et al., 2007).

**Services Delivery for Adolescent Clients with Clinical Mental Health Concerns.**

Since adolescents with clinical mental health concerns require a different approach than other populations, specialized services have been necessary for successful counseling with this challenging population. Often, these services require a different setting and collaboration among multiple systems of care. The *system of care* approach to the treatment of children and adolescents with mental health concerns has been described as utilizing a coordinated network of services and supports designed to meet the diverse and changing needs of this population (Stroul & Friedman, 1996). Within this approach, it is necessary that services are offered within a multiagency, collaborative environment (UDHHS, 1999). Cook-Morales (2002) described this collaboration as taking place within the home-school-agency triangle, which consists of the client, the client’s family, and the various teachers, administrators, physicians, and other community agency professionals that work with the client. Furthermore, specialized treatment options, like residential treatment facilities, home-based family counseling (HBFC), or outdoor
behavioral healthcare (OBH), have all been discussed as potential treatment options for adolescents with clinical mental health concerns.

For adolescents with the most severe mental health concerns, treatment can be administered in psychiatric hospital settings or residential treatment centers. Both settings provide 24-hour mental health care and, generally, treatment to individuals with psychoses, antisocial behaviors, substance abuse, or issues of self-harm. Additionally, partial hospitalizations or day treatments have been used as treatment options, and these include periods of transition from more restrictive settings (USDHHS, 1999). Generally, these more intensive services involve psychiatric treatment, psychosocial education, and counseling.

Mental health clinicians use home-based family counseling (HBFC) to strengthen families when more intensive services are either unwarranted or unavailable or when preventing out-of-home placements is a treatment goal. HBFC, also described as multisystemic therapy or intensive in-home therapy, consists of intensive services within the client’s home (UUDHS, 1999). Stroul (1988) originally identified the three primary goals of home-based services as preserving the family by avoiding out-of-home placement, linking the patient and family with community resources, and developing a family’s coping strategies. Although HBFC has continued to increase in use and to develop in sophistication, the field has not yet been professionalized. Hammond and Czyszczon (2014), however, recommended that this socially just intervention receive adequate professionalization, including the adoption of training standards and guidelines for supervision.

Outdoor behavioral healthcare (OBH) is an additional mental health service that primarily serves the adolescent population. Often referred to as Wilderness Therapy or Adventure-Based Counseling, outdoor behavioral healthcare has become the preferred term due
to its connection with the Outdoor Behavioral Healthcare Council, a professional organization that has sought to regulate the specialized field (Bray, 2015). This therapeutic modality engages clients in outdoors setting while utilizing both traditional counseling techniques and adventure-based experiences (Davis-Berman & Berman, 1994). Adventure-based experiences have included ropes courses, rock climbing, hiking, camping, and kayaking. These experiences are then been translated to real life through a therapeutic dialogue called "processing" (Fletcher & Hinkle, 2002). Hill (2007) argued that mental health counselors should consider this treatment modality as an option for their clients due to its potential therapeutic benefits.

Training to Work with Child and Adolescent Mental Health Concerns

The need to specify training recommendations for working with children and adolescents who have clinical mental health concerns has been a germane discussion for decades. In 1978, the president of the APA section of Clinical Child Psychology, Paul Wohlford, acknowledging the ongoing debate concerning a potential shortage in the manpower required to meet the service needs of children and adolescents, encouraged clinical psychology and its related disciplines to provide more systematic and thorough training in order to meet this population’s needs. This sparked an upsurge in research surrounding training practices in clinical child psychology during the early 1980s, including program reviews (Mannarino & Fisher, 1982; Roberts, 1982; Tuma & Grabert, 1983) and surveys of clinicians (Tuma & Pratt, 1982). Overall, these studies found diverse training methods as well as inconsistencies between training and practice in the clinical child psychology field, and most scholars supported either specialized graduate training or postgraduate training as the best practice for preparing clinicians to work with child and adolescent populations.
Scholars who supported specialized training in clinical child psychology contended that such an early concentration was needed given the complexities involved in the specialty area. For example, Perry (1978) argued that training in the specialization of clinical child psychology was preferable to postdoctoral training due to the complexity of childhood functioning and concerns. She stated, a “developmental approach to problems is unique and not simply a downward extension of adult pathology and psychotherapy” (p. 677). She also held that it is necessary to have an understanding of family and other milieus in ways not typically considered in adult treatment.

Other research has provided support for the need for postgraduate training. For example, Goldman (1982) advised that specialty predoctoral programs in clinical child psychology may be impacted by competition with other emerging fields in psychology (e.g., geriatric and neuropsychology) and that postdoctoral certification should be supported better. Still, Goldman (1982) noted that adult-oriented and clinical child psychology programs both need specific clinical child development courses in order to ensure that generalist trainees are skilled adequately to address the full range of development into adolescence. Ollendick (1984) added that although specialty training has its merits, postdoctoral training and continued education to ensure that clinicians stay abreast of the field should not be discounted.

Following this initial proliferation of research, a period of relative inattention occurred until Pidano, Kurowski, and McEvoy (2010) revisited the subject by surveying the directors and staff of 29 clinical child psychology training programs about their methods of preparing graduates to work with youth populations. Pidano and Whitcomb’s (2012) study, in which they surveyed 227 psychologists and psychology doctoral students about their training related to youth populations, followed shortly thereafter. These two studies found that training in
psychology related to youth populations encompassed the various domains necessary to prepare graduates for working with this population and that graduates were well prepared to cope with the shortage of mental health services for children.

**Adolescent Populations in Counselor Education**

Research on the preparation of graduates for the field of counseling has been exceedingly limited, with only two journal articles identified. First, Mellin, Hunt, and Lorenz (2009) surveyed the faculty of 46 CORE-accredited rehabilitation counselor programs about the preparation of their graduates to work with youth with psychiatric disabilities. They found that, although the faculty indicated that this was a population of interest for their students, their graduates received minimal instruction or clinical experience related to the population. Mellin, Hunt, and Lorenz further found that the majority (58%) of the programs they surveyed identified their graduates as being only “somewhat prepared” to work with adolescents with psychiatric disabilities. They concluded that more attention to this topic was necessary.

Second, Mellin and Pertuit (2009) used the Delphi method to cultivate potential research topics related to youth populations with mental health concerns. By polling 12 counselor educators and 15 practicing counselors, the authors identified sample research questions in the areas of assessment, counselor characteristics, counselor training, family involvement, prevalence, prevention, systems issues, and treatment. From these research questions, Mellin and Pertuit (2009) discussed the implications for the counseling field related to professional development, research, and counselor preparation. For example, based on differences between the group of counselor educators and practicing counselors, the researchers suggested that when counselor educators prepare research studies, they should include practicing counselors to better align research and practice. Additionally, Mellin and Pertuit (2009) suggested that offering
coursework specializing in child and adolescent concerns was the most efficient method of counselor preparation, although they acknowledged that administrators may be reluctant to add such options to their curricula due to the extensive core requirements already included in their accredited programs. The researchers, therefore, recommended infusing youth-specific coursework into their core classes (Mellin & Pertuit, 2009). They determined that this direction of research was crucial to ensuring that the counseling field was meeting the needs of this population.

In 2010, The Association for Child and Adolescent Counseling (ACAC) was chartered to represent counselors who serve youth populations. (Shallcross, 2011). Although this group remains in its infancy, the development of the Journal of Child and Adolescent Counseling allowed it to begin disseminating research. Although the majority of related articles published to date have focused on play therapy interventions with children, some researchers have included or targeted adolescent populations in their studies.

The JCAC, for example, has published recent articles about adolescents that were both general to the population and specific to adolescent subgroups. Holliman and Foster (2016), for example, highlighted the importance of authenticity in adolescent counseling and provided case vignettes as practical examples and guidelines. More specifically, Perron and Pender (2015), demonstrated the importance of taking a trauma informed approach to counseling children and adolescents and discussed trauma assessment and treatment planning. Similarly, Balkin and Schmit (2016) offered the Crisis Stabilization Scale as a tool to help counselors evaluate and stabilize adolescents in crisis.

Furthermore, JCAC scholars have suggested specific treatment options for adolescent populations. For example, in his meta-analysis, Lenz (2015) found support for The Coping Cat
program as a treatment option for adolescents with severe anxiety. Additionally, Del Conte, Lenz, and Hollenbaugh (2016) evaluated the use of Dialectical Behavioral Therapy for adolescents being treated in a partial hospitalization setting and found notable improvements in coping, emotional regulation, and mindfulness among the participants.

**Conclusion**

With high prevalence rates of mental health concerns among adolescents (Commission, 2003; USDHHS, 1999) and shortages in mental health providers for this population (Huang, Macbeth, Dodge, & Jacobstein, 2004), adolescents with mental health concerns have been established as a group that requires targeted attention from the clinical mental health counseling community. It has been established in this literature review that adolescence is a unique developmental stage that requires a specialized knowledge base (Berzonsky, 2000; Hall, 1904; Lerner & Steinberg, 2009). It is a period of conversion that begins with a transition out of childhood and ends with a transition to adulthood. During this time, adolescents are faced with identity development in a multitude of areas, including ethnic identity development (Phinney, 1989), racial identity development (Cross, 1971), and sexual identity development (Cass, 1979).

Although adolescents in general are expected to experience a certain amount of distress during this tumultuous time, for many this distress reaches a clinically significant level. As seen in this literature review, adolescents frequently experience various internalizing and externalizing mental health disorders (Geldard & Geldard, 2010). These disorders are often atypical compared to similar disorders seen in adults—for example, depression in adolescents often manifests as irritability as opposed to sadness (Brent & Birmaher, 2002). Additionally, mental health disorders, such as ODD and CD, are not commonly diagnosed in adults (APA, 2013), requiring mental health counselors to have specialized knowledge and assessment skills to
identify them in adolescents. Further, other mental health concerns, such as eating disorders and nonsuicidal self-injury, are often associated with adolescence, and they require unique skills to treat (Gonzalez, Kohn, & Clarke, 2007; Ross & Heath, 2002). Overall, the literature demonstrates that mental health concerns in adolescence manifests differently than at other developmental stages, and those differences require clinical mental health counselors to have an appropriate scope of training.

Not only do the mental health concerns of adolescents differ from similar concerns at other developmental stages, but the way adolescents approach services differs as well. Adolescents, for example, are more likely to seek assistance as they age, and they are also more likely to use informal resources, like peers, than formal resources (Cheung & Liu, 2005; Dubow et al., 1990; Ocampo et al., 2007). Adolescents also seek services for unique reasons and encounter unique barriers to service utilization (Samargia, Saewyc, & Elliot, 2006; McKay et al., 2004; Thompson, Bender, Lantry, & Flynn, 2007; Oruche, Downs, Holloway, Draucker, & Aalsma, 2014). Given these issues, specialized models of service delivery have been developed to treat this population (UDHHS, 1999). Home-based family counseling and outdoor behavioral healthcare are two examples of this.

Because of these unique factors related to adolescent mental health concerns and services, mental health professionals have explored educational methods to train clinicians to meet the needs of the population. For example, in the field of psychology, researchers have developed training standards and surveyed programs to evaluate the level of training that their graduates are receiving (Pidano, Kurowski, & McEvoy, 2010). Researchers in psychology have even surveyed graduates about their perceptions of their training (Pidano & Whitcomb, 2012).
To keep pace with the broader mental health field, clinical mental health counselors need to be prepared adequately to work with adolescents. Although counselors have worked with adolescents historically, the literature base and professional identity development with regard to this population continues to increase. Indeed, Mellin and Pertuit (2009) have suggested that the profession as a whole make the preparation of counselors to work with youth populations a research priority. The present study, therefore, was designed to explore the training to work with adolescent populations that clinical mental health counselors receive.
CHAPTER III
METHODOLOGY

In Chapter Two, the literature review highlighted the uniqueness of adolescence in the life cycle. It also discussed the multiple clinical mental health concerns that occur during this stage of development and demonstrated that the field of counselor education needs further information on how it trains its graduates to work with the adolescent population. These findings support the purpose of the present study, which was to explore the extent to which clinical mental health counselors are trained to work with adolescents. This chapter outlines the research design and data analysis for the present study. Included in this chapter are discussions of the population studied, the sampling strategies, the survey instrument, the data collection procedure, and the data analysis.

Research Design

The present study will be conducted using survey research, which is appropriate in instances where the goal of a study was to describe a trend (Creswell, 2012). Since the purpose of the present study was to describe trends in the beliefs and experiences of clinical mental health counselors related to their educational and practical experiences with adolescent populations, survey research was appropriate for this research. The survey was cross-sectional in that the data were collected data at one point in time. Likewise, the purpose of this study was primarily descriptive, focusing on describing the current attitudes, beliefs, and practices of the individuals surveyed. The survey also allowed for the investigation of exploratory group comparisons. This investigation answered the following research questions:
Research Question 1

How are clinical mental health counselors prepared to work with adolescent populations in their coursework and internships?

Research Question 2

How do attending a CACREP accredited program, taking a specific course on counseling children and/or adolescents, and the level of content about adolescent counseling that a graduate counseling program infuses into its coursework affect the degree to which a student feels prepared to work with adolescents at internship, the amount of direct contact a student has with adolescents during internship, and the variety of presenting concerns among adolescents encountered during the internship?

Research Question 3

To what extent are graduates providing counseling to adolescents and receiving postgraduate training to work with this population, and what factors of graduate training predict the postgraduate development of expertise in counseling adolescent populations?

Participant Recruitment

The population for the present study consisted of mental health professionals who were members of the American Mental Health Counselors Association (AMHCA). AMHCA allowed access to their members’ e-mail addresses via INFOCUS Marketing, INC, and it was used to recruit participants for the present study.

AMHCA represents clinical mental health counselors, and its membership exceeds 7,000 individuals, with approximately 4,000 of these clinical members. Clinical memberships exclude associate (non-clinical), retired, and student members. Of these approximately 4,000 clinical members, 2,000 participants were randomly sampled from the AMHCA membership database by
selecting a third member. These selected potential participants were then sent a recruitment email (Appendix A) inviting them to participate in the study. The recruitment email consisted of an introduction to the study and a link to the informed consent document (Appendix B).

The informed consent document outlined the nature, purpose, and duration of the study, along with the conditions of participation. It also identified the risks and benefits related to participation and the procedure for completing the instrument. Finally, it discussed issues of confidentiality, and potential participants were informed that they could to refuse participation, stop their participation, or refuse to answer questions without any penalty. A link to the survey instrument was then provided, along with a statement that individuals who wished to participate in the study should access the link. Since potential participants were adults with graduate educations, accessing the link implied their understanding of informed consent and their desire to participate in the present study.

Instrumentation

In the review of the literature, two studies were identified as similar to the present study. In the first, Pidano and Whitcomb (2012) surveyed psychologists and psychology doctoral students on their training to work with child and adolescent populations. The second study, by Mellin, Hunt, and Lorenz (2009), questioned faculty of CORE-accredited rehabilitation counselor programs regarding the preparation of their graduates to work with youth with psychiatric disabilities. Both instruments were used as a model for the present study’s survey, which included questions modified for the counseling profession about program information and accreditation, coursework, and clinical experiences related to youth. Additional questions related to training experiences with specific mental health concerns, diverse adolescents, and postgraduate training were also included in the survey. The adaption process resulted in a 24-
item questionnaire (Appendix C) designed to explore the training that clinical mental health counselors receive in preparation to work with adolescent populations. The survey was divided into five sections: demographics, curricular content, practicum, internship, and professional experiences/current competencies.

Section 1 (items 1-7) of the questionnaire was created to obtain demographic and program information from each of the participants. Items 1-4 inquired about the individuals’ gender, race/ethnicity, age, and year they graduated with their degree. In items 5 and 6, the participants established the state in which their program was located and the program's concentration. In item 7, they reported on whether their program was accredited by CACREP.

Section 2 (items 8-9) obtained information about the participant's curricular coursework related to adolescent content. In item 8, the survey inquired into whether the participant’s program offered a specific course on children and adolescent counseling. For item 9, the participants indicated the degree to which the treatment of adolescent populations was covered in each of the eight CACREP core competencies: professional orientation and ethical practices, social and cultural diversity, human growth and development, career development, helping relationships, group work, assessment, and research and program evaluation.

The items in Section 3 (items 10-16) inquired into the participants' internships. In the first question (item 10), the setting of the experience was established. The next item consisted of a matrix with which the participants were able to indicate how often during their education experiences they had direct contact with individuals in early adolescence, individuals in middle adolescents, individuals in late adolescence, adolescents in a group setting, and adolescents from racial or ethnic minority groups. Participants were able to choose between never, rarely (>10%), sometimes (~30%), frequently (~50%), usually (~70%), and every time.
Item 12 consisted of a matrix in which participants reported whether they had direct contact, minimal direct contact, or no direct contact with adolescents who had the following issues: mental or emotional disorders, behavioral issues, developmental or social and cultural issues, bullying, and trauma/traumatic experiences. The questionnaire consisted of a branched item, where participants could identify the ethnic minority groups with whom they had direct contact in their practicums or internships and the racial ethnic group that was primarily served during the practicum or internship. Next, item 14 allowed participants to rate, on a 5-point Likert type scale (1=not at all satisfied to 5=extremely satisfied), their satisfaction with the training they received in their internships to work with adolescents. The final item in Section 3 was a text box for participants to provide additional information about their practicum/internship experience.

Section 4 (items 19-21) was similar to Section 3, but instead of evaluating the participants' educational experiences, this section asked about the participants' professional practices. First, item 16 established whether an individual was fully licensed as a professional counselor. Next, item 17 identified the type of training that the individual had received outside of graduate training, and item 18 established the participants' current employment settings. Items 19 and 20 were matrices in which participants could identify how often they had direct contact in their professional experiences with individuals in early adolescence, individuals in middle adolescents, individuals in late adolescence, adolescents in a group setting, and adolescents from racial or ethnic minority groups with the following mental health concerns: mental or emotional disorders, behavioral issues, psychotic disorder, suicidality, an eating disorder, and non-suicidal self-injury. Participants could select never, rarely (>10%), sometimes (~30%), frequently (~50%), usually (~70%), or every time. The final questions of Section 4 (items 21 and 22)
mirrored the question in Section 3, which identified the racial or ethnic groups with which the individual had contact.

Section 6 (item 22) contained a single matrix designed to assess the participants’ perceived level of competency in 18 domains identified from the list of clinical mental health counselor competencies in the CACREP 2009 standards (CACREP, 2008). Drawing from Roberts et al.'s (1998) definitions of competency, participants could rate themselves as having exposure (introduction to the topic area), experience (practice), or expertise (coursework and extensive experience in the subject) in each domain.

**Data Collection**

Potential participants were contacted once through email to be recruited for the present study. Data were collected and managed using REDCap (Research Electronic Data Capture) electronic data capture tools hosted at Western Michigan University. REDCap is a secure, web-based application designed to support data capture for research studies, providing a) an intuitive interface for validated data entry, b) audit trails for tracking data manipulation and export procedures, c) automated export procedures for seamless data downloads to common statistical packages, and d) procedures for importing data from external sources (Harris, Taylor, Thielke, Payne, Gonzalez, & Conde, 2009).

**Data Analysis**

The demographic and survey responses collected in REDCap were coded and analyzed in Statistical Analysis Software (SAS) version 9.4. These data were used to describe the survey participants and to assist in the identification of potential groups of comparison based on CACREP program attendance, having taken a specific course in counseling children and/or adolescents, and attending a program with a high level of infused adolescent content into the core
coursework. Data analysis consisted of calculating descriptive statistics drawn from the survey responses in order to develop a profile of the educational experiences that clinical mental health counselors have received to work with adolescent populations. Additionally, regression models were used to compare differences between the outcome measures and independent variables of training. A significance level of 0.05 was used for all statistical tests.

**Research Question 1.** How are clinical mental health counselors prepared to work with adolescent populations in their coursework and internships?

**Descriptive Statistics.** First, the responses to the following questions on specific coursework related to counseling youth populations were summarized (n and %): “Did your program offer a specific course focusing only on counseling children and/or adolescents?” (8), “Was it a requirement?” (8a.), and “Did you take it?” (8b.). Second, the responses to item 9 (“For each of the competency areas below, please indicate how well you feel that adolescent populations were covered by your program”) were summarized (n and %) for each of the eight core competency areas: Professional Orientation and Ethical Practice, Social and Cultural Diversity, Human Growth and Development, Career Development, Helping Relationships, Group Work, Assessment, and Research and Program Evaluation. Third, the responses for item 11 (“Please indicate how often you had direct contact with the following populations in your internship.”) were summarized (n and %) for the following populations: individuals in early adolescence, individuals in middle adolescence, individuals in late adolescence, adolescents in groups, and adolescents from racial/ethnic minority groups. Fourth, the responses to item 12 (“Please indicate whether you had direct contact with adolescents with the following mental health concerns in your internship.”) were summarized (n and %) for the following mental health concerns: Mental/emotional disorders, behavioral issues, developmental/social and cultural
issues, bullying, and trauma/traumatic experiences. Fifth, the results of item 13 ("What racial/ethnic groups were represented among the adolescents of whom you had face to face contact with during your practicum") were summarized (n and %) for the following groups: American Indian or Alaskan Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Pacific Islander, White American, and other. Finally, the results for item 14 ("How prepared from your training were you to work with adolescents in your internship?") were calculated. The five point Likert scale was collapsed into three categories not prepared, moderately prepared, and very prepared. New category responses were displayed (n and %).

**Research Question 2.** How do attending a CACREP accredited program, taking a specific course on counseling children and/or adolescents, and the level of content about adolescent counseling that a graduate counseling program infuses into its coursework affect the degree to which a student feels prepared to work with adolescents at internship, the amount of direct contact a student has with adolescents during internship, and the variety of presenting concerns among adolescents encountered during the internship?

**Inferential Statistics.** Three regression models were analyzed to answer Research Question 2. The outcome measures, predicative variables, and potential confounders are described in this section.

*Outcome Measures. Data for Perceived preparation for working with adolescent populations* was created from item 14 (“How prepared from your training were you to work with adolescents in your internship?”). The five-point Likert scale ranged from Not at all prepared to Extremely prepared, and it was coded from 1 to 5.

Data for *Direct contact with adolescent populations in internship* (see table 1) were created from item 11 (“Please indicate how often you had direct contact with the following
populations in your internship”) utilizing the responses to “individuals in early adolescence,” “individuals in middle adolescence,” and “individuals in late adolescence,” which were measured on a 6-point ordinal scale ranging from never to every time; the overall measure was the sum of the items, where never was coded as 1 and every time coded as 6.

Data for Presenting concern variability among adolescents seen in internship (see table 1) were created from item 12 (“Please indicate whether you had direct contact with adolescents with the following mental health concerns in your internship”) by utilizing the responses to the individual items, which were considered individually as ordinal variables. These items included the following mental health concerns: mental/emotional disorders, behavioral issues, developmental/social and cultural issues, bullying, and trauma/traumatic experiences. Possible responses to this item were on a three point ordinal scale with the options of direct contact, minimal direct contact, and no direct contact, which were coded from 3 to 1. The item also included the option to select I can’t remember, but those responses were excluded from the data.

Independent Variables. Research Question 2 had three independent variables. CACREP accreditation was a dichotomous variable created from item 7 (“Was your program CACREP accredited?”), whereas specific coursework in counseling children and/or adolescents was created from item 8b. (“Did you take the course?”). Responses to either variable indicating that the participant could not remember were excluded. The third variable was infused content (see table 1), and it was created from item 9 (“For each of the competency areas below, please indicate how well you feel that adolescent populations were covered by your program.”). The eight core areas were treated as individual ordinal variables, with possible responses including Satisfactorily covered, Not satisfactorily covered, and Not covered, which were coded from 3 to
1. The data for this variable was derived from the summation of these responses, with answers from those who selected that they could not remember being excluded.

**Confounding Variables.** There were four potential confounding variables in this study. Three of the variables were categorical, including *gender* (item 1, “How do you identify your gender?”) and *master’s degree concentration* (item 6, “What is the concentration of your Master’s degree?”). The third categorical variable, *race*, was created from item 2 (“How do you identify your race and ethnicity?”). Responses of “American Indian or Alaskan Native,” “Asian,” “Black or African American,” “Native Hawaiian or Pacific Islander,” “other,” and all participants who selected multiple categories were categorized as “non-White.” The fourth confounding variable was the continuous variable *years since graduation*. It was created from item 4 (“In what year did you earn your degree?”) by subtracting the response from 2016.

**Statistical Analysis.** The associations between the dependent variables (*perceived preparation for working with adolescent populations, direct contact with adolescent populations in internship, and presenting concern variability among adolescents seen in internship*) and the independent variables (*CACREP accreditation, specific coursework in counseling children and/or adolescents, and infused content*) were of interest in Research Question 2. Linear regression models were used to examine these relationships individually (Model 1) and collectively (Model 2). Additionally, the associations between these variables while adjusting for potential confounding variables (*gender, race, master’s degree concentration, and years since graduation*) were also investigated using linear regression (Model 3); the independent variables of interest least square means (SE) for each level of the categorical variable or beta-estimates (SE) for continuous variables are reported.
Research Question 3. To what extent are graduates providing counseling to adolescents and receiving postgraduate training to work with this population, and what factors of graduate training predict the postgraduate development of expertise in counseling adolescent populations?

**Descriptive Statistics.** First, the responses from item 17 (“What training specific to adolescent populations have you received outside of your graduate training?”) were displayed (n and %) for the following options: informal training at my place of employment, formalized training at my place of employment, informal training outside of my place of employment, formalized training outside of my place of employment, clinical supervision, ACA conference, AMHCA conference, other ACA/AMHCA affiliated conferences, or other. Participants could also select I have not received training related to adolescent populations. Next, responses to item 19 (“Please indicate how often you had direct contact with the following populations in your professional practice”) were summarized (n and %) for the following populations: individuals in early adolescence, individuals in middle adolescence, individuals in late adolescence, adolescents in groups, and adolescents from racial/ethnic minority groups. Then, the responses to item 20 (“Please indicate whether you had direct contact with adolescents with the following mental health concerns in your professional practice.”) were summarized (n and %) for the following mental health concerns: mental/emotional disorders, behavioral issues, developmental/social and cultural issues, bullying, and trauma/traumatic experiences. Next, the results from item 21 (“What racial/ethnic groups were represented among the adolescents of whom you had face to face contact with during your professional work time”) were summarized (n and %) for the following groups: American Indian or Alaskan Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Pacific Islander, White, and other. Finally, the domains of item 22 (“For the following knowledge domains, please indicate your current
level of expertise related to adolescent populations.”) were summarized (n and %). The domains included the following: individual psychotherapy interventions, family therapy, parent training, group therapy interventions, interagency collaboration, advocacy and public education, preventatives interventions, evidence-based practices, psychopharmacological interventions, clinical evaluations, personality and/or intellectual assessments, psychopathology, substance abuse, developmental models, case management and community resource utilization, risk assessment, mental health service delivery, and clinical supervision.

**Inferential Statistics.** There was one regression analysis examined to answer Research Question 3. The outcome measures, independent variables, potential confounders, and statistical analysis are described in this section.

**Outcome Measures.** The outcome measure for the variable *expertise in adolescent counseling* (see table 1) was used for the regression model in Research Question 3. It was created from item 22 (“For the following knowledge domains, please indicate your current level of expertise related to adolescent populations”) by treating each domain as an individual ordinal variable. Each variable was then coded from 1 to 3 for the following response options: exposure, experience, and expertise. The outcome measure was the sum of all 18 domains.

**Independent Variables.** The independent variables of *CACREP accreditation, specific coursework in counseling children and/or adolescents, and infused content*, as described in Research Question 2, were also used in Research Question 3.

**Potential Confounders.** The potential confounders of *gender, race, master’s degree concentration, and years since graduation*, as described for Research Question 2, were used in Research Question 3.
**Statistical Analysis.** The associations between the dependent variables (expertise in adolescent counseling) and the independent variables (CACREP accreditation, specific coursework in counseling children and/or adolescents, and infused content) were all of interest in Research Question 3. The same modeling as seen in Research Question 2 was utilized for Research Question 3, with the relationships explored both individually (Model 1) and collectively (Model 2). Again, the associations between these variables while adjusting for potential confounding variables (gender, race, master’s degree concentration, and years since graduation) was also investigated using linear regression analysis (Model 3); the independent variables of interest least square means (SE) for each level of the categorical variable or beta-estimates (SE) for continuous variables are reported.

Table 1

**Internal Consistency of Scaled Variables**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Cronbach-Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct contact with adolescent populations in internship</td>
<td>9.13</td>
<td>4.47</td>
<td>3</td>
<td>18</td>
<td>.883</td>
</tr>
<tr>
<td>Presenting concern variability among adolescents seen in internship</td>
<td>6.39</td>
<td>3.48</td>
<td>0</td>
<td>10</td>
<td>.908</td>
</tr>
<tr>
<td>Infused content</td>
<td>11.96</td>
<td>3.94</td>
<td>0</td>
<td>16</td>
<td>.856</td>
</tr>
<tr>
<td>Expertise in adolescent counseling</td>
<td>37.02</td>
<td>10.69</td>
<td>4</td>
<td>54</td>
<td>.916</td>
</tr>
</tbody>
</table>

**Conclusion**

The methodology and statistical procedures described above were used to survey recent graduates of counseling programs to determine the extent to which they have been prepared to work with adolescent populations. The survey results yielded a profile of the current training
that counselors receive and their perceptions of the quality of that training. The exploratory
groups identified in the study were compared for their differences and their level of postgraduate
training was reviewed. The results of the study are presented in the following chapter.
CHAPTER IV
PRESENTATION AND ANALYSIS OF DATA

The results of the present study are summarized in this chapter. With the purpose of surveying graduates of counseling programs to determine the extent to which they were prepared to work with adolescent populations, the data have been organized to answer the five research questions. Included in these research findings are a description of the demographic data of the study participants and a presentation and analysis of the research questions.

Demographic Data

Of the 2,000 individuals who were randomly sampled, 9.4% participated in the study. Specifically, the sample consisted of 188 clinical members of AMHCA who completed the self-administered questionnaire, with 155 completing the questionnaire and 33 not completing the questionnaire. The demographic characteristics examined were gender, race/ethnicity, age, graduation year, program region, program concentration, program accreditation, licensure status, setting of professional practice, and childhood experiences with counseling.

Gender. Of the 188 participants in the study, 172 identified their gender. There were 53 (30.8%) participants who identified as male, and 119 (69.2%) participants identified as female. No participants in this study specified a gender identity other than male or female.

Race/Ethnicity. Of the 173 participants who identified their race, 152 (87.%) identified their race/ethnicity solely as White. Of the remaining participants who identified their race, 5 (3%) identified as Black or African American, 4 (2.4%) identified as Hispanic or Latino, and 2 (1.2%) identified as Asian. Another 7 (4%) identified their race as other. Finally, 3 individuals identified as multiracial by selecting 2 of the race/ethnicity categories. Of those individuals, 2
(1.2%) identified as American Indian or Alaskan Native and White and 1 (0.6%) identified as Hispanic or Latino and White.

**Age.** A total of 162 participants identified their age. The mean age of the sample was 52.78 with a standard deviation of 13.8. The survey participants who identified their ages were categorized into three age groupings, with 52 (30.2%) between the ages of 26 and 45, 62 (36%) between 46 and 60, and 58 (33.4%) 61 or older.

**Graduation Year.** One hundred and sixty nine individuals identified the year in which they graduated. The mean graduation year was 1998.71, and there was a standard deviation of 10.91. The year of graduation was categorized into three groupings. Thirty four (20.12%) of the participants graduated in 2009 or later, whereas 50 participants (29.59%) graduated between 2000 and 2009. The majority, or 85 participants (50.30%), reported a graduation date before 2000.

**Program Region.** There were 159 participants who identified the state where they completed their master’s degree. These areas were categorized according to the five regions that make up the Association for Counselor Education and Supervision: the North Atlantic, North Central, Rocky Mountain, Southern, and Western regions. The majority of the sample came from 2 regions, with 84 participants (52.83%) graduating in the North Atlantic region and 60 (37.73%) graduating in the Southern region. The remainder of the participants graduated in the other three regions, with 11 (6.92%) participants graduating in the North Central region, 3 (1.89%) graduating in the Western region, and 1 (0.62%) graduating in the Rocky Mountain region.

Within the regions, the states with the highest respondents were Florida (27 participants, 17%), Massachusetts (25 participants, 15.7%), New York (20 participants, 12.58%), and New
Hampshire (17 participants, 10.69%). There were fewer than 10 participants in each of the remaining states, and 29 participants did not identify the state where they completed their master’s degree.

**Program Accreditation.** Of the 172 participants who answered the question concerning the accreditation status of their master’s programs, 84 (48.8%) reported that their master’s program was accredited by CACREP and 61 (35.5%) reported that their master’s program was not accredited by CACREP. Twenty-seven (15.7%) participants reported that they could not remember whether or not their program was CACREP accredited.

**Program Concentration.** Of the 170 participants who identified the program concentration of their master’s degree, 112 (66.7%) indicated that their master’s degree concentration was in Clinical Mental Health Counseling and 27 (16.1%) reported that their master’s degree concentration was in the closely related Community Counseling field. Additional concentrations included School Counseling (14 participants, 8.3%), Marriage and Family Counseling (6 participants, 3.6%), and College Counseling (2 participants, 1.2%). Finally, 28 (16.7%) selected “Other” regarding the concentration of their master’s program. The most commonly occurring program concentrations noted under the category of “Other” were rehabilitation counseling and some variation of psychology (i.e., clinical, counseling, general).
Licensure Status. Of the 160 participants who identified their current licensure status, 150 (93.8%) were fully licensed professional counselors and 10 (6.3%) reported that they were in the process of obtaining a counseling licensure to practice independently.

Internship Setting. Of the 169 participants who responded to the inquiry about internship setting, 121 (72.0%) reported that they had multiple settings for their placement. The majority \(N = 82, 47.6\%\) reported that they completed internship hours at a community agency. Following community agency in order of most selected were a school \(N = 27, 16.1\%\), hospital \(N = 27, 15.5\%\), private practice \(N = 20, 11.3\%\), university/college counseling center \(N = 18, 10.7\%\), day treatment facility \(N = 18, 10.1\%\), and residential facility \(N = 17, 9.5\%\). The category identified the least was a university managed training clinic \(N = 7, 4.2\%\).

Additionally, 19 participants \(11.3\%\) indicated that they had an internship site outside of the selection list (see Table 1).

Setting of Professional Practice. Of the 161 participants who identified the setting of their professional practice, 27 identified multiple settings (Table 2). Most participants in the sample identified a private practice \(N = 118, 73.3\%\) as at least one of their professional practice settings. After that, community agency \(N = 33, 20.5\%\), university/college counseling center \(N = 18, 11.2\%\), and school \(N = 15, 9.3\%\) were the three most frequently identified settings. No more than 5\% of participants in the sample identified a setting outside of the 4 settings previously discussed, and no participants identified as unemployed.
Table 2

*Frequency of Identified Internship and Professional Settings*

<table>
<thead>
<tr>
<th>Internship Settings</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community agency</td>
<td>82</td>
<td>48.5</td>
</tr>
<tr>
<td>School</td>
<td>27</td>
<td>16.0</td>
</tr>
<tr>
<td>Hospital</td>
<td>27</td>
<td>16.0</td>
</tr>
<tr>
<td>Private practice</td>
<td>20</td>
<td>11.8</td>
</tr>
<tr>
<td>University/college counseling center</td>
<td>18</td>
<td>10.7</td>
</tr>
<tr>
<td>Day treatment facility</td>
<td>18</td>
<td>10.7</td>
</tr>
<tr>
<td>Residential facility</td>
<td>17</td>
<td>10.1</td>
</tr>
<tr>
<td>University managed training clinic</td>
<td>7</td>
<td>4.1</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>11.2</td>
</tr>
</tbody>
</table>

Professional Settings
Table 2 - continued

<table>
<thead>
<tr>
<th>Location</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private practice</td>
<td>118</td>
<td>73.3</td>
</tr>
<tr>
<td>Community agency</td>
<td>33</td>
<td>20.5</td>
</tr>
<tr>
<td>University/college counseling center</td>
<td>18</td>
<td>11.2</td>
</tr>
<tr>
<td>School</td>
<td>15</td>
<td>9.3</td>
</tr>
<tr>
<td>Hospital</td>
<td>8</td>
<td>5.0</td>
</tr>
<tr>
<td>Residential facility</td>
<td>5</td>
<td>3.1</td>
</tr>
<tr>
<td>Day treatment facility</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>8.1</td>
</tr>
<tr>
<td>Unemployed</td>
<td>0</td>
<td>0.0</td>
</tr>
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</table>

**Presentation and Analysis of Data**

The purpose of this study was to explore trends related to the training that clinical mental health counselors receive before working with adolescent populations. More specifically, this study sought to report how many participants were offered a course in counseling children and/or adolescents and the degree to which their program infused adolescent content into the core coursework. Also of interest was how prepared the participants perceived themselves to be to
work with adolescents at the end of their internships, the degree to which participants had contact with adolescents in internship, and the kinds of presenting concerns that their adolescent clients exhibited. Finally, the scope of participants' postgraduate training to work with adolescents and the level of expertise on adolescents that the participants perceived themselves to have were also significant to the present study. The presentation and analysis of the present study’s data have been organized by research question, with each of the five research questions answered using the appropriate descriptive and multivariate statistics, which are presented in the following sections.

**Research Question 1.** How are clinical mental health counselors prepared to work with adolescent populations in their coursework and internships?

**Results.** The results for Research Question 1 are presented in the following section, which consists of a description of the outcomes of the survey pertaining to adolescence related coursework and internships in the participants’ graduate training. First, descriptive data for the degree to which participants took specific coursework related to counseling children and adolescents were gathered. This was followed by a description of the how much the participants’ programs infused adolescent content into the core coursework. Next, descriptive data for the populations and presenting concerns encountered during the participants' internships were presented. This section concludes with descriptive data showing the degree to which participants felt that they were prepared to work with adolescents at the end of their internships.

**Specific Courses on Counseling Children and/or Adolescents.** Participants were asked whether their master’s program offered a specific course that focused only on counseling children and/or adolescents, with 172 answering. Of those who responded, 99 (57.7%) reported that their program did offer a course; 58 (33.7%) reported that their program did not offer a course; and 15 (8.7%) reported that they could not remember. Of those participants who
reported that their program did offer such a course, 36 (20.9%) reported that the course was required by their program and 94 (54.65%) reported that they took the course.

*Infused Adolescent Content into Core Courses.* Participants reported on whether the adolescent population was satisfactorily covered in respect to each of the eight core CACREP competency areas. Respondents reported that work with adolescent populations was most satisfactorily infused with the Human Growth and Development, Professional Orientation and Ethical Practice, and Helping Relationships (see Table 3) areas. Furthermore, adolescent counseling content was notably lower in the remaining concentration areas, with the least coverage occurring in the Career Development and Research and Program Evaluation areas (see Table 3).

Table 3

*Perceived Level of Adolescent Content Infused in the CACREP Core Competency Areas*

<table>
<thead>
<tr>
<th>Satisfactorily Covered</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Human Growth and Development</td>
<td>149</td>
</tr>
<tr>
<td>Professional Orientation and Ethical Practice</td>
<td>121</td>
</tr>
<tr>
<td>Helping Relationships</td>
<td>116</td>
</tr>
<tr>
<td>Assessment</td>
<td>107</td>
</tr>
</tbody>
</table>
Table 3 - continued

Social and Cultural Diversity 101 60.1

Group Work 99 58.6

Career Development 92 55.0

Research and Program Evaluation 86 50.9

Adolescent Populations Served in Internship. As demonstrated in Table 4, the majority of the participants in this study had no or rare contact with early and middle adolescents. More participants had contact with late adolescents than early adolescents. Few indicated that they had direct contact only with early, middle, or late adolescents.

Table 4 shows the percentage of time that participants had contact with adolescents of racial or ethnic minority groups in their internships. In total, 22.3% (N = 37) of this study's participants indicated that they had no contact with adolescents from racial/ethnic minority groups, and the number of participants decreased as the percentage of time they had with racial/ethnic minority groups increased. The most common racial/ethnic group served in the internship (by the 152 participants who answered this question) was White adolescents, with nearly 90% of participants reporting that they had direct contact with adolescents of this group. Meanwhile, over 60% reported that they worked with African American or Hispanic/Latino adolescents. Few participants reported that they had direct contact with any other racial/ethnic group.
Further, as Table 4 demonstrates, the participants did not have many experiences with adolescents in groups during their internships, with 67 (40.6%) indicating that they had no group experiences with adolescents. Those that had group experiences with adolescents reported high levels of frequency, with 52 of them (31.5%) reporting that they had direct contact with adolescents in groups and 46 (27.9%) reporting that they had direct contact to a lesser degree.

Table 4 also shows that the most common presenting concern among the adolescents seen by participants in the course of their internships were mental/emotional disorders. Behavioral issues and trauma were also common presenting concerns that participants encountered. Less common were developmental/social and cultural issues and bullying.

Table 4

| Frequency of Direct Contact in Internship with Adolescent Populations and Presenting Concerns |
|-----------------------------------------------|-----------------|-----------------|-----------------|-----------------|
| Direct Contact | Minimal Direct Contact | No Direct Contact |
|----------------|-----------------|-----------------|-----------------|-----------------|
| N | % | N | % | N | % |
| Early adolescence | 63 | 38.2 | 51 | 30.9 | 51 | 30.9 |
| Middle adolescence | 62 | 38.0 | 55 | 33.7 | 46 | 28.2 |
| Late adolescents | 75 | 46.0 | 63 | 38.7 | 25 | 15.3 |
| Adolescent in groups | 52 | 31.5 | 46 | 27.9 | 67 | 40.6 |
| Mental/emotional disorder | 112 | 68.3 | 20 | 12.2 | 32 | 19.5 |
| Behavioral issues | 101 | 61.2 | 29 | 17.6 | 35 | 21.2 |
Table 4 - continued

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>%</th>
<th>Males</th>
<th>%</th>
<th>Females</th>
<th>%</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma/traumatic experiences</td>
<td>93</td>
<td>57.1</td>
<td>37</td>
<td>22.7</td>
<td>33</td>
<td>20.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental/social and cultural issues</td>
<td>71</td>
<td>43.0</td>
<td>49</td>
<td>29.7</td>
<td>45</td>
<td>27.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bullying</td>
<td>59</td>
<td>36.4</td>
<td>47</td>
<td>29.0</td>
<td>56</td>
<td>34.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Racial/ethnic minority groups</td>
<td>63</td>
<td>38.0</td>
<td>66</td>
<td>39.8</td>
<td>37</td>
<td>22.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>136</td>
<td>89.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>112</td>
<td>73.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>92</td>
<td>60.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>26</td>
<td>17.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>17</td>
<td>11.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>3</td>
<td>2.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>4.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Perceived Level of Preparation. Of the 160 participants who reported their perceived level of preparation to work with adolescents during their internships, 67 (42.4%) reported that they were not prepared to work with adolescents. Another 55 (34.8%) indicated that they were moderately prepared. Only 36 (22.8%) reported that they were very prepared to work with adolescents during their internships.
**Research Question 2.** How do attending a CACREP accredited program, taking a specific course on counseling children and/or adolescents, and the level of content about adolescent counseling that a graduate counseling program infuses into its coursework affect the degree to which a student feels prepared to work with adolescents at internship, the amount of direct contact a student has with adolescents during internship, and the variety of presenting concerns among adolescents encountered during the internship?

**Results.** The results for research question 2 are presented in the following section. First, a comparison of the perceived preparation rates by program accreditation status is presented, as well as whether an individual attended a specific course on counseling children and/or adolescents and the degree to which adolescent content was infused into the core content areas of their programs. This is followed by a comparison of the direct contact with adolescent rates by program accreditation status, whether an individual attended a specific course on counseling children and/or adolescents, and the degree to which adolescent content was infused into the core content areas of their programs. Finally, among program accreditation status groups, the variety of adolescent presenting concerns, specific courses on counseling children and/or adolescent attendance groups, and the degree to which adolescent content was infused into the core content areas of their program are discussed.

*Comparison of Perceived Preparation.* The independent variables of whether a participant attended a CACREP accredited program, whether an individual took a course in counseling children and/or adolescents, and the degree to which child and adolescent development content was infused into the core content of the program were used as predictors against the dependent variable of perceived preparation during internship to work with adolescents. In the first model, the independent variables were run separately against the
dependent variable; in the second model, they were run together. In the final model, the independent variables were run together with the control variables of gender, race, master’s degree concentration, and years since graduation applied.

When run independently in the first model, two of the predictors were found to be significant (see Table 5). A one-way between subjects ANOVA demonstrated that CACREP accreditation status did not have a significant effect on the degree to which individuals felt prepared to work with adolescents during internship \( F(1,132) = 0.19, p = .667 \), while there was a significant effect for those who took a course or courses on counseling children and/or adolescents \( F(1,151) = 10.55, p = .0014 \). Those who took a course felt more prepared to work with adolescents during their internships than those who did not. Similarly, a simple linear regression revealed that participants who had more infused content in their graduate program felt more prepared to work with adolescents in their internships \( F(1,157) = 29.66, p < .0001 \).

Furthermore, when run together in the second model, the overall results were found to be significant \( F(3,122) = 10.73, p < .0001 \), with the two variables remaining significant as well. Finally, the third model demonstrated that the addition of the control variables of gender, minority status, master’s degree concentration, and years since graduation suggested few adjustments. The overall multivariate ANCOVA remained significant \( F(7,118) = 4.89, p < .0001 \), and there were only slight changes in the significance of the predicting variables (see Table 5).
Table 5

*Multiple ANCOVA Models for Perceived Preparation to Work with Adolescents at Internship*

<table>
<thead>
<tr>
<th>Variables of Interest</th>
<th>Model I</th>
<th>Model II</th>
<th>Model III</th>
</tr>
</thead>
<tbody>
<tr>
<td>CACREP Accreditation</td>
<td>t(132) = -0.43</td>
<td>t(122) = -0.17</td>
<td>t(118) = -0.44</td>
</tr>
<tr>
<td></td>
<td>p = .667</td>
<td>p = .863</td>
<td>p = .664</td>
</tr>
<tr>
<td>Yes</td>
<td>2.81(0.13)</td>
<td>2.84 (0.12)</td>
<td>2.82 (0.13)</td>
</tr>
<tr>
<td>No</td>
<td>2.88(0.12)</td>
<td>2.87 (0.11)</td>
<td>2.89 (0.11)</td>
</tr>
<tr>
<td>Specific Coursework</td>
<td>t(151)) = 3.25</td>
<td>t(122) = 2.84</td>
<td>t(118) = 2.6</td>
</tr>
<tr>
<td></td>
<td>p = .0014</td>
<td>p = .005</td>
<td>p = .011</td>
</tr>
<tr>
<td>Yes</td>
<td>3.09 (0.11)</td>
<td>3.09 (0.11)</td>
<td>3.07 (0.11)</td>
</tr>
<tr>
<td>No</td>
<td>2.56 (0.13)</td>
<td>2.63 (0.12)</td>
<td>2.64 (0.12)</td>
</tr>
<tr>
<td>Infused content</td>
<td>t(157) = 5.45</td>
<td>t(122) = 4.62</td>
<td>t(118) = 4.46</td>
</tr>
<tr>
<td></td>
<td>p = &lt;.0001</td>
<td>p = &lt;.0001</td>
<td>p = &lt;.0001</td>
</tr>
<tr>
<td>B = 0.105 (0.019)</td>
<td>B = 0.096 (0.021)</td>
<td>B = 0.095 (0.02)</td>
<td></td>
</tr>
</tbody>
</table>

Note. The dichotomous variables of interest were presented with least squares means for each level. For continuous variables of interest, the beta-estimates (SE) were presented. Model 1 included the variables of interest run separately. Model 2 included the variables of Model 1 run together. Model 3 included the variables of Model 2 with the potential confounding variables: Gender, Race, Master’s concentration, and years since graduation.

*Comparison of Direct Contact with Adolescents in Internship.* The independent variables of a whether a participant attended a CACREP accredited program, whether an individual took a course in counseling children and/or adolescents, and the degree to which child and adolescent
content was infused into the core content of the program were run as predictors against the dependent variable of direct contact with adolescents during internship. In the first model, the independent variables were run separately against the dependent variable; and in the second model, they were run together. In the final model, the independent variables were run together with the control variables of gender, race, master’s degree concentration, and years since graduation.

The three independently run tests of the first model yielded two significant results on the amount of direct contact with adolescents in internship (see Table 6). First, the CACREP accreditation status of the participants' graduate programs did not have a significant effect on the dependent variable $[F(1,138) = 0.14, p = .708]$. Conversely, taking a course in counseling children or adolescents $[F(1,156) = 10.83, p = .001]$ and having a higher degree of infused adolescent content in the graduate program $[F(1,163) = 6.73, p = .01]$ led to higher rates of direct contact with adolescents during internship. When combined in the second model, the same variables were found to have a similar effect, and the overall model remained significant $[F(3,127) = 4.06, p = .009]$. Finally, adding the control variables of gender, minority status, master’s degree concentration, and years since graduation into a multivariate ANCOVA did not alter the results, with the results from the overall model remaining significant $[F(7,122) = 2.81, p = .01]$. In the final model, the control variable of gender was found to be significant, with male participants reporting more direct contact with adolescents than females.
Table 6  
*Multiple ANCOVA Models for the Degree of Direct Contact with Adolescents at Internship*

<table>
<thead>
<tr>
<th>Variables of Interest</th>
<th>Model I</th>
<th>Model II</th>
<th>Model III</th>
</tr>
</thead>
<tbody>
<tr>
<td>CACREP Accreditation</td>
<td>$t(138) = 0.37$</td>
<td>$t(127) = 0.23$</td>
<td>$t(122) = 0.35$</td>
</tr>
<tr>
<td></td>
<td>$p = .708$</td>
<td>$p = .818$</td>
<td>$p = .729$</td>
</tr>
<tr>
<td>Yes</td>
<td>$9.21 (0.60)$</td>
<td>$9.28 (0.59)$</td>
<td>$9.38 (0.59)$</td>
</tr>
<tr>
<td>No</td>
<td>$8.91 (0.50)$</td>
<td>$9.1 (0.51)$</td>
<td>$9.1 (0.51)$</td>
</tr>
<tr>
<td>Coursework</td>
<td>$t(156) = 3.29$</td>
<td>$t(127) = 2.56$</td>
<td>$t(122) = 2.36$</td>
</tr>
<tr>
<td></td>
<td>$p = .001$</td>
<td>$p = .012$</td>
<td>$p = .0197$</td>
</tr>
<tr>
<td>Yes</td>
<td>$10.29 (0.46)$</td>
<td>$10.18 (0.53)$</td>
<td>$10.15 (0.52)$</td>
</tr>
<tr>
<td>No</td>
<td>$7.99 (0.53)$</td>
<td>$8.2 (0.57)$</td>
<td>$8.33 (0.57)$</td>
</tr>
<tr>
<td>Infused content</td>
<td>$t(163) = 2.59$</td>
<td>$t(127) = 2.16$</td>
<td>$t(122) = 2.26$</td>
</tr>
<tr>
<td></td>
<td>$p = .01$</td>
<td>$p = .033$</td>
<td>$p = .026$</td>
</tr>
<tr>
<td></td>
<td>$B = 0.23 (0.09)$</td>
<td>$B = 0.21 (0.1)$</td>
<td>$B = 0.21 (0.1)$</td>
</tr>
</tbody>
</table>

Note. The dichotomous variables of interest were presented with least squares means for each level. For continuous variables of interest—the beta-estimates (SE)—were presented. Model 1 included the variables of interest run separately; Model 2 included the variables of Model 1 run together; and Model 3 included the variables of Model 2 with the potential confounding variables: Gender, Race, Master’s concentration, and years since graduation.

*Comparison of Adolescent Presenting Concern Variability in Internship.* Similar to the previous comparison, the three independent variables of whether a participant attended a CACREP accredited program, whether an individual took a course in counseling children and/or
adolescents, and the degree to which child and adolescent content was infused into the core content of the program were run as predictors against the dependent variable of variety of presenting concerns during internship (see Table 7). The first ANOVA showed a significant effect on the variety of mental health concerns seen in adolescents during internship for those who attended a CACREP accredited program and those that did not [$F(1,137) = 4.9, p = .029$], with those attending an accredited program encountering more variety. In the second ANOVA, it was found that those individuals who took a CACREP accredited course had more direct contact with a multitude of adolescent mental health concerns during their internships [$F(1,155) = 9.52, p = .002$]. Meanwhile, in the linear regression, a significant regression equation was found [$F(1,162) = 7.4, p = .007$]. A higher level of reported infused content in the training program predicted more variety of mental health concerns that were seen in adolescent clients during the participants’ internship. The second model demonstrated no significant changes to the $p$ values, with the overall results found significant [$F(1,126) = 6.87, p = .0003$]. Finally, adding the control variables of gender, minority status, master’s degree concentration, and years since graduation into the third model did not change the significance of the predicting variables, with the overall multivariate ANCOVA being found significant [$F(7,121) = 3.52, p = .002$]. Still, an unexpected significance was discovered for the control variable of gender, with male participants reporting more mental health concern diversity among their adolescent clients during their internships than female participants.
Table 7

Multiple ANCOVA Models for the Degree of Presenting Concern Variety among the Adolescents Counseled During Internship

<table>
<thead>
<tr>
<th>Variables of Interest</th>
<th>Model I</th>
<th>Model II</th>
<th>Model III</th>
</tr>
</thead>
<tbody>
<tr>
<td>CACREP</td>
<td>t(137) = 2.21</td>
<td>t(126) = 2.41</td>
<td>t(121) = 2.38</td>
</tr>
<tr>
<td></td>
<td>p = .029</td>
<td>p = .017</td>
<td>p = .019</td>
</tr>
<tr>
<td>Yes</td>
<td>7.16 (0.46)</td>
<td>7.25 (0.43)</td>
<td>7.31 (0.44)</td>
</tr>
<tr>
<td>No</td>
<td>5.83 (0.39)</td>
<td>5.85 (0.38)</td>
<td>5.90 (0.38)</td>
</tr>
<tr>
<td>Coursework</td>
<td>t(155) = 3.10</td>
<td>t(126) = 2.72</td>
<td>t(121) = 2.42</td>
</tr>
<tr>
<td></td>
<td>p = .002</td>
<td>p = .007</td>
<td>p = .017</td>
</tr>
<tr>
<td>Yes</td>
<td>7.21 (0.41)</td>
<td>7.33 (0.39)</td>
<td>7.31 (0.39)</td>
</tr>
<tr>
<td>No</td>
<td>5.54 (0.35)</td>
<td>5.76 (0.42)</td>
<td>5.91 (0.43)</td>
</tr>
<tr>
<td>Infused content</td>
<td>t(162) = 2.72</td>
<td>t(126) = 2.67</td>
<td>t(121) = 2.68</td>
</tr>
<tr>
<td></td>
<td>p = .007</td>
<td>p = .009</td>
<td>p = .009</td>
</tr>
<tr>
<td>B = 0.19 (0.07)</td>
<td>B = 0.19 (0.07)</td>
<td>B = 0.20 (0.07)</td>
<td></td>
</tr>
</tbody>
</table>

Note. The dichotomous variables of interest were presented with least squares means for each level. For continuous variables of interest, the beta-estimates (SE) were presented. Model 1 included the variables of interest run separately. Model 2 included the variables of Model 1 run together. Model 3 included the variables of Model 2 with the potential confounding variables: Gender, Race, Master’s concentration, and years since graduation.
Research Question 3. To what extent are graduates providing counseling to adolescents and receiving postgraduate training to work with this population, and what factors of graduate training predict the postgraduate development of expertise in counseling adolescent populations?

Results. The results of research question 3 are presented in the following section, which discusses the descriptive data of the professional training experiences of the participants. This is followed by a summary of the degree to which participants are counseling adolescent populations. Next, results for the perceived level of expertise among the participants are presented. This is followed by a comparison of the expertise rates by program accreditation status, whether an individual attended a specific course on counseling children and/or adolescents, and the degree to which adolescent content was infused into the core content areas of their specific programs.

Post-Graduate Training to Work with Adolescent Populations. As shown in Table 8, the most frequently identified forms of post-graduated training for working with adolescent populations among the 163 participants who responded were formalized training outside of the participants’ place of employment and clinical supervision. Additionally, more than 50% of participants indicated that they received informal training both inside and outside of their place of employment. Fewer than 30% of the participants reported that they had received training at ACA, AMHCA, or any other counselor affiliated conferences. Only 9 participants (5.4%) reported that they had no post-graduate training to work with adolescent populations.
<table>
<thead>
<tr>
<th>Training</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal training-outside place of employment</td>
<td>119</td>
<td>73.0</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>113</td>
<td>69.3</td>
</tr>
<tr>
<td>Informal training-outside place of employment</td>
<td>99</td>
<td>60.7</td>
</tr>
<tr>
<td>Informal training-place of employment</td>
<td>97</td>
<td>59.5</td>
</tr>
<tr>
<td>Formal training-place of employment</td>
<td>78</td>
<td>47.9</td>
</tr>
<tr>
<td>AMHCA conference</td>
<td>47</td>
<td>28.8</td>
</tr>
<tr>
<td>Other ACA/AMHCA affiliated conference</td>
<td>41</td>
<td>25.2</td>
</tr>
<tr>
<td>ACA conference</td>
<td>35</td>
<td>21.5</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
<td>17.8</td>
</tr>
<tr>
<td>No training</td>
<td>9</td>
<td>5.5</td>
</tr>
</tbody>
</table>
Adolescent Populations Served in Professional Practice. Table 9 shows the amount of
direct contact that the participants reported having in their professional practice. Participants
reported more contact with older adolescents than middle or younger adolescents. Regarding
racial/ethnic minorities, the highest frequency participants indicated that less than 10% of their
time was spent with these groups, and fewer than 5% of participants reported that all of their
direct service time was spent with adolescents from racial/ethnic minority groups. The majority
of participants reported that they had contact with White, African American, and Hispanic/Latino
adolescent clients (see Table 9). Less represented in their training experiences were Asian,
American Indian/Alaskan Native, and Native Hawaiian/Pacific Islander adolescent clients. As
Table 8 also shows, the participants did not report much time spent with adolescent groups. In
fact, over 50% of those surveyed indicated that they had spent no time with adolescents and only
23 (14.3%) participants had extensive direct contact with adolescents in groups.

Shown in Table 9 is the variability of presenting concerns that the participants saw in
their professional practice. Common concerns included emotional and behavioral disorders,
while non-suicidal self-injury and suicidality were fairly common. Psychotic disorders and
eating disorders were less frequently encountered. The majority of the counselors surveyed
reported that they experienced these presenting concerns in the adolescents that they served
approximately 10% of the time or less.
### Table 9

**Frequency of Direct Contact in Professional Practice with Adolescent Populations and Presenting Concerns**

<table>
<thead>
<tr>
<th>Presenting Concern</th>
<th>Direct Contact</th>
<th>Minimal Direct Contact</th>
<th>No Direct Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early adolescence</td>
<td>46 28.9%</td>
<td>78 49.1%</td>
<td>35 22.0%</td>
</tr>
<tr>
<td>Middle adolescence</td>
<td>57 35.8%</td>
<td>74 46.5%</td>
<td>28 17.6%</td>
</tr>
<tr>
<td>Late adolescents</td>
<td>72 45.0%</td>
<td>80 50.0%</td>
<td>8 5.00%</td>
</tr>
<tr>
<td>Adolescent in groups</td>
<td>23 14.3%</td>
<td>49 30.4%</td>
<td>89 55.3%</td>
</tr>
<tr>
<td>Mental/emotional disorder</td>
<td>93 58.1%</td>
<td>58 36.3%</td>
<td>9 5.6%</td>
</tr>
<tr>
<td>Behavioral issues</td>
<td>71 44.7%</td>
<td>74 46.5%</td>
<td>14 8.8%</td>
</tr>
<tr>
<td>Non-suicidal self-injury</td>
<td>33 20.6%</td>
<td>107 66.9%</td>
<td>20 12.5%</td>
</tr>
<tr>
<td>Suicidality</td>
<td>23 14.6%</td>
<td>110 69.6%</td>
<td>25 15.8%</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>8 5.0%</td>
<td>112 70.0%</td>
<td>40 25.0%</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>9 5.6%</td>
<td>87 54.4%</td>
<td>64 40.0%</td>
</tr>
</tbody>
</table>
Table 9 - continued

<table>
<thead>
<tr>
<th>Racial/ethnic minority groups</th>
<th>46</th>
<th>28.4</th>
<th>98</th>
<th>60.5</th>
<th>18</th>
<th>11.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>147</td>
<td>86.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>122</td>
<td>71.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>109</td>
<td>63.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>65</td>
<td>38.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>20</td>
<td>11.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>12</td>
<td>7.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>7.1</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Perceived Level Of Expertise Related To Adolescent Populations.* As shown in Table 10, most participants reported a level of expertise related to adolescent populations in the areas of individual psychotherapy interventions, risk assessment, and clinical evaluations. The fewest participants reported a level of expertise related to adolescent populations in the areas of psychopharmacological interventions, personality/intellectual assessments, advocacy and public education, and case management and community resources utilization. Finally, between 30% and 50% of this study's participants identified as experts in the other clinical domains.
Table 10

*Perceived Level of Expertise Related to Adolescent Populations*

<table>
<thead>
<tr>
<th>Service</th>
<th>Exposure N</th>
<th>N</th>
<th>Exposure %</th>
<th>Experience N</th>
<th>N</th>
<th>Experience %</th>
<th>Expertise N</th>
<th>N</th>
<th>Expertise %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual psychotherapy</td>
<td>9</td>
<td>50</td>
<td>32.68</td>
<td>94</td>
<td>61.44</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Risk assessment</td>
<td>12</td>
<td>53</td>
<td>34.87</td>
<td>87</td>
<td>57.24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical evaluations</td>
<td>17</td>
<td>51</td>
<td>33.77</td>
<td>83</td>
<td>54.97</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health service delivery</td>
<td>19</td>
<td>55</td>
<td>37.16</td>
<td>74</td>
<td>50.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-based interventions</td>
<td>17</td>
<td>61</td>
<td>40.94</td>
<td>71</td>
<td>47.65</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>29</td>
<td>49</td>
<td>34.03</td>
<td>66</td>
<td>45.83</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychopathology</td>
<td>25</td>
<td>63</td>
<td>41.72</td>
<td>63</td>
<td>41.72</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent training</td>
<td>32</td>
<td>55</td>
<td>36.91</td>
<td>62</td>
<td>41.61</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family therapy</td>
<td>27</td>
<td>61</td>
<td>40.94</td>
<td>61</td>
<td>40.94</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 10 - continued

<table>
<thead>
<tr>
<th>Service Type</th>
<th>N</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental models</td>
<td>27</td>
<td>18.37</td>
<td>61</td>
<td>41.5</td>
<td>59</td>
</tr>
<tr>
<td>Preventative interventions</td>
<td>24</td>
<td>16.11</td>
<td>69</td>
<td>46.31</td>
<td>56</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>28</td>
<td>18.54</td>
<td>68</td>
<td>45.03</td>
<td>55</td>
</tr>
<tr>
<td>Interagency collaboration</td>
<td>38</td>
<td>26.39</td>
<td>60</td>
<td>41.67</td>
<td>46</td>
</tr>
<tr>
<td>Group therapy</td>
<td>35</td>
<td>24.31</td>
<td>64</td>
<td>44.44</td>
<td>45</td>
</tr>
<tr>
<td>Case management</td>
<td>36</td>
<td>25.00</td>
<td>70</td>
<td>48.61</td>
<td>38</td>
</tr>
<tr>
<td>Advocacy/public education</td>
<td>48</td>
<td>33.57</td>
<td>59</td>
<td>41.26</td>
<td>36</td>
</tr>
<tr>
<td>Personality/intellectual</td>
<td>57</td>
<td>40.56</td>
<td>56</td>
<td>39.16</td>
<td>29</td>
</tr>
<tr>
<td>assessments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychopharmacological interventions</td>
<td>57</td>
<td>40.43</td>
<td>63</td>
<td>44.68</td>
<td>21</td>
</tr>
</tbody>
</table>

Comparison of Perceived Expertise to Work with Adolescents. The independent variables of a whether a participant attended a CACREP accredited program, whether an individual took a course in counseling children and/or adolescents, and the degree to which child and adolescent
content was infused into the core content of the program were used as predictors for the
dependent variable of adolescent counseling expertise (see Table 11). In the first model, the
independent variables were run separately against the dependent variable; in the second model,
they were run together. In the final model, the independent variables were run together with the
control variables of gender, race, master’s degree concentration, and years since graduation.

The first group of comparisons revealed only one statistically significant relationship
between these variable. There was no significant effect on the level of expertise of the
participants for those who attended a CACREP accredited program and those that did not \[ F \]
\( (1,131) = 0.46, p = .500 \] or related to the degree to which their training program infused
adolescent content into the core content areas \[ F(1,154) = 1.48, p = .226 \]. By contrast, there
was a significant effect on level of adolescent expertise for those who took the course and those
who did not \[ F (1,149) = 11.17, p = .001 \], with those individuals who took the course developing
more expertise than those who did not \[ F (3,122) = 3.8, p .012 \] and no changes to the
significance of the predictor variables. The third model was also significant \[ F (7,118) = 2.58, p \]
.0163], with those who took a course demonstrating a higher levels of expertise. As expected,
the number of years since graduation also had a significant effect, with individuals who had been
out of school longer having higher levels of expertise.

Table 11

*Multiple ANCOVA Models for Expertise to Work with Adolescents*

<table>
<thead>
<tr>
<th>Variables of Interest</th>
<th>Model I</th>
<th>Model II</th>
<th>Model III</th>
</tr>
</thead>
</table>

99
Table 11 - continued

<table>
<thead>
<tr>
<th>CACREP</th>
<th>t(131) = -0.68</th>
<th>t(122) = -0.99</th>
<th>t(118) = -0.62</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>p = .5</td>
<td>p = .322</td>
<td>p = .539</td>
</tr>
<tr>
<td>Yes</td>
<td>35.84 (1.48)</td>
<td>35.92 (1.4)</td>
<td>36.29 (1.41)</td>
</tr>
<tr>
<td>No</td>
<td>37.14 (1.24)</td>
<td>37.75 (1.2)</td>
<td>37.45 (1.21)</td>
</tr>
<tr>
<td>Coursework</td>
<td>t(149) = 3.34</td>
<td>t(122) = 3.12</td>
<td>t(118) = 3.17</td>
</tr>
<tr>
<td></td>
<td>p = .001</td>
<td>p = .002</td>
<td>p = .002</td>
</tr>
<tr>
<td>Yes</td>
<td>39.69 (1.07)</td>
<td>39.68 (1.22)</td>
<td>33.97 (1.36)</td>
</tr>
<tr>
<td>No</td>
<td>34.05 (1.3)</td>
<td>33.98 (1.37)</td>
<td>39.77 (1.22)</td>
</tr>
<tr>
<td>Infused content</td>
<td>t(154) = 1.21</td>
<td>t(122) = 0.65</td>
<td>t(118) = 1.13</td>
</tr>
<tr>
<td></td>
<td>p = .226</td>
<td>p = .515</td>
<td>p = .261</td>
</tr>
<tr>
<td></td>
<td>B = 0.25 (0.21)</td>
<td>B = 0.147 (0.23)</td>
<td>B = 0.26 (0.29)</td>
</tr>
</tbody>
</table>

Note. The dichotomous variables of interest were presented with least squares means for each level. For continuous variables of interest, the beta-estimates (SE) were presented. Model 1 included the variables of interest run separately, model 2 included the variables of Model 1 run together, and Model 3 included the variables of Model 2 with the potential confounding variables of Gender, Race, Master’s concentration, and years since graduation.
CHAPTER V

SUMMARY AND DISCUSSION

In this final chapter, the results of the present study are summarized and discussed. Following a final review of the problem statement, research design, and findings, this chapter highlights how the results of this research study will influence the counseling field by providing implications for both counselor preparation and counseling practice. In the conclusion of this chapter, the identified limitations of this study and recommendations for future research are discussed.

**Problem Statement**

The counseling of adolescents with clinical mental health concerns requires specialized preparation due to the unique factors present in the developmental stage and within the psychopathology of the group. Therefore, counselors need to adjust their service delivery to meet the particular needs of this unique population. Although the counseling field, historically, has encouraged the use of a developmental framework for working with clients, the CACREP 2016 standards do not require specific training for the counseling of adolescent populations (CACREP, 2015). This is problematic because of the high prevalence of clinical mental health concerns among adolescent populations (Commission, 2003; USDHHS, 1999) and current shortages of helping professions who work with this group (Huang, Macbeth, Dodge, & Jacobstein, 2004). For these reasons, the present study sought to collect baseline information on the preparation that clinical mental health counselors receive to work with adolescent populations.

For the present study, 188 clinical members of AMHCA completed a 24-item questionnaire survey. Potential participants were emailed information about the study and a link
to the survey. Data were collected in the REDCap application and statistical analysis was completed using the Statistical Analysis System. The statistical analysis included frequency distributions and multivariate modeling. The results of the analyses provided baseline data on the preparation of clinical mental health counselors to work with adolescent populations. The analysis also established implications for counselor preparation.

**Discussion**

Overall, the majority of the participants in this study reported having expertise related to adolescent populations in individual counseling, risk assessment, and clinical evaluation. However, the majority of participants reported having no expertise in interagency collaboration, case management, or mental health service delivery, which were all fundamental principles of youth counseling identified in the Surgeon General’s seminal report on mental health in the United States (USDHHS, 1999) and were all core aspects of clinical mental health counseling identified in the CACREP 2016 standards (CACREP, 2015). Equally noteworthy was the finding that more than a third of participants reported a lack of expertise in preventative interventions or advocacy/public education, which is important because several scholars (e.g. Cheung & Liu, 2005; Dubow et al., 1990; Ocampo et al., 2007) have acknowledged that proactive interventions are crucial to working with adolescent children and their families. Clearly, this is an area requiring further investigation.

Similarly, the counselors surveyed in this study did not feel adequately prepared to work with adolescents in their internships even though majority of the participants had direct contact with adolescents in both their internships and in their professional practice. Given that adolescents are a vulnerable population with unique needs, this finding should not be overlooked. Without adequate training and expertise, counselors could be violating the ACA
Code of Ethics (2014) by operating outside of their scope of practice and, more concerning, they could be providing an ineffective service or doing unintended harm to young clients. Further, Mellin (2009) indicated that adolescents who do not receive adequate services are likely to experience negative effects in school performance, juvenile delinquency, and substance use. Incompetent service could also result in missed risk factors, leading to suicide or homicide, which are the second and third most common causes of death among young people (CDC, 2016).

The most distinct findings were found in the multivariate analysis. Specifically, those who took specific coursework about children and adolescents or those who had more infused adolescent content in their counseling core coursework felt more prepared to work with adolescents in their internships. It was also found that those individuals who took a counseling youth course reported higher levels of adolescent counseling expertise, whereas having more infused content did not have an effect. Even with this strong evidence of the benefits of taking specific coursework, fewer than 60% of participants attended a program that offered specific coursework on counseling adolescents and only 20% of the programs required this coursework.

It is also important to acknowledge that counselors in this study who took a course in counseling children or adolescents during their graduate programs or who had a high degree of infused adolescent content in their core counseling coursework had higher rates of direct contact with adolescents in their internships. These individuals also encountered a greater variety of mental health concerns in their internships. However, it is possible that participants who took specific coursework were already interested or developed an interest in youth populations and, therefore, sought internship experiences where they could counsel adolescents.

However, closer examination of the level of infused content uncovered discrepancies between those core areas that had high levels of infused content and those that did not. Overall,
the participants did report high levels of infused content in the core courses, with the strongest infusion occurring in the areas of Human Growth and Development, Professional Orientation and Ethical Practice, and Helping Relationships. Still, there were core areas in which the participants reported less infused content. The areas of Social and Cultural Diversity, Career Counseling, Assessment, Group Work, and Research and Program Evaluation were found to be less infused into course content than the other core courses. This is a concern because these courses have unique components relevant to adolescent populations that are likely to be encountered in a clinical mental health counselor’s internship (e.g., group counseling with youth and addressing multicultural concerns with young clients). Furthermore, the majority (almost 60%) of participants reported minimal to no direct contact with adolescents in group counseling, which means that counselors may be facilitating these specialized groups with little-to-no training.

Of those variables considered potentially influential on training outcomes, CACREP accreditation status was found to have the least impact. For example, those who attended a CACREP accredited program did not report higher levels of perceived preparation to work with adolescents in their internships or higher levels of postgraduate expertise in counseling adolescents. In fact, CACREP accreditation status was found to influence only the variety of presenting concerns seen among the adolescents encountered in the internships (e.g., emotional or behavioral disorders), with those counselors who attended a CACREP program reporting more encounters with youth with emotional or behavioral disorders. This may be the result of clinical mental health programs requiring their students to complete their internships in mental health facilities.
Although this was a notable finding, the overall lack of impact attributable to CACREP accreditation was surprising, especially with the ACA Governing Council having recently voted to endorse CACREP as the accrediting body for counselors (Duffy, 2016). If CACREP will be responsible for future training in the counseling profession, then it will need to ensure that counselors are trained adequately to meet the needs of all their clients, including children and adolescents. However, specific phases of the lifecycle, like adolescence, were not addressed in either the 2009 or the 2016 CACREP standards (CACREP, 2009, 2015). In other words, CACREP neglected a phase of the lifecycle at which one in ten individuals has a severe mental health concern (Burns et al., 1995; Kessler, Berglund, Demler, et al., 2005; Knopf, Park, & Mulye, 2008; U.S. Department of Health and Human Services [USDHHS], 1999), and they have not prioritized addressing the shortages in mental health professionals who are specifically prepared to work with this population that were identified by Huang, Macbeth, Dodge, and Jacobstein (2004). Perhaps more specific language in the standards or requiring counselor trainees to take a course in counseling children and adolescents would provide some of the needed focus on this vulnerable population.

Exploration of the infused content identified a notable finding related to the training that the participants received that was relevant to adolescent social and cultural diversity. For example, two-thirds of the participants reported that adolescent populations were adequately covered in their Social and Cultural Diversity coursework, and a large majority of participants had some direct contact with adolescents from racial/ethnic minority groups. Yet, many participants noted that they did not address cultural issues in their practicum or internship experiences. It should be rudimentary that when a counselor is working with an individual from a racial/ethnic minority group that cultural issues are acknowledged, so this finding could
indicate a lack of counselor training or preparation in multicultural counseling in general and with children of color in particular. This should alarm counselor educators given the importance of multicultural competencies to the counseling field. Since Multicultural Counseling Competencies have been central to the counseling field since their inception (Sue, Arredondo, and McDavis, 1992) over 20 years ago and since they continue to be relevant to the counseling field, with AMCD developing their competencies by integrating social justice into the framework (Ratts, Singh, Nassar-Mcmillan, Butler, & McCullough, 2016). As the necessary multicultural competencies increase in complexity, the training that counselors receive in this area is paramount. Still, Smith, Ng, Brinson, and Mityagin (2008) reported that more research is needed for counselor trainees and practicing counselors in the areas of evidence-based practice and training. Although the counseling field has made multicultural development a priority, the findings of the present study suggest that clinical mental health counselors may not be comprehending cornerstone concepts.

Finally, it was reassuring that the majority of the participants reported having postgraduate training to work with youth populations, including both formal and informal training and clinical supervision. However, most of this training was done outside of the ACA profession. Specifically, many participants had not attended ACA conferences, including an AMHCA conference. This is of serious concern since clinical mental health counselors are being trained to work with adolescents by other professional organizations, which could compromise identity counselors. The counseling profession has placed a strong emphasis on maintaining its professional identity, especially the identity of counselors who work with children and adolescents, by chartering the ACAC to promote research and counseling services (Shallcross, 2011). Hopefully, the ACAC will be able to increase the training options at ACA
affiliated conferences by promoting educational content specific to child and adolescent populations.

**Implications**

The present study revealed important findings that have important implications for the counseling profession. These implications were most closely related to the areas of counselor education training and postgraduate training and practice.

**Counselor Education Training.** The present study demonstrated that counselor educators should address those counseling domains where the participants reported lower levels of expertise. It was clear that the participants were more confident about their ability to provide routine individual therapy to adolescent clients; however, adolescents with more complex mental health concerns require more sophisticated approaches. Counselor educators should include coursework in their programs on the counseling domains to allow their graduates to operate within the system of care, including case management, interagency collaboration, and advocacy/preventative interventions.

Further, counselor education programs should explore their methods of disseminating content related to adolescent counseling throughout their curricular offerings. Specific coursework and infused content were both shown to have merits, but specific coursework did yield higher levels of reported expertise among the participants. Counseling programs should, at least, offer a specific course in counseling youth populations. Requiring such a course, infusing adolescent content across the core courses, and including experiences with adolescents in internships would ensure that counseling program graduates are competent to work with adolescents after graduation.
Also highlighted in the present study was the lack of impact that CACREP accreditation had on the participants’ curricular experiences and that it did not influence the development of an expertise in counseling children and adolescents. Recognizing the importance of programs preparing counseling graduates to work with adolescent populations, CACREP should focus on measures to address this concern. First, CACREP could add more specific language to the next edition of their training standards mandating that programs require curricular experiences with more individuals across the lifespan, in particular with adolescents. It could be recommended that programs infuse adolescent content into their coursework but, more importantly, CACREP could have programs require specific coursework in counseling children and adolescents. As seen in the present study, taking specific coursework improved participants' perceived preparation to work with adolescents, increased their direct contact with adolescents at internship, and ultimately led to higher rates of reported expertise in adolescent counseling.

Additionally, counselor education programs should be aware of possible deficiencies in their training specific to diversity issues among adolescents. Again, the present study demonstrated some confusion among the participants as to how social and cultural issues impacted adolescents from ethnic and cultural minority groups. Counselor education programs should ensure, therefore, that their graduates understand that social and cultural issues affect all individuals from minority groups and that this understanding should be integrated into a counselor's practice. This message should be infused throughout the curricular experiences of a counselor education program.

Postgraduate Practice and Training. Practicing counselors should be mindful of their approach to counseling adolescent clients. The present study demonstrated that clinical mental health counselors feel more confident with traditional counseling interventions like individual
psychotherapy and risk assessment. Unfortunately, individual psychotherapy is the customary approach to counseling adults, and Lawrence and Kurpius (2000) warned about simply providing adult interventions with youth populations. Adolescent populations, especially those with clinical mental health concerns, require a system of care approach, with the counselor intervening at multiple levels. Practicing mental health counselors, thus, should be linking with other agencies, providing family inventions, and engaging in preventative measures. Further, expert adolescent counselors should be knowledgeable of multiple service delivery settings and models, including evidenced-based practices.

Since the majority of the participants in this study reported that they had not attended ACA, AMHCA, or other affiliated training specific to youth populations, it is evident that the counseling profession needs to increase postgraduate training opportunities in this area. Both ACA and AMCHA could increase the number of youth trainings at their yearly conferences and offer smaller, more frequent trainings over a wider range of geographic regions. Additionally, the ACAC could expand its presence in the ACA. The ACAC was created to give child and adolescent counselors a home in the counseling profession, and its mission includes providing professional development opportunities (Ray, 2015). Since the ACAC is a newer ACA association, its impact should increase as it develops. In the end, the counseling profession needs to ensure that counselors receive postgraduate training in youth populations from counseling organizations to ensure that this counselor identity remains strong.

While a strong identity remains paramount in the counseling field, its importance is miniscule in comparison to the counseling profession’s ability to address a societal problem and/or tragedy. Whether it is the tragic deaths of Megan Meier and Rebecca Sedwick or the unfortunate events that took place at Sandy Hook Elementary School, counselors often encounter
opportunities to intervene. As a result, counselor education programs must produce graduates who can work effectively with children and adolescents and who will develop a level of expertise during their professional career. The ACA (2014) Code of Ethics states that a core professional value of the counseling profession is “enhancing human development throughout the lifespan.” (p. 3). The profession needs to ensure that adolescents are included in this statement.

**Limitations**

As found in any research study, the present study had limitations. For example, the research instrument did not receive rigorous examination of its reliability and validity since it was crafted from two survey instruments that had been used in published studies. Additionally, participants could have responded to the study multiple times, although the statistical analysis sought to eliminate this by looking for surveys that had similar answers.

Another limitation was related to the generalizability of the sample. Since the study only included clinical members of AMHCA, any clinical mental health counselor who was not a member was excluded. Further, only half of the clinical members of AMHCA were emailed the survey, and less than 10% completed the survey. Some members may have had invalid or unused emails registered in the AMCHA database. Additionally, subgroups within AMHCA were not overtly represented, as the sample was predominately White, female, over the age of 40, and had completed their training in the northeast or southern regions. The predominately east coast sample provided further limitations to generalizability, because licensure requirements can vary between states.

Finally, the study was limited in that the research was, fundamentally, based on the self-report of the participants. In survey research, the study will always be limited by the potential
for participants to report inaccurately. For example, social desirability can influence a participant to represent their qualities inaccurately because they want to be perceived in a more positive manner.

**Recommendations for Future Research**

There are multiple recommendations for future research to emerge from this study. First, the influence that specific coursework and infused content have on counseling graduates needs further attention. There was an identified inconsistency related to the influence that infusing adolescent content into the core courses had on the participants’ training and development of expertise. A qualitative study to explore the contextual data related to how graduate students experience infused content could address these inconsistencies. Additionally, the present study highlighted the positive influence that a specific youth counseling course had on the participants. However, only about 20% of the participants attended a program that required specific coursework on this topic. A survey of graduate programs directors that includes questions about the barriers preventing graduate programs from offering this specific coursework could explain why only about half of programs have offered specialized curricula.

Additionally, the lack of impact that CACREP accreditation had on the participants warrants further exploration. By more closely examining where the deficiencies are in the CACREP programs, researcher could offer more specific recommendations. Also, additional research focusing on other unique populations along the life cycle could strengthen the argument for CACREP including more specific standards related to lifespan in their next revision.

Further studies to explore the potential shortages in training related to social and cultural diversity could be beneficial as well. A study to explore how counselors perceive social and cultural issues among diverse adolescents might highlight inaccuracies that could be addressed in
training. Furthermore, the development of an evidenced-based social and cultural curriculum could ensure that graduates will develop and retain the important aspects of social and cultural diversity.

Finally, the lack of attendance at ACA affiliated trainings needs to be addressed. A study to clarify why the participants did not attend ACA affiliated trainings on adolescents could lead to a better understanding of what the counseling profession needs to do to ensure a strong professional identity among adolescent counselors. Additionally, a qualitative study to further understand how adolescent counselors understand counselor identity could lead to valuable information that could be utilized in future ACA affiliated trainings.
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U.S. Department of Health and Human


Appendix A

Recruitment Email
Dear Counseling Professional,

My name is Brian Russ and I am a doctoral student from the Counselor Education and Counseling Psychology department at Western Michigan University. I am writing to invite you to participate in my research study about the training experiences of clinical mental health counselors to work with adolescent populations. You're eligible to be in this study because you are clinical member of the American Mental Health Counselor Association (AMHCA). I obtained your contact information from the AMHCA contact database.

If you decide to participate in this study, you will be asked to complete a 31 question survey that takes 15 to 20 minutes. The survey will ask questions about your graduate training and professional practice regarding adolescent populations.

Remember, this is completely voluntary. You can choose to be in the study or not. If you'd like to participate or have any questions about the study, please click on the link below.

Thank you very much.

Sincerely,

Brian R. Russ  
Doctoral Candidate  
Western Michigan University
Appendix B

Informed Consent
Informed Consent

Please read this consent information before you begin the survey.

You are invited to participate in a research project entitled “Counselor Preparation and Adolescent Youth: A Study of Clinical Mental Health Counselors” designed to explore the training experiences that clinical mental health counselors receive to work with adolescent populations. The study is being conducted by Dr. Carla Adkison-Johnson and Brian R. Russ from Western Michigan University, Department of Counselor Education and Counseling Psychology. This research is being conducted as part of the dissertation requirements for Brian R. Russ.

This survey is comprised of 31 multiple selection questions and will take approximately 15-20 minutes to complete. Your replies will be completely anonymous. When you begin the survey, you are consenting to participate in the study. If you do not agree to participate in this research project simply exit now. If, after beginning the survey, you decide that you do not wish to continue, you may stop at any time. You may choose to not answer any question for any reason. If you have any questions prior to or during the study, you may contact Dr. Carla Adkison-Johnson at 269-387-3504 or carla.adkison-johnson@wmich.edu, Brian R. Russ at 616-901-3630 or brian.r.russ@wmich.edu, the Human Subjects Institutional Review Board (269-387-8293) or the vice president for research (269-387-8298).

This study was approved by the Western Michigan University Human Subjects Institutional review Board (HSIRB) on (date). Please do not participate in this study after (one year after approval).

Participating in this survey online indicates your consent for use of the answers you supply.
Appendix C

Survey Instrument
Survey

Directions:
You will be asked for some basic information about your training experiences related to adolescent youth. Please answer each question as accurately as possible. You will be allowed to go back to previous pages and change your responses and you will also be able to complete a portion of the survey, save it, and return to it later if you like.

Section 1: General Information:

1. How do you identify your gender:
   - Male
   - Female
   - Other, (please specify)____________________________________

2. How do you identify your race or ethnicity? (select all that apply)
   - American Indian or Alaskan Native
   - Asian
   - Black or African American
   - Hispanic or Latino
   - Native Hawaiian or Pacific Islander
   - White
   - Other, (please specify)____________________________________

3. How old are you?
   - 25 or less
   - 26-30
   - 31-35
   - 36-40
   - 41-45
   - 46-50
   - 51-55
   - 56-60
   - 61-65
   - 66-70
   - 71-75
   - 76 or older

4. In what year did you earn your degree? (please specify)______________

5. In what state/province was your program completed? (please specify)______________
6. What was the concentration of your Master’s degree (select all that apply)?
   - Clinical Mental Health Counseling
   - Community Counseling
   - School Counseling
   - Marriage and Family
   - College Counseling
   - Other (Please explain)________________________

7. Was your program CACREP accredited?
   - Yes
   - No
   - I can’t remember

Section 2: Please answer the following questions related to your master’s program.

8. Did your program offer a specific course focusing only on counseling children and/or adolescents?
   - Yes
   - No
   - I can’t remember

Was it a requirement of your program?
   - Yes
   - No
   - I can’t remember

Did you take the course?
   - Yes
   - No
   - I can’t remember

9. For each of the competency areas below, please indicate how well you feel that adolescent populations was covered.

<table>
<thead>
<tr>
<th>Competency Area</th>
<th>Satisfactorily Covered</th>
<th>Covered, but not sufficient</th>
<th>Not Covered</th>
<th>I can’t remember</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Orientation and Ethical Practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social and Cultural Diversity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10. What was your internship setting (choose all that apply)?

- University managed training clinic
- Community agency
- Day treatment facility
- Residential facility
- Hospital
- School
- Private practice
- University/college counseling center
- Other (please specify)_____________

11. Please indicate the how often you had direct contact with following populations in your internship. (Percentages refer to direct service hours.)

<table>
<thead>
<tr>
<th>Individuals in early adolescence</th>
<th>Never</th>
<th>Rarely (~10%)</th>
<th>Sometimes (~30%)</th>
<th>Frequently (~50%)</th>
<th>Usually (~70%)</th>
<th>Every time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals in middle adolescence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals in late adolescence</td>
<td></td>
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<tr>
<td>Adolescents in a group setting.</td>
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<td></td>
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<tr>
<td>Adolescents from racial/ethnic minority groups</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
12. Please indicate whether you had direct contact with adolescents with the following mental health concerns in internship.

<table>
<thead>
<tr>
<th>Mental/emotional disorder (depression, bipolar disorder, anxiety, PTSD, etc.)</th>
<th>Direct Contact</th>
<th>Minimal Direct Contact</th>
<th>No Direct Contact</th>
<th>I can’t remember</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Behavioral issues (ADHD, ODD, conduct disorder, fighting, etc.)</th>
<th>Direct Contact</th>
<th>Minimal Direct Contact</th>
<th>No Direct Contact</th>
<th>I can’t remember</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Developmental/social and cultural issues (racial identity development, sexual identity development, poverty, etc.)</th>
<th>Direct Contact</th>
<th>Minimal Direct Contact</th>
<th>No Direct Contact</th>
<th>I can’t remember</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Bullying</th>
<th>Direct Contact</th>
<th>Minimal Direct Contact</th>
<th>No Direct Contact</th>
<th>I can’t remember</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Trauma/traumatic experiences</th>
<th>Direct Contact</th>
<th>Minimal Direct Contact</th>
<th>No Direct Contact</th>
<th>I can’t remember</th>
</tr>
</thead>
</table>

13. What racial/ethnic groups were represented among the adolescents of whom you had face to face contact with during your internship? (select all that apply)

- American Indian or Alaskan Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Pacific Islander
- White
- Other (please specify)_______________________

14. How prepared from your training were you to work with adolescents in your internship?

- Not at all prepared
- Slightly prepared
- Moderately prepared
- Very prepared
- Extremely prepared

15. Is there any additional information we should know about your experience in internship related to adolescent populations? (Free text box)

Section 5: Please answer the questions related to your professional experiences:

16. Please choose the most accurate statement regarding your licensure:

- I have graduated and I am currently in the process of obtaining counseling licensure to practice independently.
I am a fully licensed professional counselor (licensed mental health counselor, licensed clinical mental health counselor, licensed professional counselor).

17. What training specific to adolescent populations have you received outside of your graduate training? (please select all that apply)
   - Informal training at my place of employment (e.g. discussions with peers, readings, etc.)
   - Formalized training at my place of employment (seminars, evidence based treatment trainings, etc.)
   - Informal training outside of my place of employment (e.g. discussions with peers, readings, etc.)
   - Formalized training outside of my place of employment (seminars, evidence based treatment trainings, etc.)
   - Clinical supervision
   - American Counseling Association (ACA) conference
   - American Mental Health Counselors Association (AMHCA) conference
   - Other ACA/AMHCA affiliated conferences
   - Other (please specify) __________
   - I have not received training related to adolescent populations.

18. What best describes your current employment setting (choose all that apply)?
   - Community agency
   - Day treatment facility
   - Residential facility
   - Hospital
   - School
   - Private practice
   - University/college counseling center
   - I am not employed
   - Other (please specify) __________

19. Please indicate the how often you have direct contact with following populations in your professional practice. (Percentages refer to direct service hours.)

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely (~10%)</th>
<th>Sometimes (~30%)</th>
<th>Frequently (~50%)</th>
<th>Usually (~70%)</th>
<th>Every time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals in early adolescence</td>
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<tr>
<td>Individuals in middle adolescence</td>
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<tr>
<td>Individuals in late adolescence</td>
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<tr>
<td>Adolescents in a group setting</td>
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</tr>
</tbody>
</table>
20. Please indicate the how often you have **direct contact** with adolescents with the following mental health concerns in your **professional practice**. (Percentages refer to direct service hours.)

<table>
<thead>
<tr>
<th>Mental/emotional disorder (depression, bipolar disorder, anxiety, PTSD, etc.)</th>
<th>Never</th>
<th>Rarely (&gt;10%)</th>
<th>Sometimes (~30%)</th>
<th>Frequently (~50%)</th>
<th>Usually (~70%)</th>
<th>Every time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral issues (ADHD, ODD, conduct disorder, fighting, etc.)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Developmental/social and cultural issues (racial identity development, sexual identity development, poverty, etc.)</td>
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<tr>
<td>Bullying</td>
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<tr>
<td>Trauma/traumatic experience</td>
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</tr>
</tbody>
</table>

21. What racial/ethnic groups were represented among the adolescents of whom you had face to face contact with during your professional work time? (select all that apply)

- American Indian or Alaskan Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Pacific Islander
- White
- Other (please specify)______________________

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22. For the following knowledge domains, please indicate your current level of expertise related to ADOLESCENT POPULATIONS.

Please use the following definitions of Exposure, Experience and Expertise (from Roberts et al., 1998). Please leave blank those areas where you have no exposure, experience, or expertise:

**Exposure:**

Introduction to the topic area of adolescent populations in a didactic seminar or through observation in an applied or research setting.

**Experience:**

The practice with adolescent populations (e.g., in a therapy or assessment case, a practicum or elective rotation, or research project)

**Expertise:**

Coursework and extensive experience in the topical area of adolescent populations at a level of competence at which a mental health professional can practice independently

<table>
<thead>
<tr>
<th></th>
<th>Exposure</th>
<th>Experience</th>
<th>Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual psychotherapy interventions</td>
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<td>Family therapy</td>
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<td>Parent training</td>
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<tr>
<td>Group therapy interventions</td>
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<tr>
<td>Interagency collaboration</td>
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<tr>
<td>Advocacy and public education</td>
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<tr>
<td>Preventative interventions</td>
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<tr>
<td>Evidence-based interventions</td>
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<tr>
<td>Psychopharmacological interventions</td>
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<tr>
<td>Clinical evaluations (diagnostic assessment, mental status, etc.)</td>
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<tr>
<td>Personality and/or intellectual assessments</td>
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<td>Psychopathology</td>
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<td>Substance Abuse</td>
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<tr>
<td>Developmental models</td>
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<tr>
<td>Case management and community resource utilization</td>
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<tr>
<td>Risk assessment (danger to self and others)</td>
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<tr>
<td>Mental health service delivery (inpatient, outpatient, partial treatment, etc.)</td>
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<tr>
<td>Clinical supervision</td>
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</tbody>
</table>

23. To better understand the perceptions of professional counselors regarding their work with adolescents;

Did you receive counseling when you were a child and/or adolescent?

- Yes
24. Did you perceive your counselor to be well trained?

- Yes
- No
- I can’t remember

- No
- I can’t remember
Appendix D

Human Subjects Institutional Review Board Letter of Approval
Date: December 3, 2015

To: Carla Adkison-Johnson, Principal Investigator
   Brian Russ, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number 15-11-33

This letter will serve as confirmation that your research project titled “Counselor Preparation and Adolescent Youth: A Study of Clinical Mental Health Counselors” has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may only be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., you must request a post approval change to enroll subjects beyond the number stated in your application under “Number of subjects you want to complete the study”). Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: December 2, 2016