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Human Service Students' and Professionals' Knowledge and Experiences of Interprofessionalism: Implications for Education

Kaprea F. Johnson, Narketta Sparkman-Key, Michael T. Kalkbrenner

Abstract

Interprofessionalism is an approach to delivering optimal client care in which providers from multiple professions work collaboratively on care teams. Human Service Professionals (HSPs) are generalists who frequently work together with professionals in related fields. The purpose of this study was to investigate the extent to which HSPs and helping professionals in related fields have engaged in interprofessional experiences. Researchers also investigated the impact that having previous interprofessional experiences had on participants' perceptions of interprofessionalism. Results revealed that professionals and students who had previous interprofessional experiences were significantly more likely to have positive perceptions about interprofessional cooperation. However, results also indicated that only a small proportion of HSPs and mental health professionals in related fields reported engaging in interprofessional experiences. Suggestions for how educators can infuse interprofessionalism into the curriculum for human services and related programs are provided.

Introduction

The field of Human Services (HMSV) has evolved and emerged as a distinct discipline with a unique professional identity over the past few decades (Neukrug, 2017). Human Services Practitioners (HSPs) work in a variety of settings with diverse client populations. As a generalist profession, it becomes increasingly important that HSPs work collaboratively with other professions to maximize the quality of service delivery to clients (Hinkle & O'Brien, 2010). However, the literature appears to be lacking research on the extent to which HSPs have experience with interprofessionalism. The literature also appears to be lacking research on the extent to which interprofessionalism has been infused into HMSV training programs. The purpose of this study is to investigate the extent to which human services practitioners and professionals in related fields have engaged in interprofessional experiences. Researchers will then provide recommendations for how human service education programs can integrate interprofessionalism into their curricula. Recommendations are also provided for how interprofessionalism can be integrated into the accreditation standards for human service education programs.

Literature Review

As generalists, HSPs work in a variety of different roles, including: crisis intervention specialists, substance abuse counselors, social service workers, case managers, probation officers, and mental health aides (Neukrug, 2017). Researchers have defined the characteristics and practice attributes of human services practitioners that enable them to work effectively as generalists (Hinkle & O'Brien, 2010). Thus, HSPs are trained to meet the needs of diverse clients through an interdisciplinary knowledge base that focuses on prevention and remediation of issues (Council for Standards of Human Service Education [CSHSE], 2015). Neukrug, (2017) also outlines how effective generalist practice includes relationship building, empathy,

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genuineness, acceptance, cognitive complexity, wellness, competence, and cross-cultural sensitivity. Snow (2013), also identifies advocacy as an essential component of human service practice and competence. Interprofessional collaboration is a holistic approach to client care that enables generalists to work on interdisciplinary teams to help clients successfully move through the stages of the helping relationship (Orchard, King, Khalili, & Bezzina, 2012).

Interprofessionalism in Human Services

Integrated health care is an emerging trend in the mental health and medical field (Substance Abuse and Mental Health Services Administration, n.d.). Integrated health care involves infusing the delivery and coordination of primary care, mental health, and substance abuse treatment. Similarly, interprofessionalism involves professionals from a variety of professions working together collaboratively to provide optimal client care (Kalkbrenner, et al., 2016; Orchard et al., 2012). The field of human services is in need of community based experiential learning opportunities (Johnson & Freeman, 2014; Nicholas, Baker-Sennett, McClanahan & Harwood, 2012). Using experiential learning techniques to teach human service students how to work collaboratively and cooperatively with other professionals has been an important component of human services education for nearly two decades (Kalkbrenner & Parker, 2016; Sweitzer, Weinswig, & Curtis, 1997). These opportunities for students in human services and counseling have come in the form of coursework, internships, and other training opportunities (Fowler & Hoquee, 2016; Johnson, Haney, & Rutledge, 2015). These continued collaborative training efforts are important because interprofessionalism has a significant impact on the health care system and patients.

The Problem

Interprofessional collaboration is a unique opportunity for human service practitioners to provide holistic service to clients (Johnson & Freeman, 2014). There is a substantial body of research that points to the importance of incorporating interprofessionalism into educational curriculum (Fowler & Hoquee, 2016; Johnson & Parries, 2016; Johnson, Fowler, Kott, & Lemaster, 2014). However, there appears to be a gap in the literature about the extent to which HSPs and helping professionals in related fields are engaging in interprofessionalism. Interprofessional collaboration among HSPs and mental health professionals in related fields is an emerging trend in which many licensing and accrediting bodies have begun to embrace (Korazim-Korosy, Mizrahi, Bayne-Smith, & Garcia, 2014). Furthermore, HSPs have an ethical responsibility to "optimize the impact of inter-professional collaboration on clients at all levels" (National Organization for Human Services [NOHS], 2015, Standard 29). However, there does not appear to be any research on interprofessionalism in the HMSV literature in clinical or educational settings. There is therefore, a need for research that investigates the extent to which HSPs and professionals in related fields are engaging in interprofessionalism.

The Current Study

This study examined the degree to which HSPs, counselors, social workers, and psychologists have engaged in interprofessional experiences. Human services, counseling, social work, and psychology are distinctly different fields, each discipline having a unique professional identity (Neukrug, 2017). Human services practitioners, however, are likely to work on interdisciplinary teams with mental health professionals in related fields (NOHS, 2015). The current researchers, therefore, included a diversity of mental health professionals in this study,

including students and professionals in human services, counseling, social work, and psychology. The primary purpose of the current study is to answer the following research questions: (1) To what extent are HSPs and professionals in related fields engaging in interprofessional experiences? (2) What is the frequency of participants' interprofessional experiences by educational level (undergraduate, graduate, and professional)? (3) To what extent are there differences in participants' perceptions of interprofessional education and practice based on whether or not they have previously engaged in interprofessional collaboration?

Methodology

The current researchers utilized a quantitative research design with survey methodology. Data was collected through a questionnaire. Nonprobability convenience sampling was used to collect data.

Procedures

Researchers first obtained human subjects approval under an exempt category from the authors' institutional review board. Participants were then recruited via online human services related listservs and human services professional organizations. Data collection began in June of 2015. Participants were given informed consent prior to beginning the survey. To ensure confidentiality, no identifying information was collected from respondents. The survey was advertised on internet forums designed for human service professionals. Recruitment was ongoing for four weeks with one post to listservs each week, and the survey closed after 45 days. The data were converted into a Statistical Package for the Social Sciences (SPSS) data file for data cleaning.

Participants

There was a total of 187 responses to the survey, -.1% accounted for missing data (2 cases), for a total of 185 valid responses. Participant demographics are displayed in Table 1. The majority of participants identified as Caucasian (65.2%, n = 122) females (77.5%, n = 145), between the ages of 21-39 (98.4%, n = 69). Approximately half of participants identified as students (52%, n = 96) and professionals (48%, n = 89). Nearly 30% of participants who identified as students had at least one previous interprofessional experience. Researchers therefore, included both students and professionals in the data analysis. See Table 1 for more details on participants' demographic characteristics.

Measures

Participants completed two questionnaires using a secured online website (esurveyspro). The first questionnaire was a demographic questionnaire. The second questionnaire was the Interprofessional Education Perception Scale (IEPS) (Luecht, Madsen, Taugher, & Petterson, 1990). The IEPS is an 18-item questionnaire that assesses participants' perceptions of interprofessional education and practice. The IEPS, uses a 6-point Likert-type scale, "strongly agree (6)" to "strongly disagree (1)" and includes four subscales: (1) Professional competence and autonomy (items 1,5,7,10, & 13) and a high score indicates that the participant believes his or her own profession is well educated and contributes significantly to the healthcare field; (2) Perceived need for professional cooperation (items 6 & 8) and a high score reflects that the participant believes in the need of other professions to work collaboratively; (3) Perception of actual cooperation (items 2,14,15,16,& 17) and a high score indicates the participant believes

that the profession works well with other professions; and (4) Understanding the value and contribution of other professions (items 11,12, & 18) and a high score indicates that the participant values other professions contributions. Luecht et al. (1990) found moderate-to-strong internal consistency reliability coefficients for the four subscales on the IEPS, 0.872, 0.563, 0.543, and 0.518 respectively and a total scale alpha of 0.872. In the current study, Cronbach's Alpha revealed that the IEPS had a strong internal consistency, $\alpha = .88$.

Data Analysis

Descriptive statistics and inferential statistics were employed to answer the research questions. The first two research questions were answered by computing cross-tabulations to determine the frequencies of participants' interprofessional collaboration experiences based on their educational status and their professional discipline. Analysis of Variance (ANOVA) was conducted to determine the extent to which there were differences in participants' perceptions of interprofessional collaboration based on their previous experiences with interprofessional collaboration.

Results

Cross-tabulations were conducted to answer the first research question (see Table 2). Results revealed that the majority of participants, 69% ($n = 129$) had not had any previous interprofessional clinical experience and 70% ($n = 130$) had not had any interprofessional education experience. Within professional disciplines, counselors reported the highest frequency, 50% ($n = 29$) of interprofessional clinical experiences, followed by social workers 46% ($n = 7$), those who identified as professionals in psychology 23% ($n = 7$), and human services professionals 15% ($n = 12$).

Cross-tabulations were also conducted to answer the second research question. Results revealed that 27% ($n = 18$) of undergraduate students had at least one previous experience with educational interprofessional collaboration. Among graduate students, 25% ($n = 12$) had at least one experience with clinical interprofessional collaboration and 28% ($n = 24$) of participants who did not identify as graduate or undergraduate students reported having at least one educational interprofessional experience. For previous clinical interprofessional experiences, 25% ($n = 12$) of undergraduate students had at least one previous experience.

A one-way Analyses of Variance (ANOVA) was conducted to answer the third research question. Prior to data analysis, the researchers checked to ensure that the assumptions for ANOVA were met. The dependent measure, scores on the perceived need for professional cooperation subscale of the IEPS, was normally distributed, skewness (-.68) and kurtosis (.42). The assumption of homogeneity of error variances was ensured by conducting a Levene's test which revealed that the error variance of the DV was not significantly different across groups, $F(1, 185) = 0.2.97$, $p = 0.087$. Furthermore, the assumption of independence of observation was ensured as it was not possible for any participant's data to appear in more than one level of the independent measure simultaneously.

Power analyses revealed that a sample size greater than or equal to 172 would provide a statistical power estimate of 0.79 or 79%. The independent measure was participants' previous interprofessional experience which had two levels (previous experience or no previous experience). The dependent measure was participants' scores on the perceived need for cooperation sub-scale of the IEPS. Results revealed that participants who had previous interprofessional experiences ($M = 5.1$) perceived a significantly greater need for

interprofessional cooperation compared to participants who had not had any previous interprofessional experience (M = 4.8), F = (1,185) = 7.5, p = 0.007, η_p^2 = 0.04.

Table 1
Demographic characteristics of sample

Variable		N	Percentage
Age	20 and under	1	.5
	21 to 39	69	36.9
	40 to 49	44	23.5
	50 to 59	43	23.0
	60 to 69	28	15.0
	70 an older	2	1.1
Gender	Male	40	21.4
	Female	145	77.5
	Transgender	2	1.1
Race	Latino/Latina	10	5.3
	American Indian	3	1.6
	Asian	2	1.1
	African American	39	20.9
	Caucasian	122	65.2
	Bi-racial	11	5.9
Home Location	Rural	36	19.3
	Urban	64	34.2
	Suburban	87	46.5
Work Experience	Less than 1 year	36	19.3
	2 to 5 years	35	18.7
	6 to 10 years	27	14.4
	11 to 15 years	22	11.8
	16 to 20 years	19	10.2
	20 plus years	47	25.1
	Missing value	1	.5
HMSV Related Prof.	Counseling	59	31.6
	HMSV	81	43.3
	Psych	31	16.6
	Social Work	16	8.6
Education	High School	14	7.5
	Associates	28	15.0
	Bachelors	34	18.2
	Masters	58	31.0
	Post Masters	8	4.3
	Doctoral	45	24.1
	Total	187	100.0

Table 2
Interprofessional Educational and Clinical Experiences

	Education experience with IPE		Clinical Experience with IPE	
Human services related professions	no	yes/other	no	yes/other
Counseling	36	23	30	29
HMSV	61	20	67	14
Psych	23	8	24	7
Social Work	10	6	8	8
Total	130	57	129	58

Discussion

The findings from the current study have started to fill the gap in the literature about the extent to which human services practitioners and helping professionals in related fields have engaged in interprofessionalism. Results revealed that the majority of participants had not had any previous interprofessional clinical experience 69% (n = 129) or any interprofessional educational experience 70% (n = 130). Between professional disciplines, counselors and social workers reported the highest frequency of interprofessional experiences. Human services professionals represented the largest professional discipline sub-sample in the current study, however HSPs reported the lowest frequency of interprofessional experiences. This finding suggests that interprofessionalism might be lacking in the human services higher education programs.

The current findings have also started to fill the gap in the literature on whether perceptions of interprofessionalism vary by interprofessional experiences. Participants who had at least one previous interprofessional experience (clinical or educational) were significantly more likely to have positive perceptions of interprofessional engagement. These findings suggest that infusing interprofessional experiences into training/education programs might be valuable in preparing students for working in the interprofessional climate which is emerging across professional boards in both medical and mental healthcare (DeMatteo & Reeves, 2013; Johnson & Freeman, 2014).

Implications for Higher Education in Human Services and Related Fields

Based on the current findings, it is recommended that educators in human services programs and programs in related fields create opportunities for their students to engage in interprofessional collaboration. It is important that students learn about the theory and practice of interprofessional collaboration to better prepare them for working on interdisciplinary teams. Consistent with the suggestion of DeMatteo and Reeves (2013), the current researchers recommend that educators introduce interprofessionalism to students early on in their training programs. It is recommended that the curriculum in introductory to human services courses include modules on interprofessional collaboration. Furthermore, instructors of introductory courses should collaborate with instructors of courses in psychology, counseling, and social work to create opportunities for their students to work interprofessionally. It is also recommended that an interprofessional component is added to internship related human service courses. Infusing interprofessionalism into human services education programs is likely to better prepare human

services students for working collaboratively with other mental health professionals in their future careers.

Recommendations for Accreditation Standards

It is recommended that an interprofessional component is added to the accreditation standards for human services education programs. The Council for Standards in Human Service Education (CSHSE) holds the responsibility of setting standards, assessing programs against those standards, and accrediting programs that meet the standards. Interprofessional education is closely related to the requirements of standard one which states, "The primary program objective shall be to prepare human services professionals to serve individuals, families, groups, communities and/or other supported human services organization functions" (CSHSE, Standard 1, 2012). More specifically, it is recommended that interprofessionalism is included into the specifications of standard one. Infusing interprofessionalism into the CSHSE's standards would most likely encourage HMSV training programs to include interprofessionalism in their curriculum.

Limitations and Future Research

The majority of participants in the current study identified as Caucasian females who lived in suburban settings. It is recommended that future researchers replicate the methods of the current study with HSPs who have greater demographic diversity. There were also limitations regarding the investigation of participants' interprofessional experiences by professional discipline. The sub-sample sizes of participants' professional disciplines were not evenly distributed, human services (43.3%), counseling (31.6%), psychology (16.6%), and social work (8.6%). Unequal sub-sample sizes, however, are a common limitation in research that seeks to compare professionals between different disciplines (Orlinsky, Schofield, Schroder, & Kazantzis, 2011). Future researchers can replicate the methodology in the current study and attempt to recruit equal sub-sample sizes to make comparisons between participants' experiences with interprofessionalism by professional discipline.

It is also recommended that future researchers use a variety of methodological approaches to extend the knowledge base on interprofessionalism in human services. Future researchers could utilize a correlational/predictive design to identify the extent to which HSP's previous interprofessional experiences predict their readiness to work in the interprofessional climate that is emerging in the field. Future researchers might also utilize a between-subjects experimental design to investigate the extent to which the implementation of interprofessionalism in higher education curriculum prepares HSPs for working on interdisciplinary teams. It is recommended that future qualitative researchers attempt to gain a more in-depth understanding about how HSPs are experiencing interprofessionalism. Prospective qualitative researchers could conduct a phenomenological study to investigate the lived-experiences of HSPs perceptions of interprofessionalism.

Conclusion

Human services practitioners are generalists who frequently work on interdisciplinary teams (Neukrug, 2017). Interprofessionalism is an emerging approach to delivering client care where a variety of professionals work collaboratively to provide optimal patient care (Orchard et at. 2012). The aim of the current study was to begin investigating the extent to which human services practitioners and professionals in related fields have engaged in interprofessional experiences. Researchers also sought to identify the extent to which participants'

interprofessional experiences have influenced their perceptions about interprofessionalism. Results revealed that participants who had at least one interprofessional experience were significantly more likely to have positive perceptions about working collaboratively with other professionals. However, findings also indicated that only a small proportion of human services students and practitioners have had interprofessional experiences. Based on the findings of the current study, researchers have provided recommendations for how interprofessionalism can be infused into the curriculum of higher education programs and into the CSHSE's accreditation standards. Interprofessionalism is an emerging trend in human services and in related fields (DeMatteo & Reeves, 2013). It is therefore, recommended that educators integrate interprofessionalism into HMSV training programs to prepare students for their future as well-rounded and collaborative HSPs.

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Taking Deliberate Steps: Working Toward a Career in Human Services in Appalachia

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Abstract

With the coal industry on the decline in Appalachia, individuals living in the region may pursue a career in the human services as it is on the rise and education opportunities exist for it in the area (Bureau of Labor Statistics, 2015a; U.S. Department of Energy, 2012). However, the unique culture of Appalachia combined with regional low levels of education make the individuals pursuing higher education in this area a population in need of research (Haaga, 2004; Pollard & Jacobsen, 2012). Using Relational Career Theory to understand Appalachian students allows for consideration of the role of culture and family in educational and career decisions (Blustein, Schultheiss, & Flum, 2004). Through qualitative analysis of interviews of Appalachian college students, researchers identified a standard progression through several domains: frequent transitions, trauma or abuse, stigma, high expectations and low levels of support, & influence of others. This indicates individuals from this region experience a unique process of career development. By analyzing these findings, and considering the relational aspects of career choices, career practitioners can better serve current and potential students.

Introduction

About 25 million people live in the Appalachian region (Pollard & Jacobsen, 2012). Central Appalachia, the focus of this research, includes Kentucky, Tennessee, Virginia, and southwest West Virginia counties falling within the Appalachian mountain chain (Appalachian Regional Commission, 2015). Central Appalachia is a largely rural area (Martis, 2005) with an economy that has long been dependent on the coal industry (Kentuckians for the Commonwealth, 2016). Coal employment has seen a strong and steady decline since its start (U.S. Department of Energy, 2012) leading to an economic crisis (Rural Policy Research Institute, 2014) and contributing to low levels of income in the area (Pollard & Jacobsen, 2012). Appalachian individuals are also less likely to earn a bachelor's degree than individuals from other areas of the United States (Haaga, 2004; Pollard & Jacobsen, 2012). With mental health services a growing field (Bureau of Labor Statistics, 2015a) and a population in high need of these services (Salob, n.d.), human services college students in Appalachia warrant special attention in career research.

Efforts to address the economic issues of the area have been intentional in their focus on educating the population (Rural Policy Research Institute, 2014). In order for these initiatives to work, and for individuals seeking higher education in the Appalachian region to succeed, educators must better understand the issues of Appalachian students. Postmodern career counseling and theories push towards a reconceptualization of careers that better accounts for current employment practices, and encourages consideration of personal and cultural attributes (Chope, 2008). One such postmodern career theory, Relational Career Theory (RCT), provides a framework for understanding career development of underserved populations and considers the contextual influence of culture and family in career development (Blustein, 2011; Blustein, Schultheiss, & Flum, 2004). As Appalachian individuals are an underserved population and

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are steeped in their culture, RCT offers a way to fully understand the career development of human services college students in Appalachia.

Appalachian Career Development

Though the career-related research on Appalachian individuals is limited, findings indicate that career aspirations and career self-efficacy may be impacted by factors such as socioeconomic status (SES) and parental support. In research conducted with Appalachian high school students, Ali and Saunders (2008) found that students with lower career self-efficacy, limited career decision outcome expectations, and from a lower SES were more likely to aspire to full-time employment after high school as opposed to planning to attend college. In another study with Appalachian high school students, Ali and McWhirter (2006) determined that Appalachian students who plan to work full-time after high school graduation have lower levels of vocational/educational self-efficacy and college outcome expectations. Students who reported seeking to gain full-time employment after high school also had the lowest SES. Finally, researchers also identified a relationship between perceptions of parental support and expectations to attend college of Appalachian high school students (Ali & Saunders, 2006). These findings indicate that family and culture may impact the career development of Appalachian individuals.

Other aspects of Appalachian culture may also influence career development. Salyers and Richie (2006) identified that Appalachian people do possess a unique cultural identity within the United States. In a seminal survey exploring the Appalachian culture, Ford (1962) identified four characteristics of the culture of region: individualism and self-reliance, traditionalism, fatalism, and fundamentalist religion. Individualism and self-reliance is likely a result of geographic isolation that leads to individuals and families being physically separated from the larger society (Ford, 1962). Other research supports the notion that Appalachian people have strong ties to the community and the land (Martis, 2005; Salyers & Richie, 2006; Tang & Russ, 2007). The characteristic of self-reliance seems to contrast with the high levels of disability and unemployment in the region and the dependence on government assistance (Flippen, 2014). However, individuals living in Appalachia seem to see this assistance as deserved and earned in other ways (Ford, 1962). Additionally, religion plays a significant role in the lives of Appalachian people, though these beliefs may be deeply individualized (Ford, 1962; Salyers & Richie, 2006; Tang & Russ, 2007). Traditional values and family influences might impact career choices and development of those living in Appalachia (Bennett, 2008; Ford, 1962; Tang & Russ, 2007). Finally, the characteristic of fatalism identified by Ford (1962) may have direct consequences on the career choices and, particularly, the actions Appalachians take to achieve career goals. Ultimately, the influences of these contextual issues are consistent with Relational Career Theory.

Relational Career Theory

Researchers have substantiated that Appalachian individuals face specific and distinctive challenges in overcoming contextual issues in their career journeys. The power of these distinguishing factors and their influence on career paths of Appalachian individuals is explained by Relational Career Theory. RCT theory holds certain beliefs and assumptions that, coupled with its framework for understanding career development, make it unique among other theories. First, RCT is a social constructionist theory that means that knowledge is created through varied and complex social interactions (Blustein, Schultheiss, & Flum, 2004). Relational career

theorists also believe that career and relationships exist in the same space and interact in complex ways (Blustein, 2001). This blurs the line between career and personal development and indicates that the two should not be considered separately. Another common assumption is that family and culture play a large part in career development (Blustein, 2011; Blustein, Schultheiss, & Flum, 2004). Finally, Relational Career theorists consider the theory a way to define career for individuals who do not hold jobs outside the home or do not have a choice in their careers (Blustein, 2011). Relational Career Theory provides a new and different way of considering the impact that family and culture have on career development.

Relational Career Theory and Appalachian Culture

Appalachian culture provides a rich context, including a strong role of family, through which individuals develop their career knowledge and make career choices. Unique Appalachian factors such as socioeconomic status and parental support impact career aspirations among the Appalachian people (Ali & Saunders, 2006; Ali & Saunders, 2008; Ali & McWhirter, 2006). This research paired with the low levels of income and education of Appalachian people (Pollard & Jacobsen, 2012) suggest a need to further consider the role of family and culture in the career development of these individuals.

By using Relational Career Theory to explore the impact of culture and family on career development, we can better understand Appalachian individuals. This study considered the career development of Appalachian college students in the human services through the lens of RCT. Specifically, we were interested in the following research question: How do contextual issues such as family and culture impact the career development of Appalachian students in the helping professions?

Methods

Context and Participants

We recruited nine participants from undergraduate and graduate classes at two universities in Appalachia. Hill (2012) recommends a sample size of at least eight participants and up to fifteen participants. The researchers suggest that fewer participants are appropriate when the interviews are more in-depth. As our interviews ranged from 30 minutes to an hour per participant, we decided to stop data collection at nine participants. All students were originally from Appalachia and attended college in the region. The two universities we recruited participants from were small, private colleges located in Central Appalachia with graduate programs in counseling. Two of the participants were male and seven were female. Ages of the participants ranged from mid-20s to 50s. All participants were White. Two of the participants were completing an undergraduate degree in Human Services, while the remaining participants were completing Master's degrees in Clinical Mental Health or School Counseling. We chose to seek participants from both the undergraduate and graduate programs in our target sites because we felt there would be more similarities than differences with the two types of students in terms of our research interest.

Data Collection

The first and second author sent emails to the students at the two schools inviting them to participate in the research. Students who responded to the emails were then interviewed face-to-face by the first and second author. Interviews were recorded and then transcribed. Interviewers

followed a semi-structured interview format that included the three basic prompts of: "Describe your career thus far"; "Talk about the impact of your family on your career"; and "How has your culture influenced your career"? Interviewers used additional open-ended questions and basic interviewing skills to elicit further responses from participants throughout the interviews. Interviews varied in length from 20 minutes to 60 minutes long.

Methodology

Before collecting data, IRB approval was obtained from both institutions where interviews were conducted. Consensual Qualitative Research (CQR), as outlined by Hill (2012), was the methodology for this study. Hill (2012) outlined three general steps to follow when using CQR. The first is to divide responses from interviews into domains or topic areas. The next step involves constructing core ideas for all material in each domain for each case. Finally, researchers conduct a cross-analysis in which categories are developed to describe core ideas within domains across cases. In CQR (Hill, 2012), researchers analyze data independently and then come together as a team to discuss ideas and reach a consensus. Additionally, Hill (2012) recommends using an auditor outside of the primary analysis team to review the raw data and develop domains and core ideas.

Credibility

To maintain credibility in our study, the researchers utilized rich rigor in the study, self-reflection, and transparency as well as triangulation (Creswell, 2007; Hill, 2012; Tracy, 2010). The first step to maintain credibility was to identify researcher biases concerning the study. Author biases were that family impacts career choices and that the coal mining culture and economy of the area impact career choices. Hill (2012) recommends this as part of the CQR process. Additionally, Tracy (2010) identifies self-reflection as a component in maintaining credibility. The authors utilized self-reflection through note-taking, emails to one another, and phone conversations during the analysis. Next, researchers used rich rigor in the analysis (Tracy, 2010) by regularly referring to the CQR methodology (Hill, 2012) and by constantly reviewing our own steps and decisions. While Creswell (2007) identifies triangulation as a method to increase credibility, Hill (2012) suggests the use of an auditor as a step to maintain credibility in analysis. Thus, an auditor, the third author, was added to our analysis of the data. Finally, the researchers maintained credibility by using transparency (Creswell, 2007; Tracy, 2010) in the detailed description of the methods of data collection and analysis.

Data Analysis

The first step to analyzing the data was to individually review the transcripts of nine interviews. The researchers began by separately reviewing one transcript at a time, developing domains directly from each transcript. Saldana (2015) described this first level of coding as descriptive in which the researchers summarized the information using words and brief phrases. The researchers then met to discuss these initial domains (i.e. valuing education, family influences, indirect career path) and condensed them down from multiple, specific domains to fewer, more general domains (Saldana, 2015). Then, as the researchers continued reviewing the interviews, they used the already developed domains (i.e. Issues in Appalachia, Presence of a Mentor, Stigma of Mental Health) and added additional ones as needed to ensure that all ideas presented by participants were included (Hill, 2012). After the researchers had individually established a list of domains based on the interviews, they shared domains and met to come to a

consensus (Hill, 2012). The researchers reviewed the domains and organized them to represent a process as per the pattern coding described by Saldana (2015) as a second cycle coding method. After meeting to come to a consensus, the first author revised the domains based on the meeting, and made sure that each core idea was accounted for and supported by raw data. The findings were then sent to the next author to review and revise. Finally, the auditor reviewed the data and findings. All three researchers met to discuss the auditor's suggestions and to incorporate them into the findings.

Findings

The researchers identified a process of career development, titled *A Path to Career, Taking Deliberate Steps*, and described cultural and contextual influences on participants' career choices. This process explores participants' efforts to distinguish themselves from their indigenous roots with the influence of others. This differentiation occurred through multiple *Deliberate Attempts*, to seek the *Most Appropriate Career Path*. This process is supported by five domains. The domains in this process include *Frequent Transitions* (Domain 1), *Trauma or Abuse* (Domain 2), *Stigma* (Domain 3), and the domain of *High Expectations and Low Levels of Support* (Domain 4). This process included an overarching domain of *Influence of Others* (Domain 5). The remainder of this section will include statements from participants illustrating the presence of the first four domains. The fifth domain, *Influence of Others*, will be highlighted as it appears throughout the examples within the career process described.

Frequent Transitions

The first domain is the presence of *Frequent Transitions* (Domain 1). The process of finding human services as a career included many jobs and frequently several different career paths. Consistently, participants recalled other professional aspirations prior to determining counseling as a career path. Also, in each example below, Andreas's father and grandfather and Holly's daughter are identified as *Influence of Others* (Domain 5) on their career paths.

> I knew that I wanted to go towards radiology, but I was pushed that way by my dad and my papaw saying that oh you need to get into something that's around this area that there's a good job in. Medical field is always a good area… So I prepared myself through that time for radiology (Andrea).

> Um at that point, I worked in a bank before I started college and during college I worked in the admissions office at Clinch Valley… From there, various jobs. From there, I worked in a clothing store. Actually, two different ones… From there I finished out my degree at that point. I went to a company that sold I guess racing stuff and other things…From there I went to a print shop…I was laid off pretty quickly. And along with the equipment, I was sort of passed along to a new print shop. Worked there for several years until I had my daughter. And I wanted to stay home with her for just a little while. That was short-lived also... When she went to pre-school, I started at the pre-school (Holly).

Trauma or Abuse

In the second domain, many participants disclosed that their career path included many attempts towards a variety of careers but surprisingly, nearly all of them reported an incident or

situation in which they felt helpless or needed help. These reports brought the researchers to see a consistent pattern of these experiences prior to seeking a career in counseling or human services. This is described as Domain 2, *Trauma or Abuse*. Domain 5, *Influence of Others*, again makes an appearance in the examples through Carrie's involvement with dangerous people and Carla's mention of family.

> Yeah, I don't think I would have been able to have handled a job at the point that I was at in my life... I cut wild and I went through a lot of different things in that period of time in my life. I became dependent on alcohol. I surrounded myself with some dangerous people. I got myself in some really dangerous situations (Carrie).

> I may cry. My mother had Alzheimer's and she was in the last phase of Alzheimer's when I had cancer and you need your momma. I had a dear aunt who just passed away last week who stepped in as my encourager, she was a survivor. Any way during that time my mother in law got a tumor that was terminal as well. Our family was just, you know they say bad things come in threes, we had three bad things all in one year. Our family was just really having a difficult time (Carla).

Stigma

Participants' descriptions of situations which were emotionally difficult intuitively unearthed issues of a stigma associated with seeking help in difficult situations. This stigma associated with seeking mental health support within the Appalachian culture is consistent among participants. The researchers identified this as Domain 3, *Stigma*. Domain 5, *Influence of Others*, is described in a broader sense within Domain 3 as participants refer to people in general and people of Appalachia.

> I guess kind of I didn't have anybody to talk to. And I don't want somebody to go through something like that so I guess that's why I'm all about trying to reach out and help people. Because people around here need help. I should have sought help. But I would have been deemed crazy if I did (Carrie).

Seeking mental health support services or counseling was something that participants believed would result in extreme responses from those in the Appalachian community. The fears of being perceived as being rejected by God, or crazy were described by multiple participants.

> I feel like there's a stigma on getting mental health services in this area. As opposed to other areas. I've done a great deal of traveling. Mental health is great, there's a positive outlook on it. There is, I feel like, a negative stigma here (Meg).

High Expectations and Low Levels of Support

The fourth domain in this process is rooted in a dichotomy, the presence of *High Expectations and Low Levels of Support* (Domain 4), and for participants this resulted in high levels of autonomy and self-reliance. Often these high expectations were self-imposed, and seen as a means to differentiating themselves or seeking a non-traditional career path. Domain 5, *Influence of Others*, again makes an appearance in these quotes as participants verbalized how these deliberate steps would impact future generations, and believed that the steps taken to

overcome Appalachian environmental factors would result in immediate benefits to their children.

> I'm showing my daughter, hey baby you can do anything if you put your mind to it, you set those goals girl, you can do it. That's always been what my parents have told me. You can do anything and just because you are not financially able to do something don't let that hold you back, just do it (Melissa).

> …mainly a personal challenge of doing anything for myself after graduating from high school. There are a number of people there that graduated high school that was it for them. So I personally challenge myself to go and do something with it as an influence (Jeffrey).

> And my other uncle, he was the - he's retired now - but he was the vice president of [company]. They're really, they're big shots. And there's a ton of them in my family, so, you're in trouble if you don't go to school. It's bad. And I actually think, not my parents so much, but other family members have given me kind of a hard time that I didn't go into engineering or business or something like that (Meg).

Discussion

The Appalachian college students in this study identified a career development process that was directly impacted by the people in their lives, their experiences, and their culture. This exemplifies the push for post-modern career theories that accounts for the role of context in career development (Schultheiss, 2003). The participants' process of taking deliberate steps towards a career describes their career paths as filled with context and interactions with others. This is a hallmark of both RCT and of postmodern career theories that highlight the role of people and culture in the way that people make meaning and construct knowledge (Blustein, 2011). As most of the participants were women, the impact of family may be especially true for women as demonstrated through qualitative findings (Tang & Russ, 2007). The Appalachian students interviewed here describe their career process as being a convoluted journey marked by trauma and impacted by the stigma, in their region, of using mental health services. The interaction of people and culture in their stories is both implicit and explicit, much as RCT describes the shared space of relationships and work in career development (Blustein, 2011). In this section, we discuss specific findings of interest in the study in terms of RCT research.

Blustein (2011) identified three attributes of working as meaning, mattering, and dignity. These attributes take place within relationships and culture. In this study, participants identified specific moments or experiences in their career paths that led them to pursue a degree in human services. This experience, often one of trauma, was also paired with a lack of support in seeking mental health services due to the stigma identified in Appalachian culture. The hesitancy to seek professional mental health services and stigma towards those who do is something deeply embedded in the Appalachian culture (Bennett, Crabtree, Schaffer, & Britt, 2011) and may be related to the deep religious beliefs held by Appalachians noted in the literature on the region (Salyers & Richie, 2006; Tang & Russ, 2007). Participants sought to pursue a career in human services that allowed them to construct meaning from their traumatic experiences (Blustein, 2011). Interestingly, it is here that participants took deliberate steps to differentiate from their culture and find meaning and mattering in their lives through work. Though our findings are

based on participants from Appalachia, where the stigma attached to mental health care is prominent (Bennett et al., 2011), a stigma against mental health care is common in the United States (Cummings, Lucas & Druss, 2013). Thus, the career development of human services workers may be related to their own experiences of trauma or another personal event and personal or societal beliefs about mental health.

The career experiences of Appalachian college students pursuing degrees in the human services emphasize the shared space of work and relationships that is the hallmark of RCT and the emerging approach to career development (Blustein, 2011; Schultheiss, 2003). The presence of trauma and stigma in these experiences brings to light the impact of environment, relationships, and culture on career development. In the face of a stigma against mental health services, these individuals are choosing to pursue a degree in human services. In addition to the stigma against their field of study, participants chose to pursue a degree in higher education which goes against the norm of the region (Haaga, 2004; Pollard & Jacobsen, 2012). The career path these individuals from Appalachia chose clearly demonstrates their taking deliberate steps to seek the most appropriate career path as a result of their lived experiences, influences of others, and impact of their culture.

While this study looks to the Appalachian community to assess RCT, previous outside research performed by Amundson, Borgen, Iaquinta, Lee, & Koert (2010) found that individual decisions regarding education and career choice were not only holistic, but also held strong relational ties within individuals' communities. This study expresses the strong desire for individuals to find interconnectedness within their career choices, and the notable influence of the presence of life roles as well as how that shapes career decisions (Amundson et. al., 2010). The specifics of what ties Appalachian individuals to their communities may be one focus of this study, however, it is evident these communal ties are a commonality among other young people, and they are integral to what determinations they make. Likewise, Schultheiss (2003) attempts to bring attention to the need for career and relational theories to become integrated in order to offer a more complete approach to aid career decisions. Realistic interventions must incorporate individuals' myriad of ways in which they interact with their communities, and how those communities affect them.

Implications for Practice

Findings from this research suggest several factors that career practitioners can consider when working with individuals from Appalachia. First, the path to a fulfilling career is often pursued in an indirect manner. This progression through multiple careers is a phenomenon which should be addressed in the curriculum of Human Service Education, to ensure practitioners support individuals through this process. This indirect career path goes against traditional career theories (Pope, 2000) and aligns with postmodern career theories that focus not on finding a job that fits, but on helping individuals find meaning and identity in work (Tang & Russ, 2007). Appalachian individuals may attempt multiple career and educational paths in an attempt to find the career that is best fitting. This is tied to career statistics that suggest individuals do not stay in careers long-term, but rather change careers often throughout life (Bureau of Labor Statistics, 2015b). Therefore, it is imperative that career practitioners, and those who educate these practitioners, consider that individuals may follow an indirect path to their chosen career. Thus, rather than focusing on career choice, career practitioners might focus on meaning and identity (Blustein, 2011). Additionally, for Appalachian students specifically, this path may also include

a need or desire to differentiate from their culture. Career counselors can support students as they navigate establishing their own beliefs and values that may contrast with those of their culture.

For human services educators in particular, this research brings to light the possibility of students having experienced a traumatic event that influenced their decision to pursue a career in this field. While this may be specific to this research and this population, this finding supports the integration of personal and career counseling suggested by post-modern career theorists (Blustein & Noumair, 1996). Career practitioners and human services educators should be aware of the impact that personal events and experiences have on career development and be prepared to address these issues in counseling as appropriate or refer to outside resources when necessary.

The students involved in this study were at private institutions and from the region of Appalachia, with its very unique culture; however, the findings from the research are useful for all career practitioners and human service educators. The findings of an indirect career path and the impact of family and life events on career development support the push in the career counseling field toward the use of postmodern career theories as well as the encouragement of continuing studies in this area of research rather than traditional career theories (Chope, 2008). This new way of conceptualizing career allows counselors and educators to listen and understand their clients and students rather than focus on career choice and prescribe career activities (Tang & Russ, 2007).

Future Research

The current study suggests some opportunities for future research. Appalachians may be likely to experience trauma or hardship and this may affect their career development. Therefore, researchers may explore the role of trauma in career development or the presence of trauma in the lives of Appalachian individuals. Additionally, a strong dichotomy exists between a traditional sense of connectivity among those in the Appalachian culture, and the need to differentiate from this culture among participants. Researchers might examine this rising trend among Appalachian people, and its relationship with the stigma associated with seeking mental health services among Appalachian people. Also, much RCT research has focused on the influence of family in career development with little research on the roles of friends and mentors. Researchers might explore the impact on careers of people outside of the family. Finally, little research has been conducted on the career development of Appalachians. This region is a significant part of the United States and warrants further research to better understand the population and their career needs.

Limitations

The findings of this study contain certain limitations, primarily with the participants. First, only nine individuals participated. Though this is sufficient for qualitative research, it does limit the generalizability of these findings. Also, participants were White individuals from the Appalachian region. As is stated above, individuals from this region possess a unique culture. Thus, findings may not generalize to a larger population. Additionally, participants were largely non-traditional college students attending private universities located in Appalachia. These participants may not be representative of other Appalachian individuals who attend public universities either in or outside of the region. Finally, the individuals in the study had a relationship with the interviewers. This relationship, though approved by IRB, may have impacted and shaped the participant responses.

Conclusion

The people of Appalachia possess a unique cultural context different from other subcultures in the United States (Martis, 2005). This culture involves characteristics that impact personal and career development. From a Relational Career Theory perspective, these developments are simultaneous and isomorphic, and culture creates the career experiences of Appalachians in unique ways (Blustein, 2011). The researcher's findings support the claims of Relational Career Theory through findings that Appalachian human services students experience a career process in which they strive to differentiate themselves from their culture and from experiences that may include trauma. Specifically, they follow a unique and common progression towards a preferable career, molded by context, values and experiences. These findings suggest that people and culture are a part of the career development of Appalachian people and should be considered in career counseling services.

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Barriers to Counseling among Human Service Professionals: The Development and Validation of the Fit, Stigma, & Value (FSV) Scale

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Abstract

This study sought to confirm rates of attendance in counseling of human service professionals and validate a 32-item questionnaire designed to identify barriers to counseling seeking behavior among this population. Results indicated that a large percentage of human service professionals attend counseling, with males and females attending at similar rates and non-Caucasians attending at lower rates. A multivariate analysis of variance and descriptive statistics identified the most common barriers to attendance in counseling and examined demographic differences in participants' sensitivity towards barriers to attendance in counseling. A Principal Factor Analysis (PFA) revealed three subscales (*fit*, *value*, and *stigma*), which we called the Fit, Stigma, & Value (FSV) Scale. How the instrument can be used with students in human service programs, and with human service professionals, to reduce barriers to attendance in counseling and ultimately ameliorate personal problems, reduce vicarious traumatization, and limit countertransference are discussed.

Introduction

Preventing and ameliorating vicarious traumatization, compassion fatigue, and burnout among mental health professionals is critical if clients are to receive effective services (Brownlee, 2016; Corey, Muratori, Austin, & Austin, 2017; Mayorga, Devries, & Wardle, 2015; Whitfield & Kanter, 2014; Wolf, Thompson, Thompson, & Smith-Adcock, 2014). Some of the many self-care activities that have been shown to be useful in this capacity include: reading for leisure, eating well, journaling, going on vacation, having a hobby, creative writing for self-awareness, practicing relaxation techniques, meditating, exercising, practicing mindfulness, avoiding traumatic events on media outlets, seeking supervision, establishing appropriate boundaries with clients, and developing a strong support system. However, the one self-care activity that most mental health professionals agree is most critical if human service professionals are to be effective is attendance in their own personal counseling (Byrne & Shufelt, 2014; Daw & Joseph, 2007; Norcross, 2010; Norcross, Bike, Evans, & Schatz, 2008; Norcross & Guy, 2005; Neukrug, Milliken, & Shoemaker, 2001).

Personal Counseling: A Critical Self-Care Activity

Multiple reasons underlie the importance for human service professionals to seek personal counseling (Knight, 2013; Malikiosi-Loizos, 2013; Norcross, 2010; Orlinsky, Schofield, Schroder, & Kazantzis, 2011). First, counseling may help limit countertransference and thus ensure that the personal issues of professionals do not interfere with their work with clients (King & O'Brien, 2011; Murphy, 2013). Working on one's own issues in counseling tends to increase self-awareness, improve the ability to deal more effectively with one's emotions (emotional intelligence), increase the ability to be insightful concerning clients' problems, sharpen helper skills, decrease the likelihood of unethical work, and increase empathy and strengthen other working alliance skills. Also, being in one's own counseling can limit

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compassion fatigue or vicarious traumatization and thus help rejuvenate the human service professional and ensure the provision of optimal services for clients (Cole, Craigen, & Cowan, 2014; McClam & Varga, 2014). Finally, because human service professionals should be positive role models for clients, being in their own counseling can help ensure that they are presenting themselves in their best light (Neukrug, 2016).

Helpers' Rates of Attendance in Counseling

Attendance in counseling by mental health professionals tends to be high. For instance, a survey of 206 human service professionals revealed that 74.8% (n = 154) were either currently in, or had received, personal counseling (Neukrug, et al., 2001). Among these human service professionals, individual counseling was most common (94.7%; n = 145), followed by group counseling (38.7%; n = 59), couples counseling (26.7%, n = 45), family counseling (26%; n = 40), and "other" type of counseling (1%; n = 4). Further, 57.1% (n = 88) of these human service professionals utilized more than one type of counseling. Also, female human service professionals were more likely to attend counseling than males (77% to 65%). It was also found that 47% (n = 73) of human service professionals attended personal counseling services prior to receiving professional training, 41.3% (n = 64) attended during their training, and 31.6% (n = 65) attended after they had completed their training. Human service professionals attended counseling for a variety of reasons, with life transitions, (17.3%; n = 72), family issues (16.8%; n = 70), and personal growth (16.6%; n = 69), being the most prevalent.

Studies of related mental health disciplines have reported similar findings to that of human service professionals. For instance, McCarthy, Pfohl, & Bruno (2010) found that 44% of counselor trainees had been in counseling, while Neukrug and Williams (1993) discovered that 80% of counselors had attended personal counseling. Similarly, Holzman, Searight, and Hughes (1996) found that 75% of clinical psychology trainees utilized counseling services. Further, Dearing, Maddux, and Tangney (2005) reported that 70% of clinical psychology trainees had been in counseling before entering graduate school and 54% engaged in counseling while in graduate training. Attendance in counseling is also a common experience for psychiatrists in training with 57% of residents having utilized some form of individual treatment while in their residency (Fogel, Sneed, & Roose, 2006). Finally, Orlinsky et al. (2011) found that 87% of a variety of helpers (e.g., psychiatrists, counselors, social workers, and medical professionals) had been in personal therapy while Norcross and Guy's (2005) review of 17 studies found that of 8,000 helping professionals, close to three-fourths had been in therapy at least once.

Barriers to Attendance in Counseling

The results of survey research indicate that between 15% and 38% of Americans seek counseling for mental health problems (Flynn, 2013; Hann, Hedden, Libari, Copello, & Kroutil, 2014). Reasons why larger percentages of Americans have not sought counseling have included: lack of insurance coverage (36%), doubting that counseling would be effective (32%), being unclear about how to find a counselor (28%), not being able to find a counselor with whom they felt compatible (21%), reluctance to face their problems (19%), and concerns about social stigma (15%). In addition, gender seems to mediate attendance in counseling, with females being more likely to seek counseling than men (Lindinger-Sternart, 2015).

Studies of those in the helping professions find that they share similar reasons for not seeking counseling as those found in the general public; however, they also have some unique concerns. For instance, Holzman et al. (1996) found that of the 24% of clinical psychology

students who had never been in counseling, 56% stated they had no need for counseling and 53% stated it was a financial burden. Dearing et al. (2005) found that for psychology graduate students, the three major concerns for not seeking counseling included cost, the amount of time it consumed, and concerns about confidentiality. They also found that concerns about confidentiality, positive attitudes about therapy, and perceived importance of therapy were the best predictors of graduate students seeking help. Fleckenstein (2003) suggested that helper vulnerability and insecurity were related to reluctance to seek personal counseling by counselor trainees and novice counselors, and Norcross (2010) suggested that counselors, like members of the public, may not seek counseling due to the perceived stigma involved. As with the public, there appear to be gender differences in help-seeking behaviors with female helpers holding more positive attitudes toward counseling and seeking counseling at higher rates as compared to male helpers (McCarthy et al., 2010; Neukrug et al., 2001). Finally, helpers' theoretical orientation has been found to be related to their help seeking behaviors with 94% of psychoanalytic-oriented, 91% of humanistically oriented, and 73% of cognitive-behavioral focused therapists seeking counseling (Orlinsky et al., 2011).

Research Questions & Hypotheses

Researchers sought to answer the following research questions: 1. What is the percentage of human service professionals who seek counseling? 2. What are the most common barriers to counseling of human service professionals? 3. What is the underlying factor structure of the Fit, Stigma, and Value (FSV) scale? 4. Are there demographic differences in participants' sensitivity to barriers to counselor seeking behavior by gender, previous attendance in counseling, and professional status? The hypotheses are as follows: The frequency of counselor seeking behavior among human service professionals will be similar to the findings of Neukrug et al. (2001), an interpretable latent factor structure will emerge from the exploratory factor analysis (EFA), and statistically significant demographic differences in participants' sensitivity to barriers to counselor seeking behavior will emerge. The purpose of an EFA is to identify the fundamental factor structure (latent variables) from a data set (Mvududu & Sink, 2013). The hypotheses of the current study, therefore, are intentionally inexplicit.

Methods

Instrument Development and Distribution

The instrument, eventually titled the Fit, Stigma, & Value (FSV) Scale, was developed to identify the most prevalent types of barriers to counselor seeking behavior among human service professionals. Content validity for the scale was established by following procedures for instrument development noted by Leedy & Ormrod (2016) and included an expert panel review followed by a pilot study. Initially, the three researchers independently reviewed the literature on barriers to counseling-seeking behavior and identified potential items for the questionnaire. Researchers had over fifty years of combined experience in the human services and counseling fields. All researchers had clinical experience, and one researcher was an expert on assessment, having taught such a course for over 35 years, written articles, and authored a book on testing and assessment. A second researcher had taught research methodology and was an expert on factor analysis. After examining the existing literature and developing independent lists of potential barriers, the researchers met three times until a consensus was reached regarding which

items to include on the scale. A completed version of the instrument was developed after the researchers met for one final review of the items on the questionnaire.

The completed version of the instrument asked information about respondents' ethnicity/racial identity; age; level of education; major or concentration in school; gender; whether they primarily identified as a student, educator, or practitioner; and whether they had ever attended counseling. To answer this last question, respondents were provided with the American Counseling Association's (2016) definition of counseling: "Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (para 2). Initial demographic items and the attendance in counseling question were followed by 42 Likert-type items which respondents rated as to whether they perceived the item as a barrier to them seeking counseling (1= Strongly Disagree, 2 = Disagree, 3 = Neither Agree or Disagree, 4 = Agree, 5 = Strongly Agree). IRB approval was obtained through the researchers' university.

The resulting scale was pilot tested (Fowler, 2014), with 47 undergraduate students in human services and graduate students in counseling. Minor changes were made to the final instrument based on the feedback received. Specifically, some items were re-worded for clarity, roman numerals were changed to numerical digits, and the stem: "I am less likely to attend counseling because," which had preceded all items, was moved to the overall instructions, making the scale more readable. The final version of the instrument, which was comprised of seven demographic and 42 barriers-to-counseling items, was then sent to all members of the National Organization of Human Services (NOHS).

Participants

The scale was developed on Qualtrics (2017), an online survey software tool. A link to the questionnaire was then distributed to all 1,725 members of NOHS via email. A total of 628 (36%) participants responded. Following removal of 118 responses due to missing and incomplete data, the final response rate was 29.6% (n = 510), which is consistent with survey research on organizations (Guo, Kopec, Cibere, Li, & Goldsmith, 2016). As suggested by Field (2013), cases with less than 5% of missing data (n = 5) were replaced with the mean of all responses to that item. Of the final sample, 80% (n = 410) identified as female, 19% (n = 97) identified as male, 0.4% (n = 2) identified as other, and 0.2% (n = 1) identified as transgendered. Of respondents, 43.1% (n = 220) identified as students, 28.8% (n = 147) identified as educators, and 28% (n = 143) as practitioners. The majority of participants identified as Caucasian 50.4% (n = 257), followed by African American 34.3% (n = 175). To ensure sample sizes large enough to make group comparisons, the remainder of participants who identified with a variety of different ethnic backgrounds were aggregated into an "other ethnic" group, 15.3% (n = 78). Participants in this group identified as, Hispanic or Latino 6.1% (n = 31), Asian 1.4% (n = 7), American Indian or Alaska Native 1.4% (n = 7), Native Hawaiian or Pacific Islander 0.4% (n = 2), and 6.1% (n = 31) identified as other. This aggregation procedure is commonly used in survey research to ensure sample sizes that are sufficient for making comparisons (Kaneshiro, Geling, Gellert, & Millar, 2011).

Statistical Analyses

Based on the recommendations of prominent psychometric researchers, the factor structure of the scale was derived using a principal factor analysis (PFA) (Mvududu & Sink, 2013). An oblique rotation, direct oblimin ($\Delta = 0$) was applied. The flowing factor retention

criteria were used: factor loading > 0.40, commonality (h^2) > 0.30, and cross-loadings > 0.40 (Beavers et al., 2013). A 2 (gender) X 2 (attendance in counseling) X 3 (professional status) MANOVA was conducted as a follow-up analysis to investigate potential participant group differences across each of the derived factors. Specifically, the first independent variable (IV), gender, had the following two levels, 1. Male or 2. Female. The second IV, attendance in counseling, had the following two levels, 1. Had previously attended personal counseling and 2. Had not previously attended personal counseling. The third IV, professional status, had three levels, 1. Educator, 2. Practitioner, or 3. Student. The dependent variables (DVs) consisted of interval level scales that were constructed from summed item scores from each of the three derived factors.

Results

Attendance in Counseling

The majority of participants, 69.6% (*n* = 355), noted that they attended at least one session of personal counseling. Of female respondents, 68.8% (*n* = 282) sought counseling, while 73.2% (*n* = 71) of male respondents sought counseling. For attendance in counseling by professional status, 66.8% (*n* = 147) of students, 66.4% (*n* = 95) of practitioners, and 76.9% (*n* = 113) of educators reported attending counseling. For ethnicity, participants who identified as Caucasian reported the highest frequency of attendance in counseling (*n* = 190, 73.9%), followed by those who were aggregated into the "other ethnic" group" (*n* = 54, 69.2%), and lastly by African Americans (*n* = 111, 63.4%).

Item Analysis

The top five barriers to counseling among participants were as follows "1. I couldn't afford it" (*M* = 2.50, *SD* = 1.40), "2. I lack the time" (*M* = 2.50, *SD* = 1.40), "3. I would be uncomfortable because my counselor could also be a colleague" (*M* = 2.35, *SD* = 1.30), "4. My counselor may have a future professional role with me (be my colleague, supervisor, etc.)" (*M* = 2.26, *SD* = 1.24), and "5. My problems don't warrant seeing a counselor" (*M* = 2.24, *SD* = 1.15). A frequency analysis of all the barriers to counseling can be found in Table 1.

Table 1
Mean Independent Scores for Barriers

Barrier	N	Mean	Std. Deviation
17. ...I couldn't afford it.	510	2.50	1.40
19. ...I lack the time.	510	2.40	1.30
36. ...I would be uncomfortable because my counselor could also be a colleague.	510	2.34	1.24
30. ...my counselor may have a future professional role with me (be my colleague, supervisor, etc.).	510	2.30	1.24
35. ...my problems don't warrant seeing a counselor.	510	2.24	1.15
38. ...I have had a bad experience with a previous counselor in the past.	510	2.19	1.25
18. ...I lack health insurance with mental health benefits.	510	2.14	1.29
29. ...I'm afraid if I am given a diagnosis, it will impact my life negatively.	510	2.11	1.23
39. ...I prefer to talk to a religious leader about my personal issues rather than a counselor.	510	2.00	1.08

31. ...I can't trust people with private matters.	510	2.00	1.10
37. ...counseling is unnecessary because my problems will resolve naturally.	510	1.97	.98
10. ...it would indicate something is wrong with me.	510	1.94	1.14
41. ...I'm afraid if I go to counseling I will re-live past traumatic experiences.	510	1.92	1.07
7. ... it would suggest I am unstable.	510	1.91	1.14
25. ...I couldn't find a counselor with my theoretical orientation (personal style of counseling).	510	1.89	1.04
21. ...the financial cost of participating is not worth the personal benefits.	510	1.88	1.02
20. ...I would not know where to find a counselor.	510	1.84	1.03
26. ...I would feel judged by my counselor.	510	1.83	1.00
42. ...I'm afraid people at my work will find out.	510	1.82	1.03
28. ...I couldn't find a counselor who would understand me.	510	1.81	0.98
12. ...it would damage my reputation.	510	1.80	1.04
27. ...I couldn't find a counselor competent enough to work with me.	510	1.80	1.00
33. ...I would find out something about myself that I do not want to know.	510	1.79	1.00
9. ...I would feel embarrassed.	510	1.79	1.04
34. ...I don't trust a counselor to keep my matters just between us.	510	1.78	0.99
16. ...I am concerned that matters I discuss would not be kept confidential.	510	1.76	1.10
1. ...my colleagues, supervisors, professors, or classmates would think less of me.	510	1.76	0.97
3. ...it would suggest I lack the ability to be an effective helper.	510	1.75	0.98
4. ...my colleagues, supervisors, professors, or classmates would not be supportive.	510	1.74	0.88
2. ...my family would not be supportive.	510	1.74	0.94
5. ...my family would think less of me.	510	1.73	0.91
32. ...I lack the emotional preparedness to be in counseling.	510	1.70	0.88
6. ...my friends would think negatively of me.	510	1.70	0.84
24. ...it is not an effective use of my time.	510	1.66	0.88
11. ...it is a sign of weakness.	510	1.65	0.92
13. ...it would be of no benefit.	510	1.62	0.87
22. ...my counselor won't understand my sexuality.	510	1.62	0.91
14. ...I would feel badly about myself if I saw a counselor.	510	1.60	0.81
23. ...there are no counselors in my immediate area.	510	1.55	.7908
40. ...I have a disability that makes it difficult to travel to a counselor's office.	510	1.52	.7720
8. ...it is difficult for me to find transportation to a counselor's office.	510	1.49	0.77
15. ...my problems are too severe for counseling to help.	510	1.44	0.70
Valid N (listwise)	510		

Participants (N = 510) responded to the Likert-type questions above with higher scores indicating a greater sensitivity to barriers (1= *Strongly Disagree, 2 = Disagree, 3 = Neither Agree or Disagree, 4 = Agree, 5 = Strongly Agree*).

Inter-Item Correlations

Inter-item Pearson Product correlations were conducted between all 42 items, ranging from 0.13 to 0.85. Initial internal consistency reliability was calculated on the 42 items, producing a Cronbach's alpha of 0.92. Reliability analysis indicated that removing 10 items (2, 8, 20, 29, 30, 32, 33, 36, 39, and 42) raised the internal consistency of the measure to 0.96. The inter-item correlation matrix was re-produced with the remaining 32 items and was favorable, with all items inter-correlating $r \geq .30$ with at least half of the other items. Item commonalities were acceptable (see Table 2), ranging from 0.31 to 0.67. Bartlett's Test of Sphericity and a Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) demonstrated that the correlation matrix was favorable for factor analysis, $B(496) = 11{,}221.52$, $p = 0.00$, KMO = 0.95.

Multiple modalities were utilized to investigate the normality of the distribution (Field, 2013). An initial inspection of histograms, skewness values, and kurtosis values indicated that the data was not normally distributed. Data were converted to *z*-scores and winsorized. Skewness and Kurtosis values were computed for the winsorized data. The majority of skewness and kurtosis values ($n = 25$, 78%) were within the ranges of a normal distribution ± 1. Item 23 displayed a negative skew while items 3, 14, 15, 16, 22, and 23 displayed positive skews. Researchers elected to keep these seven items in the factor analysis as normality is not required for all items when using a principal axis factor extraction method (Beavers et al., 2013). These seven items also demonstrated favorable inter-item correlations ($r \geq .30$) with at least half of the other items, suggesting that it would be valuable to keep them in the factor analysis.

Exploratory Factor Analysis and Emergent Factor Structure

A Principal Factor Analysis (PFA) with a direct oblimin rotation was conducted. The Kaiser Criterion ($\Lambda > 1.00$), scree plot, and meaningful variance accounted for ($\geq 5\%$) and were used to identify the appropriate number of factors to extract (Fabrigar & Wegener, 2011). A three factor structure emerged (see Table 2) based on these criteria. Factor 1, which was named *Fit*, accounted for 42% of the variance in the total model and involved one's sense of comfort being in counseling and trust in the process of counseling. Some examples of items that loaded on this factor included: "15. My problems are too severe for counseling to help," "38. I have had a bad experience with a previous counselor in the past," and "28. I couldn't find a counselor who would understand me." Factor 2, *Stigma*, accounted for 7.6% of the variance and referred to shame or embarrassment about being in counseling. For example, "1. My colleagues, supervisors, professors, or classmates would think less of me," "12. It would damage my reputation," "9. I would feel embarrassed" are found in this factor. Factor 3, *Value*, accounted for 5.1% of the variance in the model and is comprised of items related to the perceived benefit of counseling. For example, "24. It is not an effective use of my time," "21. The financial cost of participating is not worth the personal benefits," and "37. Counseling is unnecessary because my problems will resolve naturally" were found in this factor. The final scale was given the name Fit Stigma Value (FSV) Scale to represent these attributes. The coefficient alpha reliability of the FSV scale was high, 0.96. Reliability coefficients of each independent factor were also high, 0.92, 0.94 and 0.86, respectively for Factors 1, 2, and 3.

Table 2
Summary of Principal Factor Analysis of the "FSV" Using Oblique Rotation (N = 510)

	Factor 1 (*Fit*)	Factor 2 (*Stigma*)	Factor 3 (*Value*)	
Item	Loadings			h^2
28. I couldn't find a counselor who would understand me	**0.77**		0.11	0.67
27. I couldn't find a counselor competent enough to work with me	**0.76**		0.12	0.63
22. My counselor won't understand my sexuality.	**0.66**	0.13	0.12	0.49
25. I couldn't find a counselor with my theoretical orientation (personal style of counseling).	**0.65**		0.20	0.58
34. I don't trust a counselor to keep my matters just between us.	**0.64**	-0.12		0.57
23. There are no counselors in my immediate area.	**0.62**			0.36
40. I have a disability that makes it difficult to travel to a counselor's office.	**0.60**		0.20	0.32
26. I would feel judged by my counselor.	**0.58**	-0.15	0.17	0.63
41. I'm afraid if I go to counseling I will re-live past traumatic experiences.	**0.54**	-0.16		0.36
16. I am concerned that matters I discuss would not be kept confidential.	**0.53**	-0.12		0.44
31.I can't trust people with private matters.	**0.53**	-0.17	0.11	0.51
38. I have had a bad experience with a previous counselor in the past.	**0.50**			0.32
15. My problems are too severe for counseling to help.	**0.49**	-0.17	0.11	0.46
7. It would suggest I am unstable.		**-0.84**	0.26	0.70
10. It would indicate something is wrong with me.	0.17	**-0.81**	0.28	0.64
12. It would damage my reputation.		**-0.80**		0.67
9. I would feel embarrassed.		**-0.77**		0.65

3. It would suggest I lack the ability to be an effective helper.		**-0.74**		0.61
11. It is a sign of weakness.		**-0.73**	0.14	0.63
1. My colleagues, supervisors, professors, or classmates would think less of me.	0.17	**-0.65**		0.54
14. I would feel badly about myself if I saw a counselor.		**-0.60**	0.30	0.65
6. My friends would think negatively of me.	0.30	**-0.56**		0.60
4. My colleagues, supervisors, professors, or classmates would not be supportive.	0.33	**-0.547**		0.57
5. My family would think less of me.	0.31	**-0.52**		0.53
21. The financial cost of participating is not worth the personal benefits.			**0.71**	0.62
19. I lack the time.			**0.61**	0.41
17. I couldn't afford it.			**0.60**	0.37
18. I lack health insurance with mental health benefits.	0.20	0.18	**0.50**	0.33
37. Counseling is unnecessary because my problems will resolve naturally.		-0.17	**0.47**	0.36
35. My problems don't warrant seeing a counselor.		-0.13	**.429**	0.31
24. It is not an effective use of my time.	0.28	-0.18	**0.42**	0.54
13. It would be of no benefit	0.16	-0.26	**0.41**	0.59
Eigenvalues	13.75	2.44	1.63	
% of variance	43%	7.6%	5.1%	

Note: Factor loadings that appear in bold mark items that loaded on that particular factor. Empty cells indicate factor loadings ≤ 0.10.

MANOVA Results

A Multivariate Analysis of Variance (MANOVA) was conducted to investigate demographic differences in participants' sensitivity to the FSV barriers. Researchers ensured that the current data set met the statistical assumptions that are required to conduct a MANOVA that are outlined by Field (2013). The Skewness values for factor 1, (0.56) factor 2, (0.80) and factor 3, (0.27) and Kurtosis values for factor 1, (-0.61) factor 2, (-0.27) and factor 3, (-0.81) were all within the range of a normal distribution. The assumption of multicollinearity was met as correlations between the DVs were as follows: factor 1 and factor 2 (r = 0.68), factor 1 and factor 3 (r = 0.67), and factor 2 and factor 3 (r = 0.61). The assumption of independence of observations was met as it was not possible for any participant to simultaneously be in more than one group.

The results of the MANOVA revealed a statistically significant main effect for attendance in counseling $F(11, 495) = 3.10$, $p = 0.03$, $\eta_p^2 = 0.02$. A Bonferroni correction was utilized. Specifically, participants who had never attended counseling ($M = 0.18$, $SD = 0.67$) were significantly more likely to be sensitive to Factor 3: *Value*, compared to participants who had previously attended counseling ($M = -0.06$, $SD = 0.65$), $F(11, 495) = 7.70$, $p = 0.01$, $\eta_p^2 = 0.02$.

Discussion

This study confirmed the relatively high rate of attendance of human service professionals in counseling (70%), although slightly lower than Neukrug et al.'s (2001) study (75%). Differences may be due to the more precise definition of counseling provided in this study or to this study's larger sample size. In either case, it appears that human service professionals attend counseling at fairly high rates, similar to rates found by other mental health professionals, and probably a fair amount higher than the general public (Flynn, 2013; Hann, et al., 2014; Orlinksy et al., 2011). This is promising, since attendance in counseling is likely related to amelioration of personal problems, reduction of vicarious traumatization, and a decrease in the likelihood of countertransference (Harrison & Westwood, 2009; Murphy, 2013).

This study found attendance in counseling of female and male human service professionals to be nearly the same. This was somewhat surprising, since past studies have shown that as compared to males, female professionals tend to be more amenable to being in their own therapy (Lindinger-Sternart, 2015; McCarthy et al., 2010; Neukrug et al., 2001). Additionally, non-Caucasian, particularly African Americans, find the helping relationship less welcoming (Lo, Cheng, & Howell, 2013; U.S. Department of Health and Human Services, 2014). So, it is not surprising that participants who identified as Caucasian in this study reported the highest rates of attendance in counseling, followed by "other ethnic," and lastly by African Americans. These results emphasize the importance of multicultural competence to ensure that the counseling process, and the helping relationship, are viewed as inviting and rewarding to all individuals (Nuttgens & Campbell, 2010). Further, the findings from the current study have extended the literature on barriers to counseling seeking behavior among human services professionals by identifying psychometrically validated types of barriers. The final version of the FSV scale was comprised of 32 items that comprise three subscales. The first barrier, *fit*, accounted for the largest amount of variance and included 13 items. This was followed by *stigma*, which included 11 items, and *value*, which included eight items. In addition, *value* seems to be particularly important for those human service professionals who have never attended counseling.

These results raise important considerations for human service education and human service professionals in general. It would seem important for human service programs, and perhaps NOHS, to develop a directory of counselors who are "trustworthy" or specialize in working with clients who are also helping professionals. Although trustworthiness is a loose concept, students may be more likely to see a counselor who has been identified by faculty as trustworthy, and if they knew that the counselor's focus or areas of expertise included specific issues that students typically face. Similarly, human service professionals may be more likely to seek counseling by an individual identified through their national organization as being duly qualified, and if the human service professional was aware of the counselor's specialty focus and areas of expertise. This may make it easier for human service professionals to seek a counselor who specializes in the problems they might be experiencing. Such a listing by NOHS might reduce the uncertainty that can be involved with finding a qualified counselor.

Relative to stigma, it is critical that human service programs, national organizations, and ethics codes make it clear that seeking counseling will not negatively impact a person's ability to find a job, continue in their training, or work with others. In fact, programs, organizations, and ethics codes should be vehicles for promoting the importance of attendance in counseling, noting how such attendance is critical in ameliorating problems and decreasing countertransference (Cole et al., 2014; King & O'Brien, 2011; McClam & Varga, 2014; Murphy, 2013). Finally, relative to value, it is recommended that human service programs and national organizations emphasize the importance of attending personal counseling so that all human service professionals realize its benefits.

On a more practical level, the FSV scale can be used by human service programs nationally. Such an instrument can be taken by students, and within classes, and results can be discussed and used to examine why students may not be attending counseling. Although such results should be discussed in a manner that does not reveal individual responses, a wide variety of issues can still be addressed through such an assessment. For instance, if many students believe there are few, if any, counselors in their area, faculty can help identify those counselors which may be nearby. If large numbers of students believe that attending counseling is stigmatizing, faculty can discuss the importance of de-stigmatizing counseling and emphasize the importance of personal counseling in decreasing countertransference and in ensuring a positive helping relationship with clients (King & O'Brien, 2011; Murphy, 2013). If relatively large numbers of students believe they cannot afford counseling, faculty can attempt to find counselors who charge lower fees and help students identify if their medical insurance will cover the cost of counseling. With training programs being an essential vehicle for mental health professionals' attendance in counseling (McCarthy, 2008; McCarthy et al., 2010; McCarthy, Bruno, & Sherman, 2010), it is hoped that research such as this can help direct the manner in which human service programs assist their students in finding counselors and in removing barriers to seeking counseling.

Limitations and Future Research

Sampling procedures in survey research can skew results. For instance, it could be that those who seek counseling have more of a tendency to respond to such a survey as compared to those who do not seek counseling. Such self-selection could give a false sense of which barriers are primarily faced by helpers.

Another limitation of the current study is the lack of an ethnically diverse sample. The majority of participants identified as Caucasian or African American, and the remaining participants were aggregated into an "other ethnic group" to ensure sample sizes large enough for group comparisons. This aggregation procedure is commonly used as recruiting an ethnically diverse sample is a common limitation in survey research (Kaneshiro et al., 2011). It is recommended that future researchers investigate differences in counselor seeking behavior with an ethnically diverse sample using inferential statistical procedures.

Future researchers may want to further validate the emergent factor structure of the FSV scale by conducting additional confirmatory factor analyses, perhaps for other mental health professionals, and for the general population. They may also want to investigate demographic differences among helping professionals to develop a deeper understanding of why different ethnic and racial groups may avoid seeking counseling. In addition, future researchers can investigate the validity of the FSV scale for predicting individuals' attendance in counseling. For

instance, one might investigate the extent to which reductions in participants' sensitivity barriers to counselor seeking behavior predicts their actual attendance in counseling.

The multivariate results in the current study suggest that participants who have not attended counseling are more likely to be sensitive to the *value* barrier. Future research should confirm this finding with different populations. Finally, the majority of the existing studies on barriers to counselor seeking behavior among helping professionals have utilized survey research methodology. Future qualitative researchers might conduct a phenomenological study to identify mental health professionals' lived experiences in relation to barriers and solutions towards counselor seeking behavior.

Summary and Conclusion

This study sought to understand the types of barriers that may be at play when a human service student or professional is considering seeking counseling. The results of an exploratory factor analysis uncovered three subscales (*fit*, *stigma*, and *value*) that may be important in understanding why some human services professionals may be reticent to attend counseling. Further studies that confirm this factor structure are important if this instrument is to become widely used. It is hoped that the FSV scale can offer a mechanism to help understand and reduce the barriers for helping professionals who may want to seek counseling to ameliorate their problems, diminish vicarious traumatization, or reduce countertransference.

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Human Services Students' Preferences for Master's Level Training

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Abstract

Human Services students close to graduation are seeking employment in the field, but many are also considering their future career paths and the training needed to reach their long-term career goals. Knowing if bachelor's level students desire graduate degrees, which focus they prefer, and how they would like to pursue the degrees may contribute to the decision-making of educators, employers, and students. This exploratory study, therefore, examined human services students' preferences for master's level training. Students' responses reflected preferences for several types of master's programs, direct acceptance, and online delivery. These themes and their implications for educators, employers, and students are discussed.

Introduction

Many human services (HMSV) students close to graduation are not only seeking employment in the field but are also considering their future career paths and the training needed to reach their long-term professional goals. Traditionally, for many in human services, their educational training moved from a certificate, to an associate's degree, to a bachelor's degree (Neukrug, 2017). In recent years, training has expanded with colleges now offering master's and doctoral programs in HMSV. Human services career opportunities and education options have grown due in part to the profession's expanded viability. It has become solid enough, that recent research, has called for human services to establish its own code within the Dictionary of Occupational Titles (Sparkman-Key & Neukrug, 2016). The need for qualified human services professionals has developed in response to current challenges in the world, and each additional degree opens up new, meaningful opportunities for work that can engage them in different ways of helping others.

HMSV Degree Descriptions

At each degree level, human services professionals are prepared for different levels of service delivery. According to the Council for Standards in Human Service Education (CSHSE, 2013, a, b, c), those with associate's degrees are prepared to address the needs of individuals and groups through case management, intake interviews, counseling, use of resources and referrals, and consultation. HMSV students with associate's degrees may also seek further certifications, such as the Human Services Board Certified Practitioner credential or the Certified Alcohol and Drug Counselor credential. Those at the bachelor's level meet all of the standards for the associate's degree, as well as obtain skills in program evaluation, systems theory, and advocacy. They also learn to take on administrative roles as human services professionals. Individuals pursuing master's degrees in human services meet all of the standards of the associate's and bachelor's degrees and are prepared to engage in human services research and evaluation. Doctoral degree programs prepare students to become human services educators.

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Graduate Degree Programming

Logically, students seek graduate level training that will position them for better employment options and allow them to quickly advance in their chosen fields. Despite the expansion of the human services field, master's degree programs in other helping fields remain far more prevalent. Based on a web search, 36 master's programs and five doctoral programs in human services were found to exist in the U.S. at this time. There are no accredited human services master's or doctoral programs (CSHSE, 2017). Considering there are few graduate programs to choose from, and none are accredited, bachelor's level HMSV students may pursue master's degrees in social work or various counseling disciplines as opposed to human services graduate degrees, based on their greater availability. However, these related programs do offer HMSV students beneficial career opportunities. A master's in social work allows graduates to work with individuals, families, and groups to optimize their functioning and promote community health (National Association of Social Workers, 2017). There are several different master's in counseling programs that students may pursue. For example, clinical mental health counseling programs prepare skilled professionals eligible for licensure who provide therapy to individuals, groups, couples, and families (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015). Individuals with a master's degree in school counseling work with children and adolescents providing individual and group counseling in the school setting to promote academic achievement. A master's in college counseling allows graduates to work with students in higher education settings. Rehabilitation counselors are licensed professionals working with individuals who have social and vocational difficulties resulting from various disabilities. Addictions counselors are prepared to address individuals' problems with substance use and abuse, as well as with other addictive behaviors including gambling, eating, video game playing, etc. They utilize individual, group, and family counseling intervention and prevention.

Other graduate programs of interest to students with a bachelor's degree in human services may include marriage and family therapy, and integrated care. Those with a master's degree in marriage and family therapy address dysfunction within the family system (American Association for Marriage and Family Therapy, 2017). With a master's in integrated care, professionals manage and organize services related to diagnosis, treatment, care, rehabilitation and health promotion for individuals, typically within large systems, such as hospitals (International Foundation for Integrated Care [IFIC], 2017). With a wide range of graduate degree options for bachelor's level human services students to pursue, it is of value to understand what they are most drawn to as a means to assist in adequate advisement and program development for students and educators, and position development for employers.

However, no prior research has investigated bachelor's level HMSV students' graduate degree seeking choices. This study focused on the perspectives of current students who had yet to complete their bachelor's training but were considering next steps and picturing what training they planned to pursue to enhance their careers. Information garnered from this study could guide future students in their decisions, empower employers by recognizing employees' long-term goals, and clarify what types of master's degrees colleges and universities should consider developing, as well as the modality in which they should offer them.

This preliminary, exploratory survey study was designed to gain a deeper understanding of the desires of current students in a Bachelor of Science program in HMSV as they considered their future career directions and needs. It is important for the profession of HMSV to know if bachelor's level students want graduate degrees, and if so, what fields they desire them in, and

how they want to pursue them. This study therefore, explored students' perspectives on what types of degrees they would like to pursue beyond their bachelor's degree, and what type of admissions and course delivery might facilitate their pursuit of this higher level of training.

Method

Participants

Participants were undergraduate students (N = 238) majoring in a Bachelor of Science program in human services at a large metropolitan institution located in the southeastern United States. All percentages are reported to the 10th of a percent. When a participant opted not to respond to an item on the survey, the percentages were calculated without their information. This is noted in the reporting of the data. Of the participants, 214 were female (89.9%), 24 were male (10.1%), and none were transgender. Self-reported race/ethnicity included 117 (49.2%) White, 94 (39.5%) Black, 10 (4.2%) Bi-racial/Multi-racial, 6 (2.5%) Latino/a, 5 (2.1%) other, 3 (1.3%) Native American, and 2 (.8%) Asian individuals. One participant opted not to respond to this item. Participants' age ranged from 18 years old to just over 60, with most students (n = 105; 44.1%) between 21-30 years of age. The remaining included 58 (24.4%) between 31-40 years old, 28 (11.8%) between 51-60, 26 (10.9%) under 20, 19 (8.0%) between 41-50, and 2 (.8%) 60 years of age or older. The majority of participants reported no special needs (n = 216; 90.8%), while the remaining students (n = 21; 9.2%) reported physical, emotional, or learning disabilities. One participant opted not to respond to this item. Of the total sample, 59 (24.8%) reported some type of military status including 27 (11.3%) veterans, 27 (11.3%) military dependents, 3 (1.3%) disabled veterans, and 2 (.8%) active duty reservists.

Related to their experiences as undergraduate human services majors, the majority of participants (n = 156; 65.5%) identified as seniors in their final year of their bachelor's degree program. Juniors accounted for 66 (27.7%) of the participants, while 12 (5.0%) identified as sophomores and 2 (.8%) as freshmen. Two participants opted not to respond to this item. Most participants were completing their courses online (n = 132; 55.5%). Face-to-face courses were completed by 23.5% (n = 56) of the participants, while 21.0% (n = 50) opted for a combination of both online and face-to-face. Most participants also identified as full time students (n = 182; 76.5%), with the remaining 23.1% (n = 55) attending part time. One participant opted not to respond to this item. The respondents consisted primarily of non-traditional transfer students (n = 135; 56.7%). These students attended community college at some point after high school, and transferred into the four-year institution at some time after completing an associate's degree, but with a substantial amount of work and life experience as well. Traditional students, who entered the four-year institution as freshmen immediately following high school, accounted for 24.4% (n = 58) of the participants. A smaller portion of the respondents reported being traditional transfer students (n = 34; 14.3%) who attended community college from high school and transferred directly into the four-year institution upon completion of an associate's degree, or non-traditional students (n = 10; 4.2%) who entered the four-year institution after years out of high school. One participant opted not to respond to this item. First generation college students accounted for 52.5% (n = 125) of the participants, and 74.8% (n = 178) worked while attending school.

Procedures

Data collected for the current study was obtained through a researcher-developed survey that included consent, demographics, and applicable questions about students' future training interests. Items were developed through a review of current graduate education options in the

mental health and social services fields, as well as through consultation with faculty in the researchers' undergraduate human services program and the department Chair and college Dean from the researchers' institution. Once the survey was developed, it was piloted on one class of 24 human services students taught by the second author. Based on feedback from these students, modifications were made to the survey that included clarifying the study's purpose, shortening the definitions provided of the various graduate programs, adding an item related to military status, and correcting two grammatical errors.

After approval by the university's Institutional Review Board, the survey was created in the university's electronic survey system, Qualtrics. A link to the Qualtrics survey was embedded into an email that addressed consent and briefly explained the purpose of the study. Participants were contacted through the human services program's email list serve. All registered human services undergraduate majors were contacted about participating in the study via this email (N = 860). Students who were interested were able to click a link and were taken to the survey that opened with an informed consent page that needed to be agreed to prior to starting the survey. All information collected on the Qualtrics instrument was de-identified and stored on a secure server. Ultimately, 238 students participated for a response rate of 28%.

Survey

The survey contained 30 questions including demographics pertaining to student status (freshman, sophomore, junior, or senior), gender, ethnicity/race, and age. It asked about several further statuses including military, first generation third college student, special needs, attendance (full or part time), and work status. Additionally, participants were asked to specify the primary modality used to take their human services courses: online, face-to-face, or a combination of both. The questionnaire provided definitions of several types of master's degrees including: mental health counseling, school counseling, college counseling, marriage and family therapy, addictions counseling, rehabilitation counseling, human services, social work, and integrated care. It asked if participants desired to pursue a master's degree, which they would prefer to pursue, and which would be their second choice. The survey also asked if participants would be more likely to pursue a master's degree if they were granted direct admittance into the graduate program based on meeting minimum entrance criteria. Finally, the survey asked students to specify their preference for graduate program delivery: online, face-to-face, or a combination.

Data Analysis

The research design of this preliminary, exploratory survey study was non-experimental, single-variable. Descriptive statistics and frequency reports were run on the demographic data. The Chi-Square Test of Independence, also called Pearson's Chi-Square Test or the Chi-Square Test of Association, was used to discover if there were relationships between the categorical variables. This was appropriate because all of the data was nominal, and each variable consisted of two or more categorical, independent groups. The study was exploratory, so no hypotheses were proposed. Its purpose was to answer the following questions: Do undergraduate human services students desire to obtain a master's degree? What master's degree programs do undergraduate human services majors prefer? In which modality (online, face-to-face, or combination) do undergraduate human services majors prefer to complete a master's degree? Are there relationships between demographic variables and undergraduate human services students' preferences for master's degree programs? Data were analyzed using SPSS.

Results

For this sample, almost all students (*n* = 223; 93.7%) intended to pursue a master's degree at some point in their futures, with only a small number (*n* = 15; 6.3%) not considering it. All students who indicated they would pursue a master's degree in the future (*n* = 223) indicated that they would definitely (*n* = 181; 81.2%), or possibly (*n* = 42; 18.8%) choose a program option in which they could automatically obtain admittance to a master's program from the human services bachelor's degree program by meeting specific GPA and professional experience requirements at the undergraduate level. The majority of students also indicated that they would be more likely to pursue their master's degree if they could complete it online (*n* = 190; 85.2%). However, a slightly smaller proportion (*n* = 145, 78.0%) indicated they prefer an online format to face-to-face.

Type of Degree

Of the 223 interested in pursuing a graduate degree, 200 (84.0%) specified that they would be interested in one described on the survey, including mental health counseling, school counseling, college counseling, marriage and family therapy, addictions counseling, rehabilitation counseling, human services, social work, and integrated care. Thirteen (5.5%) participants indicated that they would pursue a different master's degree from those specified, including business administration (*n* = 2), higher education (*n* = 1), leadership (*n* = 1), art therapy (*n* = 1), funeral services/mortician (*n* = 1), public health (*n* = 1), quality assurance (*n* = 1), occupational therapy (*n* = 1), occupational and technical studies (*n* = 1), juvenile justice (*n* = 1), and gerontology (*n* = 1). One individual did not specify a different type of degree, and 10 participants did not respond to this item.

Pertaining to the type of master's degree program preferred from those described on the survey, 26.0% (*n* = 58) indicated a preference for social work. This was the most preferred master's degree program by a 10% margin. The next most frequently selected master's program was human services (*n* = 36; 16.1%). Closely following was school counseling at 14.8% (*n* = 33). Equally preferred at 11.2% were mental health counseling (*n* = 25) and marriage and family therapy (*n* = 25). Addictions counseling was most preferred by 24 respondents (10.8%). College counseling, rehabilitation counseling and integrated care were least preferred at 5.4% (*n* = 12), 3.6% (*n* = 8), and .9% (*n* = 2) respectively. When asked to select a second choice, the following were chosen in order of preference: social work (*n* = 43; 19.3%), human services (*n* = 40; 17.9%), mental health counseling and marriage and family counseling (*n* = 30; 13.5% each), addictions counseling (*n* = 21; 9.4%), rehabilitation counseling (*n* = 20; 9.0%), college counseling (*n* = 17; 7.6%), school counseling (*n* = 16; 7.2%), and integrated care (*n* = 6; 2.7%).

Associations with Demographics

Relationships between several variables were explored. A non-significant relationship was found between gender and participants' intention to pursue a master's degree at some point in their future $X^2(2, N = 223) = 1.795$, $p = .180$. Further, Phi effect size value ($\varphi = .087$) suggested a weak association between the variables. Neither was there a significant relationship between age and intent to pursue a master's degree $X^2(2, N = 223) = 9.072$, $p = .106$. The Phi effect size value ($\varphi = .195$) suggested a weak association between these variables as well. Likewise, one's race/ethnicity was not significantly related to participants' desire to obtain a master's degree in the future $X^2(2, N = 223) = 1.837$, $p = .934$. The Phi effect size value ($\varphi = .088$) also suggested a weak association between these variables. There was no significant

relationship between being a first generation college student and intent to pursue a master's degree $X^2(2, N = 223) = .004$, $p = .948$. The Phi effect size value ($\varphi = -.004$) suggested a weak association between these variables as well. Finally, no significant relationship was found between participants' work status: full or part time $X^2(2, N = 223) = .004$, $p = .952$. The Phi effect size value ($\varphi = -.005$) suggested a weak association between these variables too. The majority of participants intend to pursue a master's degree in the future regardless of how they identify.

With regard to the type of master's degree participants were interested in pursuing, there were significant differences between males and females $X^2(2, N = 223) = 26.174$, $p = .001$. The association between gender and type of master's degree participants were interested in pursuing was moderate ($\varphi = .343$). However, due to the disparity in sample sizes (24 males and 214 females), these results should be considered with caution. For both males and females, few if any were interested in pursuing a master's in integrated care (0.0% and 1.0% respectively). Males and females were comparably interested in pursuing a marriage and family therapy degree (12.5% and 11.1% respectively). Likewise, males and females were similarly interested in pursuing mental health counseling (16.7% and 10.6% respectively) and rehabilitation counseling (8.3% and 3.0% respectively). Differences emerged with the remaining degrees. While no males were interested in pursuing school counseling, 16.6% of females wished to pursue this degree. Males (12.5%) were more interested in college counseling than were females (4.5%). Likewise, males (33.3%) were substantially more interested in addictions counseling than were females (8.0%). Conversely, females were far more interested than males in pursuing both social work (28.1% and 8.3% respectively) and human services (17.1% and 8.3% respectively).

While there was no significant relationship and a moderate association between preferred type of master's degree to pursue and participants' race/ethnicity $X^2(2, N = 223) = 45.004$, $p = .596$, $\varphi = .450$, there was a significant relationship with regard to age $X^2(2, N = 223) = 80.758$, $p = .000$. The Phi effect size value ($\varphi = .602$) suggested a strong association between age and preferred type of master's degree to pursue. The two individuals who were 60 or older indicated a preference for a human services master's degree (100%), while the majority (64%) of the 23 participants between the ages of 51-60 desired a graduate degree in addictions (41.7%) or human services (21.7%). The other degree options were either selected by one participant each (school counseling and college counseling), two participants each (marriage and family therapy, rehabilitation counseling, and social work), or no participants (mental health counseling and integrated care). The 18 participants between 41 and 50 were more diverse in their selections. School counseling was selected by five (27.8%), social work was selected by four (22.2%), marriage and family therapy and addictions counseling were both selected by three (16.7%), mental health counseling was selected by 2 (11.1%), integrated care was selected by one (5.6%), and no one selected college counseling, rehabilitation counseling, or human services. Those between 31 and 40 years of age ($n = 56$) were most interested in human services ($n = 16$; 28.6%) and social work ($n = 11$; 19.6%). None were interested in integrated care, but seven selected marriage and family therapy (12.5%), six each selected mental health counseling (10.7%) and school counseling (10.7%), five selected addictions counseling (8.9%), three selected college counseling (5.4%), and two selected rehabilitation counseling (3.6%). The largest category of participants fell between the age range of 21-30. The 98 respondents preferred social work (28.6%) and school counseling (18.4%) for graduate degrees. Mental health counseling (14.3%) was the next most frequently selected degree, closely followed by human services (12.2%). Marriage and family therapy was selected by 9.2%, while college counseling and addictions

counseling were both selected by 6.1% of participants. Rehabilitation counseling was selected by 4.1% of respondents, and integrated care by 1.0%. The 26 participants between 18 and 20 were most interested in a master's in social work (50.0%). None selected integrated care, rehabilitation counseling, or addictions counseling. Marriage and family therapy was selected by four (15.4%), while mental health counseling and school counseling were both selected by three individuals (11.5%). Two (7.7%) participants selected college counseling. A master's degree in human services was only selected by one (3.8%) participant.

There was also a significant relationship between type of graduate program selected and whether or not one identified as a first generation college student $X^2(2, N = 223) = 15.758$, $p = .046$. However, the Phi effect size value ($\varphi = .266$) suggested a weak association between these variables. First generation students and non-first generation students selected the following at a similar rate: social work (27.4% & 24.5% respectively), school counseling (13.7% & 16.0%), mental health counseling (10.3% & 12.3%), college counseling (6.8% & 3.8%), and integrated care (.9% & .9%). Differences were evidenced between first generation college students and those who are not with regard to the following: human services (12.0% & 20.8%), rehabilitation counseling (6.0% & .9%), marriage and family therapy (7.7% & 15.1%), and addictions counseling (15.4% & 5.7%).

A significant relationship was found between current format in which participants were completing their courses, and likelihood of pursuing a master's degree if offered online. Those currently completing their bachelor's degree solely online, or with a combination of online and face-to-face courses, were significantly more likely to pursue a graduate degree if it were available online than those currently completing courses face-to-face $X^2(2, N = 223) = 61.877$, $p = .000$. The Phi effect size value ($\varphi = .527$) suggested a strong association between these variables. It is important to note that a far greater percentage of students completing their undergraduate studies solely online (98.4%), or through a combination of online and face-to-face (88.4%), indicated that they would be more likely to pursue their master's if offered online. However, over half (53.6%) of those who were strictly completing their courses face-to-face also indicated that they would be more likely to pursue their master's if offered online. While this percentage was significantly lower, it still accounted for over half of that population. Overall, it appears that students would prefer the convenience of online instruction when considering their preference for instructional format.

Limitations and Directions for Future Research

There are several limitations regarding the results of this study. First, the sample was drawn from a single metropolitan state university's HMSV undergraduate program with only master's programs in counseling offered by the university. Furthermore, the study represents only the perspectives of those students who self-selected to participate. Moreover, there were disparities in the sample sizes when disaggregating some of the demographic data. As such, caution should be taken with regard to interpreting the results when making comparisons between groups. The results are not generalizable, but only represent the first steps in understanding HMSV students' experiences and preferences when considering future career directions.

Additionally, this was survey research to obtain information, but no formal psychometric instrument was used. Several dichotomous questions were included on the survey. These items were primarily used to simplify the survey experience for respondents and increase survey

completion rates, but they may have failed to capture the extent of respondents' experiences of the various programming formats.

Future research should diversify sampling by using students from several universities, programs and settings. Future research should also seek to expand the number of students assessed. It should also examine the reasons why students are considering a master's degree, as well as their reasons for preferring certain programs such as social work over counseling, or counseling over human services, or online versus face-to-face. In addition, it would be helpful to track the types of master's level training HMSV students actually pursue after graduation, why they chose their field, their starting salaries, and occupational satisfaction. This information could help clarify motivations that may assist future students as they consider types of master's programs to pursue. It could also assist employers as they consider positions to create and fill within agencies. Finally, it could assist educators as they consider types of graduate programs to offer. It would also be helpful to explore the primary employers of bachelor's level HMSV graduates to determine which types of degrees they prefer for advancement and increased responsibility.

Discussion

Results indicate a significant interest in pursuing master's level education amongst this sample of human services bachelor's level students. Over 94% of students who responded indicated this desire. Furthermore, there were no significant differences in desire to pursue graduate education based on demographic variables. Students, regardless of how they identified, appear to be planning to pursue educational training beyond the bachelor's, and seem to view their bachelor's degree as a step in their educational training, but not the end of it. This appears to indicate that these students view additional education as a means to gain something, be it greater responsibilities, opportunities, specialization and/or financial security (U.S. News & World Report, 2017).

It may be surprising to realize that so many of these students expect the need for master's level training in order to enhance their careers and lives. In the Current Population Survey addressing educational attainment, the U.S. Census Bureau (2016) revealed that the attainment of master's degrees has been steadily increasing, with 16.5% of those surveyed having a master's degree in 2015 compared to 12.5% in 2009. This is believed to be due to the chance to earn higher wages, although entry-level positions in more fields now require a master's degree (Torpey & Terrell, 2015). With regard to the mental health and social service fields in particular, graduate degrees tend to be even more important for career success and financial solvency; the wage premium between bachelor's and master's degrees in these fields ranges from $13,000 to $20,000 (Torpey & Terrell, 2015). Based on this data, it is no surprise that the undergraduate human services students in our study overwhelmingly plan to pursue graduate degrees.

However, whether or not they actually pursue graduate degrees based on their interest to do so is yet to be seen. To make their interest a reality, students may need to plan for more time and money to pursue graduate level education as a means to be competitive in the job market. Higher education is a costly endeavor, with the mean debt having risen from approximately $40,000 in 2004 to almost $60,000 in 2012 (U.S. News and World Report, 2017). It also calls for students to perform at a high level in their undergraduate studies and on the Graduate Record Exam, as high scores are often needed for graduate school admittance and success (Kjelgaard & Guarino, 2012; Kuncel, Wee, Serafin, & Hezlett, 2010; Briihl & Wasieleski, 2004; Schmidt, Homeyer, & Walker, 2009; Smaby et al 2005).

Further, if more students turn their interest to pursue graduate education into the actual obtaining of master's degrees, mental health agency employers may need to meet their service needs through the creation of positions for applicants with graduate degrees as opposed to bachelor's or associate's degrees. This means they will also need to be prepared to pay higher salaries (U.S. News and World Report, 2017). If they do not wish to employ individuals with graduate degrees, they may need to put greater effort into recruiting students while still in their associate's or bachelor's degree programs. Institutions of higher education also benefit from an awareness of the plans of undergraduate human services students with regard to graduate degrees. Offering graduate degree programs of interest to undergraduate human services students could be a lucrative endeavor for institutions, as so many of these students intend to continue their education.

In addition, based on the results, it appears clear that allowing for direct admittance into a master's program from a bachelor's program would increase the chances that a student would pursue that master's program. This option is becoming increasingly more popular and is offered at institutions all over the country including Boston University, Portland State University, Florida Atlantic University, and the University of Texas, to name a few. A combination of grade point average and life/work experience make up the typical components of this admissions option. Many institutions that offer this option eliminate the need for submitting the Graduate Record Exam (GRE) scores and essays. Providing such an option for undergraduate students completing their degrees in human services may increase the number of students likely to enroll in the same college's master's level programs. Master's level programs seeking to enhance quality student enrollment would do well to develop direct admittance programs to encourage undergraduate students to perform at a high academic level and secure a program seat without having to go through the traditional lengthy application processes.

Along with direct admittance, the present study's results indicate that institutions and students would benefit from master's degree programs being offered online. A large majority of the participants in the current study indicated that they would be more likely to pursue their master's degree if they could complete it online. This finding included students who were taking their undergraduate courses only in the traditional face-to-face format. Even when they prefer the face-to-face format, they indicated that they would be more likely to pursue a master's degree if it were offered online. Offering the program online appears to provide individuals with the flexibility and convenience needed to pursue a master's degree while balancing the commitments and responsibilities of their work and life. This finding is consistent with reasons given for taking online courses in human services (Rehfuss, Kirk-Jenkins, & Milliken, 2015) and in other academic fields, and points towards one of the reasons for online learning's growth (Allen & Seaman, 2011; Chandras & Chandras, 2010; Burt et al, 2011; Blackmon, 2013; Tsokris, 2011). Master's level graduate programs may benefit from offering or developing online programs in addition to face-to-face programs in order to meet the needs of future students.

Human services students in the current study were interested in pursuing a variety of graduate degree programs, though the majority selected social work and human services. These two professions were selected as the top second choices as well. This might be due to greater awareness or exposure to these professions. As current students of human services, professional opportunities, including continued education in the field, are inherently taught throughout the baccalaureate degree program in courses including introduction to human services and professional issues, to internship (CSHSE, 2013b). Related fields are also discussed, thus exposure to mental health professions such as social work and counseling. Since social work has

been in existence longer and requires master's level training for licensure and practice, it makes sense that human services students see the added benefit of such a degree and training. Social work degree programs have been recognized since the 1920s (Wieler, 2009), while master's in human services programs have only been offered since the latter part of the 20th century (Fullerton, 1990). Furthermore, master's in social work programs are offered extensively throughout the country with approximately 267 accredited programs for students to choose from (Council on Social Work Education, 2017). On the other hand, since master's degrees in HMSV are relatively new, there are far fewer programs available throughout the country. Currently, there are no accredited master's programs in human services according to the Council for Standards in Human Service Education (2017). There is value for institutions of higher education in noting the interest current undergraduate students of human services have in pursuing human services master's degrees. In addition to providing a desired field of study to its students, offering a master's in human services, particularly with direct admittance and online, may be a wise economic decision for these institutions.

With regard to other mental health fields addressed in the current study, following social work and human services, participants expressed interest in school counseling, mental health counseling, marriage and family therapy, and addictions counseling. There was relatively equal interest in these counseling-focused degree programs, and combined, their numbers were greater than either social work or human services alone. This may be due to the field of counseling and these related specialty areas being well established and more familiar to the general public. Counseling has been an established field since the early 1900s (Gladding, 2013). Mental health counseling has been established since the 1910s, school counseling since the 1950s, marriage and family therapy since the 1960s, and addictions counseling since the 1960s. Furthermore, most students interacted with school counselors while in k-12 education since they are mandated in public education settings in most states (American School Counselor Association, 2017). Many may have also either participated in their own mental health counseling, or know friends and family who have. Even if individuals don't have direct experience with marriage and family therapy or addictions counseling, it is highly publicized in the media, either through representation in movies or through advertisements (Thomason, 2013). This public awareness of these mental health professions may make them seem viable as degree programs to pursue.

On the other hand, college counseling, rehabilitation counseling, and integrated care were selected by far fewer participants. While college counseling and rehabilitation counseling are quite well established (college counseling since the 1980s and rehabilitation counseling since the 1950s [Gladding, 2013]), integrated care is a far newer profession with graduate degree programs only being offered since the early 2000s (IFIC, 2017). These professions seem less publicized in the media as well. College students meet with advisors for curricular and professional information, but may be less aware that college counselors are available to address personal-social concerns. Students may assume these issues must be addressed by outside mental health counselors. As such, students' awareness of this as a career path may be limited. Similarly, lack of personal exposure to rehabilitation counselors and integrated care specialists may also result in a lack of awareness of these as viable professions to pursue. If employers wish to hire college counselors, rehabilitation counselors, and integrated care specialists, and graduate programs wish to recruit students for programs in these areas, they may need to exert additional efforts to better inform students of these career paths to promote interest and ensure qualified individuals pursue degrees in these areas.

The findings from the present study also highlighted some important differences in the type of master's degree programs participants were interested in pursuing based on gender, age of participant, and whether or not one identified as first generation college student. Of note, 17% of female participants selected a master's program in school counseling while no males selected this degree. School counseling is known to be overrepresented by females, with 77% of school counselors being women (Bridgeland & Bruce, 2011). Ongoing efforts to recruit males to this field continue to be needed. Males were four times more likely to select a master's degree in addictions counseling than females, while females were more than three times more likely to select social work than males. Gender specific recruiting efforts may be needed for these degree areas as well. Pertaining to human services, females were twice as interested in graduate degrees than were males. While male participants seemed more interested in a master's degree in human services than in school counseling or social work, more efforts to promote male interest may be needed during undergraduate education to help equalize interest in a human services graduate degree as well.

Age also influenced participants' interests in graduate degrees. Mental health counseling was selected by far more individuals who were 30 years of age or younger than those over 30, while addictions counseling was favored by those over 30. Social work was favored by those under 30, but human services was of interest to everyone regardless of age. This generalized interest in a master's in human services may be due to the participants' current enrollment in an undergraduate human services program. Recognizing the interest these students had in continuing with a master's in the same field as their bachelor's may be valuable for colleges and universities who may consider providing a path toward achieving this, particularly if they include direct admittance and offer the programming online.

Status as a first generation college student also influenced preferences for graduate degrees in this study. First generation college students were two times more likely to prefer a master's in college counseling, and almost three times more likely to prefer a master's in addictions counseling than those who did not identify as first generation college students. Of the eight students who selected a graduate degree in rehabilitation counseling, seven were first generation college students. Conversely, those who did not identify as first generation college students preferred a master's degree in marriage and family therapy at almost two times the rate of those who did. Finally, more of those who were not first generation college students preferred a master's in human services than those who were. The reasons for these preferences were not explored in this study. Follow-up research might examine the reasons for the differences in preferences for master's degrees among participants with varying demographics.

Conclusion

The current preliminary, exploratory survey study aimed to shed light on whether or not undergraduate students of human services desire to obtain a master's degree, and if so, what type of master's degree they prefer. It also aimed to explore participants' preferences for automatic admissions to master's programs, and preferences for programming format. The results indicated that undergraduate students of human services do indeed plan to continue their education and pursue a master's degree, and that they prefer to pursue this degree online and through a direct admittance process. Moreover, they are most interested in pursuing a master's degree in social work or human services. Students also indicated an interest in several counseling related master's degrees. Some variations in preferences for master's degrees exist based on demographic variables including gender, age and first generation college student status. These variations may be taken into consideration when considering marketing and recruiting strategies for both

employers and institutions of higher learning. As human services students begin to consider their future, it is vital that their undergraduate programs, related master's level programs, and employers provide sound insight and direction so that students can have a successful start, and a full and rewarding career throughout their work lives.

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Professional Standards: Embracing Preventive Ethics in Human Services

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Abstract

Recent updates to the National Organization for Human Services Code of Ethics create an opportunity for further recognition within the field. The next logical step to recognition is the adoption of the concept of preventive ethics, in which ethical codes set the tone for the development of grievance procedures and agency level policies. Fostering an environment of preventive ethics within the human services profession will further establish awareness and recognition within the field. This discussion provides support for the development of a grievance process through the conceptual lens of preventive ethics and suggests a framework for the development of a grievance process to be considered by the members of the National Organization of Human Services.

Introduction

The National Organization of Human Services (NOHS) has been at the forefront of increasing recognition and growth of human services. One result of this has been the adoption of the 1996 NOHS ethical code and the more recent, 2015 revision (NOHS, n.d.; Wark, 2010). Ethics are a critical aspect of the human services field as practitioners are often faced with challenging ethical dilemmas. It is important in practice that practitioners have the ability to make thoughtful and informed ethical decisions resulting in the greatest good for the field (Milliken & Neukrug, 2009). Consequently, the NOHS ethical code serves as the standard of ethical practice in the human services profession, and human services professionals agree to uphold the ethical standards of the profession as a result of their membership in NOHS (NOHS, n.d.).

Ethical codes serve three purposes: (1) educating professionals and the general public about responsibilities; (2) providing a framework for professional accountability through the enforcement of ethical codes and (3) serving as a basis for self-monitoring and improving practice (Cory, Schneider, Corey & Haynes, 2015). Though the NOHS ethical code serves these purposes and sets the standard for the field of human services, there is an absence of grievance procedures as well as recognition of the use of the code within professional agencies. In fact, many professionals note the ethical codes of other professions as leading their decision making processes (Sparkman & Neukrug, 2014). As a result, there is a need for further recognition and advancement of the NOHS ethical code that extends beyond creating standards.

NOHS Ethical Code

The revised ethical code provides the opportunity for practitioners to be informed in ethical decision-making (NOHS, n.d.) while addressing responsibilities of human services professionals that were missing in previous versions of the code (Milliken & Neukrug, 2009). The preamble of the ethical code notes the importance of ethical decision-making processes and consideration of standards when making choices (NOHS, n.d.). Additionally, it addresses the foundational values of the human services profession and discusses the overarching purpose of the ethical code. Emphasized in the revision are five areas of responsibility for the human

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services practitioner: (1) responsibility to clients, (2) responsibility to the public and society, (3) responsibility to colleagues, (4) responsibility to self, and (5) responsibility to students (NOHS, n.d.). As part of their responsibility to the profession, NOHS members are expected to consider these standards when making ethical decisions. Wark (2010) contends that "following the code of ethics protects practitioners in malpractice suits and provides professional organizations self-control instead of potential regulation by government" (p. 18).

Despite the recent revisions, the ethical code does not outline a process for addressing grievances (Wark, 2010). Higgs-Kleyn and Kapelianis (1999) argue that the first step in promoting ethical behavior of professionals is to "ensure that leaders of the professional community advance the importance of ethical conduct and the power to ensure this rests in the hands of the professional governing bodies" (p. 365). The responsibilities of governing bodies extend beyond the development of an ethical code, and include the need to foster adherence to the code. The absence of a grievance process suggests that NOHS ethical codes are aspirational with little implication toward enforcement of violations (Sparkman & Neukrug, 2014; Wark, 2010). In fact, developing a grievance process allows the human services field to join other helping professions such as social work, counseling, and psychology in holding members accountable for their actions. By increasing and enforcing accountability, the expectation of responsibility to clients, public/society, colleagues, and students as noted in the NOHS ethical code (NOHS, n. d.) increases in credibility (Mabry, 1999). Addressing the call for a grievance process sets the foundation for advancement of the ethical code. However, this is only the initial step in supporting a profession that relies on the standards of ethical decision-making and seeks to utilize those standards in practice.

Preventive Ethics

"Preventive ethics" is a term coined within the health field which describes the phenomenon that occurs when agencies create policies and procedures to embrace the ethical codes of their respective professions (Levine-Ariff, 1990). The ideology of preventive ethics extends beyond the notion of creating standards of ethical practice and includes the goal of minimizing and/or preventing ethical conflict (Levine-Ariff, 1990). Embracing preventive ethics ideology ensures that ethical decision-making is thoughtful and beneficial to the populations served by NOHS members as a move toward preventive ethics includes clear ethical standards developed by the organization.

Preventive Ethics in Action

While preventive ethics aims to meet the goal of preventing conflict, it is not without its limitations as individual agencies or professionals may conclude differing outcomes for the same violation if there are no established guidelines within that professional organization (Levine-Ariff, 1990). Despite this limitation, the focus of preventive ethics is the utilization of professional organizations' codes of ethics within agencies to develop comprehensive policies which inform and address ethical decision making at the agency level. The policies developed serve to help professionals plan for situations that require prompt intervention, provide guidance on how specific situations should be handled, promote dialogue and collaboration among colleagues, and affirm commitment to institutional standards (Levine-Ariff, 1990). They also help to clarify the organizational mission, promote accurate and timely communication with clients, and clarify what conduct is ethically prohibited, ethically required, and ethically permissible. The notion of preventive ethics assumes the responsibility of developing policies on

ethical issues that reflect the most up-to-date thinking on ethical decision making within the field (Levine-Ariff, 1990). Policies promote practices that confirm ethical standards within the profession as well as adhere to laws and regulations within the field.

The process of implementing policies based on ethical standards of professional organizations at agency level includes discussing their development within the context of an institution. The policy itself must demonstrate a specific process and incorporate certain concepts specific to the institution implementing the policy (Levine-Ariff, 1990). In order to be effective in the development of such policies, a multidisciplinary committee of professionals impacted by the policy should outline the content. Also involved in the process should be an ethics committee of the institution or outside consultation from ethicists well-versed in ethical decision-making. Research suggests that during drafting of policies, informational sessions should be held for those who will be impacted by new policies. The push toward agencies adopting professional ethical standards in the human services field is a process that requires education within the field. Therefore, professional organizations must educate the field on the importance of ethical standards in policy development and disseminate this information to stakeholders in charge of policy development (Levine-Ariff, 1990). Professional organizations are at the forefront of the move towards preventive ethics within the field. The overarching goal is to create an organizational structure that has a direct focus on fostering ethical behavior.

Professional Organizations and Preventive Ethics: Implications for NOHS

Embracing the concept of preventive ethics within human services agencies suggests the need for NOHS to provide concrete guidelines for violations within the ethical standards. In order to avoid erroneous outcomes for violations of the NOHS ethical codes, the development of a grievance process is the next logical step in influencing practice within human services. After its development and implementation, increasing awareness of its existence for current and future membership holders is vital to increasing adherence.

Professional organizations of other helping professions can serve as examples of successful implementation of ethical codes and grievance procedures. The disciplines of counseling, social work, and psychology have been identified as helping professions that are governed by professional organizations (Castro-Atwater, 2015). Each of the aforementioned disciplines has identifiable professional organizations with established ethical guidelines (Kaplan & Gladding, 2011; McDonald, Boddy, O'Callaghan, & Chester, 2015). Similar to NOHS, each professional organization provides membership to professionals who meet specific criteria for their discipline with corresponding guiding principles and expectations (American Counseling Association [ACA], 2014; American Mental Health Counseling Association [AMHCA], 2010; American Psychological Association [APA], 2010; National Association for Social Work [NASW], 2015).

Overview of Professional Organizations

Within the ethical guidelines for professional membership affiliation, each organization has consistent goals of protecting their respective profession as well as maintaining the best interest of the public in terms of health, welfare, and safety (ACA, 2014; AMHCA, 2010; APA, 2010; NASW, 2015). While the goals of these organizations parallel those set forth by NOHS, a major difference was found when comparing the grievance processes for ethical violations within these professional organizations. Specifically, the previously mentioned disciplines addressed

their grievance processes for violations while this information was lacking in the ethical codes adopted by NOHS.

The grievance processes of the professions of social work, counseling, and psychology have gained recognition within the helping field and could serve as a model for human services. Using these processes as a guide, consideration should be given to the following concepts that have been identified in other helping professions and/or within the ethical decision making process: (1) identification of how complaints would be accepted (ACA, 2014; AMHCA, 2010; NASW, n.d; Luke, Goodrich & Gilbride, 2013); (2) defining what constitutes a complaint (ACA, 2014; AMHCA, 2010; NASW, n.d; Luke et al., 2013); (3) selection and description of ethical committee (ACA, 2014; AMHCA, 2010); (4) identifying the jurisdiction of the overseeing committee (ACA, 2014; AMHCA, 2010); and (5) identification of what actions could be taken if a complaint was found to be valid (ACA, 2014; AMHCA, 2010; NASW, n.d.; Luke et al., 2013).

Helping professions with established processes for addressing ethical violations provide NOHS with a framework to develop a successful grievance process. Common practices among those professional organizations have included a letter sanctioning the individual, or suspension and/or revocation of one's membership (ACA, 2014; APA, 1996). Sanctions identified by other helping professions included placing limitations on membership, suspension of membership, and the possibility of communicating severe complaints to licensing boards, credentialing bodies, and employers (ACA, 2014; AMHCA, 2010; NASW, n.d.). Additionally, many of these organizations have established review boards who oversee the appropriateness of membership renewal or ethical committees to review grievances and complaints (APA, 1996; ACA, 2014; AMHCA, n.d.).

Ethical committees serve as a benefit to professionals who often view the mediating role of these committees as a practical means to avoid more legal conflict whenever ethical issues arise in their professional practice (Marcus, Shank, Carlson, & Venkat, 2015). The American Psychological Association (APA, 1996) and the American Counseling Association (ACA, 2014) have established ethics committees which receive and adjudicate allegations of unethical conduct that may impact a professional's ability to obtain or renew membership within that respective organization. While AMHCA (2010) also has an established ethics committee, this committee does not take responsibility for investigating and adjudicating ethics-related issues. However, the committee will revoke membership in the event a member has his/her license suspended or revoked by an appropriate state licensure board (AMHCA, 2010). Within each of the aforementioned professional organizations, professionals are expected to cooperate with the requirements and investigations of the ethics committee or review board (ACA, 2014; AMHCA, 2010; APA, 2010; NASW, 2015).

The establishment of guidelines is only useful if there are processes that address sanctions or disciplinary actions for those who violate them, as ethical codes are "meaningless without vigorous intention toward ethical behavior" (Mabry, 1999, p. 210). The ethical codes of the aforementioned professional organizations present consistent evidence of established guidelines in response to issues of ethical misconduct that may impact the membership status of professionals (ACA, 2014; AMHCA, 2010; APA, 2010; NASW, 2015). Establishing a grievance process for ethical dilemmas within NOHS is important to encourage the adoption and use of the code within human services agencies. This would require agencies to not only provide knowledge on the ethical standards and grievance processes outlined by NOHS, but also to develop policies and procedures that adhere to the guidelines.

Interorganizational Collaboration of Ethical Violations

Literature did not support the identification of processes or collaborations utilized by other helping professions in the development of their respective ethical guidelines and grievance processes. However, it was noted that several of the organizations consider communicating violations of ethical codes to other stakeholders such as licensing boards, membership and credentialing bodies (ACA, 2014; AMHCA, 2010; NASW n.d.). Considering this, NOHS should consider developing its own protocol for the inclusion of human services stakeholders that have advanced the discipline and can play an active role in the support and development of sanctions. One suggestion is that NOHS consider collaborating with the Center for Credentialing in Education (CCE), which established and currently provides oversight for the Human Services—Board Certified Practitioner (HS-BCP) credential (Hinkle & O'Brien, 2010). This collaboration could benefit NOHS as CCE recently developed its own ethical code for those who become credentialed as HS-BCP (CCE, 2009), many of whom are also NOHS membership holders. Collaborating with the CCE could be mutually beneficial in the enforcement of both organizations' ethical codes as well as in supporting the development of a grievance plan that supports the field overall.

Implications for Human Services

The National Organization for Human Services has been leading the field in establishing ethical guidelines within the field of human services (Sparkman & Neukrug, 2014). Despite this, researchers have called for more focus on ethics within helping professions to prevent harm to clients, agencies, and society as a whole (Milliken & Neukrug, 2009). NOHS' consideration of adopting an established process for addressing grievance processes will further establish the field of human services among other helping professions and distinguish it as a distinct field. It will also address the call for more focus on ethics within the profession (Milliken & Neukrug, 2009). While grievance processes and ethical guidelines are significant to practice since they provide accountability within the field, research suggests that grievance processes have limited influence on a professional's behavior if there are no consequences for violations (Healy & Iles, 2002). An established grievance process with clear consequences for ethical violations will hold NOHS members accountable for their actions and will also hold NOHS accountable for enforcing the code established for members of the organization. This accountability extends beyond identifying ethical dilemmas and emphasizes the importance of remaining ethical in the responsibility to the field of human services as a whole.

Research notes the tendency for professionals to disregard ethical codes as oftentimes the ethical codes and grievance processes are produced and subsequently published with little to no enforcement (Healy & Iles, 2002). The lack of a grievance process for the revised ethical codes adopted by NOHS (2015) leaves the membership holder without guidance as to how ethical violations will be addressed thus significantly reducing accountability. This has negative implications for the discipline as the lack of enforcement creates opportunities for professional organizations to be represented by membership holders who engage in unethical behavior (Beets & Killough, 1990). Unethical behavior of membership holders negatively impacts the credibility of the professional organization as it contradicts NOHS' stated responsibility to the client, public and society, colleagues, and to students (NOHS, n.d.). This contradiction creates scrutiny for the human services field that in turn impedes the growth of the human services profession as a whole.

Developing a grievance process that addresses potential ethical violations, validates the ethical code, and provides accountability within the profession which is essential in protecting membership holders' professional identity and supporting the mission and purpose of NOHS. Luke et al. (2013) state that the core components of ethical decision making processes include problem identification, reference to the organization's ethical code of conduct, establishing the scope of the ethical dilemma, creating strategies to address the dilemma, consideration of the consequences for each course of action, and assessment and selection of an action plan. The ethical decision making process could serve as the foundation for creating a grievance process that meets the needs of the human services profession and supports the revised version of the already established ethical code.

Professional governing bodies serve as custodians of professional tradition by keeping moral commitments of the profession relevant (Frankel, 1989; Higgs-Kleyn Kaplianis, 1999). Due to their role in leading the field, professional organizations have the obligation of addressing ethical dilemmas as they arise as affected agencies rely on the professional organization and code of ethics to promote ethical practice and ethical behavior in the delivery of services (Lonne, McDonald & Fox, 2015). Professional obligations of these organizations extend beyond creating and publishing an ethical code, but also include an obligation to enforce the codes as a requirement of the profession. Dissemination of the requirements among members of the profession is important in order to ensure that the community is aware of the ethical code. Having an established grievance process to assist in examining and adjudicating those concerns provides professionals with guidelines of what to expect from the professional organization which governs the field when ethical violations arise.

Conclusion

With the adoption and implementation of its revised ethical codes, the National Organization of Human Services continues to advance the field of human services and define ethical practice. While development and revision of the codes are important to the discipline and provide a guideline for ethical practice for membership holders, lack of enforcement of these codes contradicts the overarching goal of the codes. Enforcement of the codes increases accountability of the professional while also serving as a vehicle to meet the goal of protecting clients, society, and other areas identified by NOHS (NOHS, n.d.). A grievance process for ethical violations should be one that is consistent with expectations of other applicable credentialing boards in order to ensure uniformity throughout the human services discipline.

In addition to developing a grievance process for ethical violations, NOHS should consider developing a communication protocol for professional organizations, licensing boards, and other respected entities to provide transparency within the helping professions. As many human services professionals hold membership in NOHS as well as the HS-BCP credential, NOHS should consider communicating ethical violations with CCE. When communicating, both entities would have to consider the differences in authority over their members in the development of a grievance process. Collaboration during the development phase may be needed to address this issue. NOHS is encouraged to consider sanctions similar to NASW and AMHCA which include adopting the sanction of public notification and notifying appropriate state licensing boards who may impose fines, probationary periods, or other appropriate actions related to licenses or certifications held by violators (Chauvin & Remley Jr., 1996). In conclusion, developing a process for responding to ethical violations within its membership that is structured, rooted in the ethical decision-making model, and addresses the field in a holistic

manner by utilizing what has been done within other helping professions as a guide would benefit NOHS and further advance the human services profession.

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Identify, Intervene, and Advocate: Human Services Workers' Role in Youth Sex Trafficking

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Abstract

This manuscript orients human services workers to sex trafficking issues by providing a synthesis of available literature as it relates to victims. This paper addresses the definition and prevalence of sex trafficking, characteristics of youth who are vulnerable, and traffickers' targeting, recruitment, and coercion techniques. In addition, recommendations present human service workers information on identifying factors, post-traumatic stress disorder, intervening, and advocating for sex trafficking victims.

Introduction

Human trafficking is a global, criminal activity. The President of the United States has referred to it as "modern slavery" (Obama, 2012). Globally, individuals are trafficked for both labor and sex within and external to their passport countries. This manuscript focuses on sex trafficking, and more specifically, the sex trafficking of minors. The United States Victims of Trafficking and Violence Protection Act (TVPA) of 2000 (U.S. Department of State, n.d.), most recently reauthorized in 2013, purported that a three-pronged approach is needed to fight sex trafficking of children and adolescents both nationally and internationally: prevention, prosecution, and protection. As human services workers are uniquely positioned to assist victims and survivors through identification, prevention, and intervention, this manuscript will orient human services workers to the definition and experience of sex trafficking. The manuscript will then outline how human services workers can recognize, intervene, and advocate for child and adolescent victims and survivors.

A Definition: Human and Sex Trafficking

Numerous definitions and perspectives throughout the literature and legislation exist for human and sex trafficking. However, the U.N.'s (2000) *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children* (also referred as the Palermo or Trafficking protocol) is the definition used for this article. Human trafficking or trafficking-in-persons consists of three factors: the act, the means, and the purpose. Human trafficking is the *act* of "recruitment, transportation, transfer, harboring, or receipt" of a person through the *means* of threat, fraud, deception, abduction, coercion, "or abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person," (Europol, 2005, p. 10) for the purpose of exploitation (U.N., 2000).

Sex trafficking is a form of human trafficking in which individuals are exploited for sexual purposes. Sex trafficking is defined by United States (U.S.) federal law as "…a commercial sex act…induced by force, fraud, or coercion, or in which the person is induced to perform such act (U.S.C. §7102(8). This includes, but is not limited to, coerced prostitution, pornography, mail-order brides, sexual demonstrations or shows, and a commercial sex act. The U.N. (2000) distinguishes between adult and child sex trafficking. Under international law, a

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child, any individual under the age of 18, can never legally consent to sex. No region of the world is exempt from sex trafficking of minors, including the United States (Kotrla, 2010).

It is estimated that there are 20.9 million trafficked victims globally, with sex trafficking accounting for about 58% of all global cases reported (The United Nations ILO, 2012). The Department of Education (2013) notes that there have been documented cases of sex trafficking in all 50 states. Women and girls constitute approximately 98% of the individuals trafficked for sex, with approximately 25% accounting for individuals below age 18 (ILO, 2012). In the U.S., 83% of victims are US citizens (Kotrla, 2010). U.S. minors are bought, sold, and traded for prostitution, pornography, escorting, stripping, or other sexual services.

Risk factors for Sex-Trafficked Minors

Common characteristics that place minors at-risk for sex trafficking have been identified. Gender, race, age, economic status, education, and history of abuse and mental health issues have been found to be risk factors for sex trafficking domestically. Individuals under 18 are most at risk for sex trafficking, with the average age being between 11 and 14 years of age, with some as young as 5 (Kotrla, 2010). Moreover, sex trafficking in the United States has a racial component. Nelson-Butler (2015) argued that the intersection of gender, class, and age propels children of color into and retains them in commercial prostitution. In addition, ethnocentric monoculturalism has historically put people of color on the margins in the United States (Sue & Sue, 2013; Sue, 2015). Although some reports indicate that children of color make up the majority of sex trafficking victims, children of color are often invisible. The exploitation of children for sex has historically been portrayed by the mass media as a White middle class issue.

The Experience of the Sex Trafficked Victim

The trafficking experience begins with recruitment. A number of tactics are used to recruit victims of sex trafficking (Siskin & Wyler, 2013). Both internationally and in the United States (U.S.), there are documented cases where minors are kidnapped via drugs or abducted via force by strangers, acquaintances, or family members for the purpose of sex trafficking (Raymond & Hughes, 2001; Silverman, Decker, McCauley, & Mack, 2009). Some children and adolescents, especially those transported to the U.S. from international locations, are promised by traffickers better lives through study or employment opportunities in the US. They are often provided with false documentation and funding for travel (Global Movement for Children, 2010). Upon arrival at the US destination, passports are confiscated. They are forced into sexual service through threat or coercion.

Children and adolescents are also recruited at U.S. coffee shops, malls, bus depots, clubs, and college campuses (U.S. Department of Education, 2013). Traffickers befriend their victims and then entrap them through emotional tactics, substance dependence, or violence. A trafficker may pretend to be a music producer wanting to launch a young girl's music career or a photographer who offers to build a portfolio for a modeling career (Clawson et al., 2009). Traffickers often prey upon vulnerabilities and entice victims using love, money, glamour, promises of belonging, and protection (Freidman, 2005; Lloyd, 2011). Children and adolescents with low self-esteem are often manipulated by promises of the love they desire, a tactic referred to as the *lover boy method*. Based on the promises of love, they agree or are forced into prostitution. Other children and adolescents run away from home. These children often run out of money, have little to no contact with their primary support system, and no way to meet their primary needs (van de Glind, 2010). Thus, they trade sex for food and shelter (U.S. Department

of Education, 2013). Kuzma (2015) stated that within 48 hours of running away, 80% of runaways are propositioned for sex. The internet is also increasingly becoming a tool that is used to recruit. Traffickers meet potential victims in chat rooms, on social networking sites, online games, and Voice-Over the Internet Protocol sites. Online, traffickers often misrepresent themselves and target children and adolescents who appear rebellious toward their parents, seek attention and affection, or are curious about sex (New York State Division of Criminal Justice Services, n.d.; Wells & Mitchell, 2014).

After minors are recruited, the trafficker uses various tactics to control victims and to exploit them. How and when a victim is exploited is dependent upon the trafficker and level of control the trafficker perceives he or she has initially (Friedman, 2005). Friedman documented that the time from recruitment to "the streets" varies from one week to about six months. Various tactics are used to gain control of victims and make them subservient to the traffickers. Some traffickers use sex and seduction to gain emotional dependence and then convince the victim to have sex on the streets for the "good" of the relationship (Estes & Weiner, 2001). Other traffickers take the victims to abandoned locations and indoctrinate them using gang rape before sending them to the streets (Friedman, 2005). As a means to demonstrate power and induce dependence and subservience, traffickers often deprive victims of food, water, and sleep (Cacho, 2014). Examining victims who were trafficked between the ages of 12 and 16, Silverman et al. (2009) found that victims were controlled via food and water deprivation, were locked in small spaces, and forced to consume alcohol and narcotics. Personal freedoms are restricted (Zimmerman et al. 2008); some victims are put under guard at compounds and brothels (Raymond & Hughes, 2001). In most cases, the victims are given false names and false identification. Sex trafficking victims are often "branded" or tattooed to signify possession of a specific trafficker.

Abuse or worse is threatened, and traffickers compel victims to continue to serve their interests through physical and psychological means (Estes & Weiner, 2001). Trafficking victims are subjected to psychological and physical torture, including threats of assault, threats to harm loved ones, intimidation, pharmacological manipulation, witness torture and murder, economic abuse, and isolation (Cacho, 2014; Gjermeni et al., 2008; Hodge & Lietz, 2007; U.S. Department of Education, 2013). Traffickers are experts at making their victims feel isolated, worthless, and lonely, convincing them that no one cares (Hodge & Lietz, 2007; Phelps, 2012). Freidman (2005) documented regular beatings; being hit with a two-by-four, baseball bat, pipes, and hammers on the back, head, arms, and toes as discipline when young girls broke the rules of their traffickers. Being pistol-whipped, burned with acid, and tied to door knobs constitute regular punishment, and broken bones, head trauma, and bruises are realities for many victims (Freidman, 2005; Raymond & Hughes, 2001; Zimmerman et al., 2003). In a news story, Parker-Bello, a sex trafficking survivor recalled that as an adolescent runaway in the US, she was forced into prostitution for years. She described the tactics used,

> We were beaten and thrown into a bathtub, stripped of our clothes, injected with drugs, hung over balconies with razor blades. We were told who we were and what we were going to have to do to survive," she said. "When I heard the term teenage prostitute I was like, well that's what I was called but I wasn't that because I wasn't out there for any reason but they were putting a gun to my head and a trafficker around the corner and I was going to die if I didn't do it. (Zibton, 2013, p. 8)

Victims are often forced to live in crowded and unsanitary conditions and are expected to work long hours to meet minimums set by their pimps. During work, they are exposed to dangerous conditions and situations, including physical violence and disease due to unprotected sexual encounters (Sadruddin, Walter, & Hidalgo, 2005). In one study, girls who were sex trafficked had, on average, 33.4 vaginal sex incidents in a period of a month (Silverman et al., 2009). Similarly, in interviewing 28 trafficked females, Zimmerman et al. (2003) found that these females endured vaginal, oral, and anal sex abuse, unprotected sex, and gang rape. Medical care is often not provided.

Exiting the life of sex trafficking can be challenging (Kortla, 2010). Children and adolescents transported into the U.S. across international borders for the purpose of trafficking often do not attempt escape due to the threat of being imprisoned for illegal immigration. Domestic sex trafficking victims are forced to commit crimes involving illegal drugs and humiliating sexual acts; threats of exposure to law enforcement or harm to the victim's family are used to ensure compliance with exploitation and deter or prohibit escape (Hom & Woods, 2013). Victims who try to escape are beaten or killed (Yen, 2008). Other victims, after an extended time, become psychologically broken or brainwashed. They do not see themselves as victims but rather criminals with no self-worth. Children and adolescents are especially vulnerable when it comes to not recognizing the exploitive situation they are in, and many may even take responsibility and blame themselves for their victimization (e.g. "This is my punishment for running away."). Some even identify with their trafficker, a phenomenon that parallels Stockholm syndrome (Friedman, 2005). This is referred to as the "trauma bond" in sex trafficking literature (Kalergis, 2009). Through dissociative mechanisms, victims come to believe that their traffickers have their best interest in mind and love them. They are convinced that the trafficker will follow through with all the promises made. Thus, upon rescue, a victim may at first be combative or protective of the trafficker, giving the illusion that the sexual exploitation is a choice or made voluntarily (Farley, 2004). Like Stockholm syndrome, those most susceptible to "trauma bonding" are those who perceive that their captors are capable of following through with a threat basic to their survival, believe they cannot escape, and are isolated from any perspective other than that of their captors (Lloyd, 2011). Many sex trafficked victims are never identified and are never given an opportunity to escape from traffickers (Macy & Graham, 2012; Okech, Morreau, & Benson, 2011). Human services workers are vital to increasing the number of minors identified and rescued. They also play a significant role in assisting survivors in gaining services needed to ensure recovery.

Identification

Although sex trafficking victims are difficult to identify because of the concealed nature of the industry, conflated by a victim's reluctance to self- identify due to training, fear, or trauma bonding, human services workers can encounter victims in their daily work as they serve on the front lines for social, legal, educational, and health care systems. For example, trafficking victims have been known to gain entrance to homeless shelters or seek services from community centers (Dabby, 2004; Salvation Army, 2006). Child protection workers have encountered reports filed by teachers who overhear elementary students telling peers about their victimization. Juvenile justice workers have identified victims when working with adolescents for unrelated charges such as routine automobile violations. Human services workers have discovered children's clothing and toys in inappropriate places during in-home visits or encountered advertisements for brothels or similar entities offering the service of "young

women." Moreover, human services workers frequent schools, a place where youth may be recruited, enticed, or transported to/from by their traffickers (Kuzma, 2015). Therefore, in their everyday work, human services workers can play a role in identifying and helping victims escape the life of sex trafficking. In their everyday work, human service workers can be aware of indicators to identify child or adolescent victims of sex trafficking. Indicators can be social, psychological, or physical (see Table 1).

Table 1. Indicators of a Child or Adolescent who has been Trafficked for Sex

Health or Physical Indicators	Psychological Indicators	Social Indicators
• signs of physical abuse or restraints • general signs of poor health • lack of food, sleep, or medical care • self-mutilation • signs of branding (tattoo, jewelry) • sexually transmitted diseases • increased sexual behavior • unexplained injuries • wearing sexually provocative clothing that is not age appropriate	• psychological trauma • extreme sadness or depression • hopelessness • extreme anger and aggression • anxiety and mood disorders • panic attacks • fearful • presenting as withdrawn • memory loss • difficulty concentrating • nervousness and tension • hyper-vigilance or paranoi • post-traumatic stress syndrome • moody • self-mutilation • suicide ideation • substance-related disorders • submission	• confused about whereabouts • loss of parental or familial contact • runaway or thrown away • lying about age • secrets or dating older person • expensive gifts, cash, or clothes • extra phone, hotel key, or fake ID • frequent school absences • decline in academics • dropped out of school • avoids friends and family • dishonesty • drinking or drugging • appears brain-washed • new, strange tattoos • lack of driver's license or ID • change in dress or appearance • new friendships and relationships • gang affiliation • using slang such as "the game, the life, daddy, manager, date, trick" • no friends of their own age • talks about traveling with groups that are not familial • displays intimidated behavior that is not age appropriate

Sources: Bayless, Roe-Sepowits, Agliano, 2015; Kotrla, 2010; & Kuzma, 2015

These indicators can also be typical of other adverse experiences including sexual abuse, witnessing abuse, parental separation or divorce, harsh and inconsistent parenting, physical or emotional maltreatment, alcohol abuse, incarceration, or mental illness (Kuzma, 2015). Therefore, if a child or adolescent is exhibiting indicators of sex trafficking, human services workers can ask a series of interview questions (see Table 2) to ascertain if sex trafficking victimization is occurring.

Because identified victims may present with combative behaviors to their protectors and supportive behaviors toward their captors, or they may be too severely frightened to admit abuse, human services workers need to practice a supportive stance and maintain a trauma-informed response when asking questions. Human services workers need to be prepared to receive coached answers to questions, which may be an indication that sex trafficking is occurring. They also need to recognize that due to the familial and social/psychological separation that occurs during sex trafficking, children and adolescents may have trouble recounting coherently and consistently their situation and circumstances.

When victims of sex trafficking are identified or suspected, human services workers need to follow their organizational and state protocols in reporting crimes and or abuse. They can also call the Human Trafficking Resource Center at 1-888-373-7888 to report potential sex trafficking.

Table 2. Example Questions to ask those who have been Trafficked for Sex

• Tell me what you do for fun.
• Do you drive there? Do you have an ID or license?
• How long have you lived here; in your house, in this area?
• Made many friends here? Who do you hang out with?
• Do you have a boy/girlfriend or partner?
• Does he/she go to school with you?
• How's that going?
• When did you last visit the doctor or dentist?
• Do you have any physical concerns, hurting anywhere?

Intervention: Case Management and Referrals

After identification and rescue, children and adolescent victims of sex trafficking have a variety of needs related to physical, emotional, personal, and legal issues consequential of the trafficking experience. Trafficking survivors need to feel safe as they exit the industry and begin to seek treatment and services. Working with survivors, human services workers need to express kindness, patience, sensitivity, and flexibility by (a) being careful to never imply that the survivor was responsible for the exploitation or inability to leave the trafficking situation at any time; (b) taking care of answering frequent questions related to fears surrounding retribution and the possible consequences of a trafficker; (c) being respectful of the survivor's cultural background, including social etiquette, ethnicity, dressing customs, religious observances and attitudes toward sex and mental health; and (d) continually conveying in action and words, "You have the right to be treated with dignity" and "Your well-being is important." Understanding the experiences endured is also essential to working effectively with a survivor of trafficking.

Human services workers can play a critical role in linking survivors with needed services and making referrals related to emergency, short-term, and long-term needs (Crawford et al., 2009). They act as case managers to help survivors first address basic needs related to safety and

survival, and later short-term and long-term needs related to mental health treatment, ongoing health care, career services, and legal issues.

An emergency need of minor survivors is safe housing as they are often alone with no support system and nowhere to go (Baker & Grover, 2013). Threats from the traffickers, whether actual or perceived, need to be considered for the survivor's sense of security. Thus they require stronger security and long-term housing, different from what is offered by homeless shelters or group homes (Shigekane, 2007). Victimized children also need the care of an adult who understands their unique needs. Human services workers can thus identify sex trafficking rescue housing or specialized foster care placements for survivors. With the help of local resources and references, they can provide information to prepare and assist caregivers in providing proper healing, stability, and safety for survivors.

In addition to housing and safety needs, health care needs are a priority given the often unsanitary conditions and physical harm that survivors may have experienced during their victimization (Busch-Armendariz, Nsonwu, & Heffron, 2011). So, recovery includes short-term and long-term treatment, such as immediate and ongoing medical care (including dental or physical care for disabilities incurred during trafficking), transportation, education or job training, and reunification with guardians (Crawford et al., 2009). Likewise, legal issues may also need to be addressed, for example criminal charges, immigration, or custody related issues.

In sum, human services workers need to be aware of and knowledgeable about the unique needs and resources available for sex trafficking survivors so that appropriate referrals can be made. Human services workers can use the National Human Trafficking Resource Center (1-888-373-7888) not only as a means for reporting but as a resource to identify community resources to help survivors and to help coordinate with local service providers. The National Human Trafficking Resource Center offers national and local information and resources in regard to community resources such as medical, housing, and schools. Local advocacy groups specializing in assisting trafficking survivors can also help make appropriate referrals and provide accurate and up-to-date information on specific needs, including food, shelter, safety, clothing, medical, counseling, and spiritual options. As there is a shortage of trauma informed and trained human services workers trained to work with sex trafficking victims, human services can also seek professional development and training in trauma care for minors in order to provide therapeutic services to victims and survivors.

Intervention: Counseling

Although safety, housing, health, and legal needs are important, Zimmerman, Hossain, and Watts (2011) purported that sex trafficking survivors' most profound need is mental health due to the severe psychological destruction perpetrated at the hand of the trafficker. The U.S. Department of State (n.d.) concurred with this assessment, noting that unaddressed psychological damages put survivors at great risk for re-victimization and poor productivity in life after trafficking.

Sex trafficking may be considered a complex trauma, as complex trauma often involves "early onset, multiple, extended, and sometimes highly invasive traumatic events, . . . of an interpersonal nature, often involving a significant amount of stigma or shame" (Briere & Spinazzola, 2005, p. 401). Complex trauma includes the repetitive exposure to childhood sexual, physical, and psychological abuse, usually within the contexts of social and emotional harm and neglect (Briere & Scott, 2015). The research on the effects of complex trauma and the trauma of severe child abuse is documented throughout the literature. When an individual experiences

multiple, severe forms of trauma in childhood or adolescence, he or she often experiences multiple and severe psychological consequences, sometimes referred to as complex posttraumatic disturbance (Briere & Lanktree, 2013). Consequences of this trauma have been documented to include mood and anxiety disorders, post-traumatic stress disorder (PTSD), eating disorders, cognitive distortions, affect regulation disturbances, somatization, dissociation, avoidance, or externalizing behaviors such as substance abuse and self-mutilation, interpersonal problems, and dysfunctional sexual behaviors (Briere, 2002; Briere & Spinazzola, 2005; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Susceptibility to revictimization and practice of self-endangering behavior that leads to revictimization are also consequences associated with this trauma (Classen, Palesh, & Aggarwal, 2005). Similar consequences of sex trafficking, with the addition of substance addiction, have begun to be documented and have begun to provide human services workers with insight of issues that may arise in counseling sessions and need to be considered in treatment planning. For example, a study that interviewed 204 trafficked women and girls between the ages of 15-45 found that they suffered high levels of post-traumatic stress disorder symptoms, such as depression and anxiety (Hossain, Zimmerman, Abas, Light and Watts, 2010). Symptoms such as inability to moderate emotions, thrill seeking, maladaptive attempts at self-soothing and sleep/eating disturbances have also been documented (Blaustein & Kinniburgh, 2010).

Few studies have examined the needs of sex trafficking victims in terms of providing rehabilitation and reintegration services (Aron, Zweig, & Newmark, 2006; Baker & Grover, 2013; Koleva, 2011; Macy & Johns, 2011). Limited personal accounts suggest that relationships with human services workers and counselors are central to the journey out of the industry (Phelps, 2012); however, factors that influence recidivism and resilience outside of the industry remain relatively unexamined in the research (Gozdzaik, 2008). While it is important to note that there is a dearth of research on planning and providing therapeutic treatment, this does not mean that there are not evidence-based models that can be drawn upon when working with sex trafficking survivors until research is conducted with this population. As survivors of sex trafficking appear to have needs, both health and mental health, similar to victims of complex trauma, especially childhood sexual abuse, sexual trauma, and torture; evidence-based treatments for working with theses populations and the associated disorders can be helpful.

Given the trauma associated with sex trafficking, trauma-based approaches may also be especially useful when working with survivors. The self-trauma model (Briere, 2002), a model that integrates cognitive, behavioral, and psychodynamic perspectives with existing theories of trauma and self-psychology, is one example. A view within this model that is becoming empirically-supported, yet not fully tested, is the idea that avoidance behaviors, such as those often exhibited by sex trafficking survivors including dissociation, self-harm, substance abuse, suicidal behavior, and sexual acting out, that arise from trauma exposure may be an attempt to cope with triggers and posttraumatic emotional states, especially when a minor's capacity for affective regulation is overwhelmed. Further, dissociation and avoidance prevent sex trafficking survivors from managing and processing the memories and feelings associated with trauma (e.g., consolidation of the memory), thus further contributing to engagement in dissociation and avoidance when distress is experienced. It is crucial that the survivor experience the traumatic memory in the absence of danger cues in a safe environment to help promote emotional and cognitive processing and consolidation of the memory; however, removing the avoidance and dissociative behaviors too quickly can overextend the survivor's coping resources and lead to more intrusive and avoidant symptoms and attrition from treatment. Thus, the human services

worker working with the trafficking survivor needs to challenge but not overload coping skills, providing a therapeutic environment that is safe and supportive, known as the therapeutic window. Counseling needs to progress sequentially with early sessions focused on the therapeutic relationship and development of skills and later sessions devoted to the cognitive and emotional processing of the traumatic events (Briere, 2002; Briere & Scott, 2015). As Barlow (2011) stated, "What we cannot hold, we cannot process. What we cannot process, we cannot transform. What we cannot transform haunts us" (para. 5). More specifically, within the earlier sessions, the human services worker needs to provide safety and support and help resolve disturbed relatedness through positive regard and modeling behavior that demonstrate a healthy relationship (Briere, 2002; Briere & Scott, 2015). Modeling appropriate boundaries is important, especially for those who were introduced to trafficking young, exhibit hypersexualized behaviors, and are unaware how to interact with others. Given the brainwashing about identity (e.g., "I am a bitch"; "My only value is sex") and knowledge of the world tainted by the lenses of the trafficker whose goal was to maintain the survivor in the industry for self-serving purposes (Cacho, 2014), facilitation of self-awareness and positive identity is essential.

More specifically, therapeutic rapport and empathy are foundational and necessary to effective treatment. If the survivor experiences reliable safety, support, and nurturance during the course of treatment, he or she will begin to recognize that he or she is not in danger physically, emotionally, or sexually, and will then recognize the disparity between the trauma experienced within trafficking relationships (e.g., violence, coercion) and the therapeutic environment (e.g., safe). Consequently, conditioned abuse related responses to others (e.g., distrustfulness, hyper-sexualization) are likely to decrease; the survivor is likely to begin to reduce avoidance behaviors and do the work necessary to build an open relationship in which memories of the trauma can be detailed and consolidated (Briere, 2002).

It is also important that survivors are made aware of professional conduct and confidentially standards (Macy & Graham, 2012). Moreover, Hom and Woods (2013) and Kalergis (2009) suggest that it is important that counselors working with sex trafficking survivors maintain a client-centered approach in which the minor is seen as the expert in his or her restoration so as to foster a sense of control and autonomy, since the victimization contributed to the disrupted sense of empowerment. Respect and appreciation for the survivor's bravery to confront his or her issues and communicating hope by helping the survivor reframe the trauma as a challenge and pain as an opportunity, in part, for growth, are essential (Briere & Lanktree, 2014).

In the earlier stages of counseling, the human services worker additionally needs to teach coping and affective regulation skills (e.g., relaxation, breathing control, mediation, yoga, and emotion regulation training) (Briere, 2002; Briere & Scott, 2015). Mindfulness training can be extremely effective in assisting trafficking survivors in developing better emotional regulation skills. Mindfulness practices focus on teaching awareness and attention for the purpose of bringing mental processes under greater voluntary control; they have been found to reduce rumination through disengagement from repetitive cognitive patterns, thus, enhancing attentional and cognitive flexibility, working memory capacities, and emotional regulation (see Chambers, Lo, & Allen, 2008; Moore & Malinowski, 2009; Walsh & Shapiro, 2006). Mindfulness training, especially within the context of cognitive therapy, is being recognized as an empirically supported treatment for a number of disorders (Hoffman, Sawyer, Witt, 2010); and evidence suggests via Functional Magnetic Resonance Imaging (fMRI) that practicing mindfulness may help the brain process emotions in a more regulated manner (Farb et al., 2010). Once sufficient

skills and functioning are developed, the human services worker can assist the survivor in intervening in intrusive, abuse-related symptoms through identifying the trauma, doing gradual exposure, activating conditioned emotional responses and cognitions, and cognitively and emotionally processing the traumatic events with the survivor (Briere, 2002; Briere & Scott, 2015).

Trauma-based approaches such as the self-trauma model (Briere, 2002) highlight the complexity of trauma and the multi-dimensional treatment strategies needed for restoration. Due to the complex and challenging nature of the problems sex trafficking survivors face, especially minors, a multimodal, multicomponent treatment strategy (e.g., cognitive-behavior therapy, exposure therapy, medication, trauma theory therapy) is recommended as a single modality is unlikely to be successful. If thought about in terms of a regression equation, each of the approaches or protocols may represent different factors of predictability and help; where improved functioning of the trafficking survivor (Y) may be associated with different approaches or interventions ($X_{1\text{-}5}$) but with different magnitudes ($b_{1\text{-}5}$) across different circumstances (presenting problem, openness to treatment, developmental level, etc.). In other words, the strengths of a particular approach or multiple approaches may be considered depending on client factors for the most successful progress. Thus, in accordance with ethical guidelines, human services workers need to seek training in a variety of approaches, including trauma approaches with a sexual and interpersonal focus, to competently work with sex trafficking survivors. And, ultimately, as the United Nations (UNODC, 2009, 2012) implores, human services workers need to begin to develop and research comprehensive, evidence-based models for working with sex trafficking survivors who are minors.

Advocacy

Advocacy is yet another way human services workers can work to eradicate sex trafficking. Human services workers can advocate in a myriad of ways, including: creating public service announcements (PSAs); leading community education sex trafficking awareness campaigns at Youth Centers and the YMCA; and, providing workshops to educate individuals who work at runaway shelters and alternative schools (Kotrla, 2010; Dank et al., 2014). They can advocate for trafficking hotlines to be posted on classified websites frequented for sex trafficking, such as Craigslist.com, Backpage.com, and social media sites with classified ads.

Knowledge is power, and few U.S. citizens realize the reality of child and adolescent sex trafficking in the U.S. Advocating to stop this exploitation includes sharing the knowledge that sex trafficking is real and occurs in the Unites States. Leading community lectures for guardians on sex trafficking and teaching youth about the realities of sex trafficking, revealing forceful, fraudulent, coercive, and exploitive tactics used by traffickers for recruitment and control can help prevent child and adolescents from falling prey. In many communities, human services workers and other professionals have begun to collaborate in order to provide sex trafficking prevention programs. Chicago's Alliance Against Sexual Exploitation, "Empowering Youth to End Sexual Exploitation," is one example. This educational program and the others created can be used or adapted to teach minors in the human services worker's community about socially influenced gender roles, gender-based violence, and sexual exploitation.

Advocacy can also occur at the state and federal level for changes in laws to protect trafficking victims and provide services for them. Human services workers can write letters to government legislators to improve laws related to sex trafficking to help assure that perpetrators are held responsible for the violence and abuse, as opposed to punishing the victims as

delinquent (Bayless, et al, 2015). They can develop sex trafficking task forces for enforcement to address fraudulent, coercive, subtle and non-physical (including online) manipulation of victims, and allow wiretaps to investigate such offenses (Dank, et al., 2014).

Conclusion

While there has been an increased focus nationally and internationally on eliminating sex trafficking, continued discussion addressing the unique and varied needs of minor victims and survivors is needed. The complexity of sex trafficking requires a system-wide response, to include collaboration between schools, law enforcement, and social service agencies (Dank, et al., 2014). The teamwork among different entities working for the same cause assists in networking for references and sharing resources to create a synergy that will more quickly end sex trafficking of children and adolescents. Human services workers must understand sex trafficking and their role in eliminating sex trafficking. It is important to note, "commercial, sexual exploitation can happen to any [one] regardless of age, race, socioeconomic status, or geographical location" (Rand, 2009. p. 141).

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Human Service Professionals and the Ongoing Need for Aging-Related Education

Melanie H. Mallers, James R. Ruby

Abstract

Population growth trends are resulting in a demand for human service professionals with knowledge and expertise in aging. Unfortunately, many have limited knowledge about gerontology and aging-related issues. Little is known regarding the training and experience of human services professionals who work with or on behalf of older adults. A baseline understanding regarding attitudes, training, and knowledge of aging is essential to developing and promoting critical aging-related curriculum and programs.

Introduction

The dramatic growth in the number and proportion of older adults is unprecedented in American history. It is projected that by 2030 there will be approximately 71.5 million Americans aged 65 years and older and by 2050, this will increase to approximately 83.7 million, nearly double that from 2012 (Ortman, Velkoff, & Hogan, 2014). This growth trend creates a demand for human service professionals with knowledge and expertise in aging. However, the growing population of older adults currently outnumbers the number of trained persons who can provide assistance. Research indicates that there is a vital need for trained providers who are proficient to serve the aging population. The current health care system is already overwhelmed by demands for gerontological care (Eldercare Workforce Alliance, 2011a). Those specializing in the care of older adults cannot meet the current demand let alone the projected needs for eldercare (Eldercare Workforce Alliance, 2011b). Unfortunately, many human service professionals do not pursue aging-related careers (Lawrence et al., 2002; Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002; Sivis and McCrae, 2010). Furthermore, research indicates that many working with older adults have limited or inaccurate knowledge about gerontology (Cowan, Fitzpatrick, Roberts & While, 2004; Cummings, Galambos, & DeCoster, 2003).

There are several factors contributing to the shortage of well-trained human services professionals with a background in gerontology. Currently, there 48 Associate- and Bachelor-level Human Service Programs accredited via the Council for Standards in Human Service Education (Council for Standards in Human Services Education, 2017). After a review of all, we determined that there are 9 programs that offer formal aging or gerontological designation (e.g., certificate, track, concentration, or minor) and only a handful that offer aging-related courses. Additionally, very few graduate-level human services oriented programs offer full programs or tracks in aging (e.g., Abramson & Halpain, 2002). While interest in aging is a key determinant of the decision to practice with older adults (Council on Social Work Education, 2001), working in the field of gerontology is not described as a high career goal (Neville, Dickie, & Goetz, 2014) and there is no indication that this is going to change soon unless major shifts and commitment to promoting the field are made. Ageist attitudes may further contribute to the gap created by the lack of effective gerontology training and the need for skilled aging practice (Berenbaum, 2000; Scharlach, Damron-Rodriguez, Robinson, & Feldman, 2000).

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This study presents a baseline understanding of experiences, attitudes and knowledge about aging among Human Services professionals. We hope the findings will raise awareness and increase commitment among educational institutions to incorporate more aging content into human services curricula and will encourage individuals to seek out training to become effective and knowledgeable aging-minded service providers.

Method

Through social media, professional networking sites, and snowball sampling, an electronic survey was distributed to human service professionals who self-identified as academic faculty, non-profit agency management, psychologists, social workers, counselors, marriage and family therapists, day care workers, ministers, and graduate students. Three different elements were included in the survey: (1) open-ended questions exploring the nature of the interaction that the respondent had with older adults (personal, professional, etc.), (2) shortened version of the Palmore Facts on Aging Quiz (Breytspraak & Badura, 2015) asking a series of true/false questions about aging such as: *As people live longer, they face more chronic health conditions* and *The modern family no longer takes care of its elderly*, and (3) 7-point Attitudes Toward Older Adults likert scale, adapted from Rosencranz & McNevin (1969), which lists 32 dichotomous stereotypic adjectives used to describe older adults, such as *Progressive* versus *Old- Fashioned* and *Exciting* versus *Dull*.

Two-hundred and twenty-four (224) individuals responded to the survey; 74% were female, 67% were Caucasian, with an average age of 44.3 years (range 22-66). Work settings included: higher education (50%), non-profit (18%), private practice (10%), hospital (6%), K-12 (5%), and other (16%). Sixty-three (63%) of respondents indicated that their present professional setting included work with, or on behalf of, older adults.

Results

Due to limited space, the following are selected findings that will inform further research efforts.

Interactions with Older Adults*:* Many respondents (31%) reported that they look forward to growing older and the majority (56%) indicated that they have a lot of respect for older adults. Most reported that when working with or spending time with older adults that they are patient (56.5%), curious (50%), empathic (50%), and sensitive (50%). Nearly half (48.4%) reported they are not fearful about growing older, nor are they bored by the elderly (78.4%). Sixty-three (63%) percent report having adequate or little preparation for working with older adults, as compared to 36.8% who report being very prepared. Additionally, 67% would like more resources, 46% would like training programs, and 28% report that they would benefit from teaching modules on aging related topics. Finally, over 66% indicate that they are not part of any gerontological organizations and 71% report they do not read any gerontological-related academic journals, though 51% reported a desire to have more aging related journal articles.

Palmore Facts on Aging: Overall, the majority of respondents correctly answered 60% of the 50 questions. Respondents lacked knowledge of older adults related to nursing home occupancy, car accident frequency, ability to work, likelihood of social isolation, socioeconomic and health status, impact of retirement, and the role of family in caring for older adults. Interestingly, responses oftentimes incorrectly favored (were more positive toward) older adults.

Discussion

Despite having positive attitudes and experiences with older adults, and substantial general knowledge of aging, the majority of respondents reported having inadequate gerontological education, including literature, training, and interactions with other aging-minded professionals. Specifically, the majority were unaware of current academic-based research findings, including best practices, and current aging-related events (conferences, seminars, grants, resources and trends). Findings suggest that there is strong need to develop and implement continuing education programs, seminars and/or modules for practitioners, academics, and non-profit professionals. Additionally, national and statewide aging networks, such as the Gerontology Society of America (GSA) and the California Council on Gerontology and Geriatrics (CCGG), respectively, could benefit from marketing to a wider-range of professionals. Infusing aging-related content into human services education will help create a more skilled workforce critical to meeting the unique and diverse needs of the aging population.

Limitations of This Study

As with any study, there are limitations. First, the variety of professions and workplace settings represented might indicate that there is a lack of focus or precision to the findings. Working in a higher education setting is quite different from working in a clinical or frontline service agency, thus future studies would benefit from intentionally gathering a more diverse sample of professionals in varied settings. Second, the respondents were overwhelmingly female and Caucasian. Drawing on a more diverse sample would allow for a better understanding of how culture and demographics might inform experiences of working with older adults.

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Review of Deliberate Practice for Psychotherapists: A Guide to Improving Clinical Effectiveness

John Paulson

Book Review

In *Deliberate Practice for Psychotherapists: A Guide to Improving Clinical Effectiveness* (2017), author Tony Rousmaniere addresses one of the most important issues that human services practitioners encounter--the need to continue to grow and improve as service providers. This becomes especially true for practitioners who have completed their formal human services education and are now working in the field. Dr. Rousmaniere explores the development of a growing field of scholarship and training for helping professionals called deliberate practice. Throughout the book he draws both from the emerging body of research on this topic and from his insights and experiences working with deliberate practice principles in his own supervision.

The author begins this text with a candid discussion of his struggles as a new clinician. He describes his concern discovering, through using client feedback measures, that only about half of his clients were demonstrating improvement. He goes on to note an additional troubling finding that a larger number of clients than he predicted either dropped out of care prematurely or declined in functioning during the course of treatment. Like most beginning providers, he sought out clinical supervision to strengthen his competency. He then spends time discussing a troubling finding from the clinical supervision literature that receiving clinical supervision does not appear to contribute significantly or directly to improved client outcomes. His own early experiences affirmed this point and suggested that supervision alone does not necessarily make one a better service provider.

These observations have led Dr. Rousmaniere, and others, to apply research findings on the acquisition of expertise to the development of direct service providers. In applying these insights to the training of helping professionals, Dr. Rousmaniere identifies five critical aspects of deliberate practice that can inform and improve the training and supervision of human services practitioners. The first principal of deliberate practice outlined is direct observation of the supervisee, with an emphasis placed on video recording the practitioner providing services. Recording allows both the supervisor and the supervisee to repeatedly view and review the interaction. This avoids a limitation in traditional supervision of relying on a description of what the supervisee remembers occurring, or believes occurred, and allows all involved to see what actually transpired.

The second principle he identifies is receiving expert feedback focused on the *edge* of the supervisee's competency. This means that more time is spent targeting and strengthening the skills the trainee needs to improve. Targeting these areas allows for the third and fourth principles of deliberate practice. The third principle includes the development of a training plan specific to the targeted skills, followed by the fourth principal of intentionally practicing those skills. The final principle is having an on-going plan for continued assessment of performance. The author then spends the remainder of the text offering suggestions for how practitioners can incorporate this focus into their training and supervision while also successfully addressing inherent challenges, especially concerning issues surrounding the recording of client interactions.

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One of the strengths of this book is its core message of hopefulness. It affirms that equipped with specific training principles, practitioners can improve their effectiveness providing services to clients and achieve better outcomes. Another asset of this book is its broad applicability. Although the author refers specifically to psychotherapists in the title, these training principles are relevant to mental health practitioners in general, including human service professionals. The approach applies to foundational helping skills as well as to the application of more advanced clinical techniques. The principles of deliberate practice are also trans-theoretical, not favoring any one model or approach to practice and intervention over another.

This book is applicable to early career human services supervisees and the supervisors and educators who work with them. It provides very clear guidelines and suggestions for how to approach one's continuing development as a practitioner. This book could also be used as a supplement to textbooks in direct practice and field education classes. The emerging focus on deliberate practice and applying these strategies to promote improved outcomes for individuals receiving social and behavioral health services will likely continue to have a significant impact on both human services education and practice.

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Review of Neurotribes: The Legacy of Autism and the Future of Neurodiversity

Shoshana D. Kerewsky

Book Review

Silberman's sweeping *Neurotribes: The Legacy of Autism and the Future of Neurodiversity* (2015) contributes a valuable, less-pathologizing vision to the growing body of literature on Autism Spectrum Disorder (ASD). This highly engaging book is easily adapted for human services classes, where it brings diagnostic and historical information to life.

In 2013, the American Psychiatric Association (APA) published its latest edition of the *Diagnostic and Statistical Manual of Mental Disorders,* DSM-5. This edition introduced the latest in a series of shifts in the diagnostic categorization of autism-related phenomena, which is now labeled Autism Spectrum Disorder. Listed as a Neurodevelopmental Disorder (APA, p. 50-59), ASD subsumes the previous DSM diagnoses of autism, Asperger's disorder, and several other developmental disorders (p. 809). The expansion and contraction of autism-related diagnoses has been a hallmark of DSM revisions, one of many topics touched on by Silberman (2015, p. 381 *ff).* The latest collapsing of categories should alert human services educators and practitioners to examine current criteria and, perhaps, to explore this frequently-changing diagnosis or set of diagnoses more thoroughly.

Silberman approaches ASD as a journalist, understanding it as an historical and cultural phenomenon. This differs from a perspective based primarily in social sciences and intervention training such as human services students and practitioners may encounter in the course of their training and professional development. Interspersing biographical chapters with the history of the development of the autism diagnoses, Silberman humanizes the diagnosis and demonstrates the range and variability of human cognitive processes. He concludes with a chapter urging a broader conception of normative neurodiversity, as well as greater inclusion of people with spectrum disorders through options afforded by expanding technology.

Inexpensive in paperback and available in electronic and audio versions, *Neurotribes* is easily incorporated in undergraduate and graduate classes. For a class devoted to ASD or neurodevelopmental issues, most or all of the book could be assigned early in the term in order to provide a historical foundation for contemporary practices and stimulate discussion about the inevitable changing nature of diagnosis and intervention.

Specific chapters could be assigned to match the course focus. For a class focused on diagnostic categories, the chapter "Fascinating Peculiarities" traces Asperger and Kanner's parallel development of distinct subcategories of ASD, which have converged and diverged over time; "Pandora's Box" examines this ongoing process in more recent editions of DSM. "The Invention of Toxic Parenting" examines Bettelheim's now-discredited assertions about the etiology of ASD and its relationship to schizophrenic spectrum disorders. Many chapters, provide case studies of people who may or may not meet contemporary criteria for ASD. The chapters most clearly describing some of the children on whom the diagnosis was based (such as "What Sister Viktorine Knew") would be useful for practice applying diagnostic criteria, as well as discussing case management, developmental considerations, abilities/challenges, and intervention strategies. Portraits of higher-functioning people, including "Princes of the Air," may be most useful for graduate students' diagnostic practice since they highlight ASD as a

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spectrum and therefore highlight the range of human cognitive diversity. "In Autistic Space" and "Building the Enterprise*:* Designs for a Neurodiverse World" further challenge the concept of all ASD as detrimental and broaden the inquiry to include strengths and skills that could be incorporated in case management, classroom management, or workplace design.

Having students read the same chapter in its paper, electronic, and audio versions leads to a productive discussion of learning style, learning preferences, and cognitive differences, highlighting the range of human variability. If used in this way, *Neurotribes* could be paired with materials such as Wolf's (2008) *Proust and the Squid: The Story and Science of the Reading Brain* to expand conversations on topics such as educational and workplace accessibility.

Biographical chapters could be used as case studies, especially in classes with a different focus in order to underscore the concept of multi-layered and intersectional identities (Hays, 2016; Kliman, 2010). Chapters also could be paired with first-person narratives of people with ASD or their family members. Many human services practitioners are familiar with Temple Grandin's accounts (for example, her 1995/2006 *Thinking in Pictures: My Life with Autism*), but are unaware of an increasing number of memoirs published on this topic. A useful selection for a longer class, representing a range of cognitive phenomena and experiences, could include accounts by parents and people with ASD.

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The *Journal of Human Services* (JHS) is a national refereed journal. Manuscripts judged by the editors that fall within the range of interest of the journal are submitted to reviewers without the names and identifying information of the authors. The principal audiences of JHS are human service faculty members, administrators, practitioners, and undergraduate and graduate students. Sample areas of interest include teaching methods, models of internships, faculty development, career paths of graduates, credentialing, accreditation, models of undergraduate and graduate study, clinical issues in human service treatment, and supervision of human service practitioners.

JHS publishes three types of submissions: 1) articles, 2) brief notes, and 3) critical reviews of instructional materials and scholarly books of interest to human service educators.

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7. Two (2) copies of the manuscript must be electronically submitted (Microsoft Word or text file versions only). The first version should include, on a separate page, the title of the article, the names of the authors, their professional titles, and their institutional affiliations. The second version must be free of any identifying information. Articles' titles and headings should be as short as possible.

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