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Terence Yee, Editor

## Editor

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### **Terence Yee, Ph.D.**

Department of Education and  
Counseling  
Villanova University  
800 E Lancaster Avenue  
Villanova, PA 19085  
Email: pcajournal@gmail.com

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# The Journal of the Pennsylvania Counseling Association

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# Hosting Mandarin-Speaking Minors and Building a Successful Cross-Cultural Experience

Hsin-Hua Lee & Ariel Virk

A growing number of Mandarin-speaking minors, i.e., parachute kids, are coming to the U.S. for educational purposes. Despite their contribution to the U.S. society, there is a lack of understanding of this unique population. Therefore, the authors summarize the literature on the risk and protective factors for parachute kids' adjustment, interventions, and responsibilities of host parents. A set of best practices for working with these minors, their parents, host parents, and educational agencies is proposed.

*Keywords: Parachute kids, host parents*

According to the Institute of International Education (2019), China and Taiwan are currently ranked number one and seven, respectively, in terms of place of origin for international students in the U.S. With a combined population of more than 370,000, these Mandarin-speaking international students contribute annually close to 16 billion dollars to the U.S. economy (Institute of International Education, 2019).

A growing number of these Mandarin-speaking international students are minors, unaccompanied by parents. These adolescents are also referred to as *parachute kids* (Hamilton, 1993a). The first significant wave of parachute kids arrived in the U.S. in the 1980s and 1990s, and they were mostly of Taiwanese descent (Zhou, 1998). The majority of them came to the U.S. to obtain a better education to make them more competitive in a global job market (Hsieh, 2007; Zhou, 1998). However, in the past 10 to 20 years, the number of parachute kids from China are outpacing those from other Asian countries and more than a quarter of them choose to land in California (Shyong, 2016). There is also a trend of Chinese students coming at an increasingly younger age (Larmer, 2017). This trend is alarming because some of these adolescents and children are at a greater risk of developing a wide range of psychological, behavioral, and academic problems due to a lack

of parental support, adjustment difficulties, and/or pre-existing familial and psychological vulnerabilities (e.g., Hsieh, 2007; Pih & Mao, 2005). While there is one study showing that the rate at which these adolescents experience psychological difficulties is no different from that of those who immigrated with their parents (Chiang-Hom, 2004), we argue that this population is at a higher risk of not receiving adequate treatment in a timely manner, as compared to other youths, because (a) they are often unfamiliar with the healthcare system in the U.S., (b) their parents are not around to notice the changes in their behaviors and provide immediate assistance, and (c) these minors do not always trust or feel that they could rely on their school and host parents for support.

More specifically, there is a dearth of literature documenting the challenges that these adolescents face (e.g., Chiang-Hom, 2004; Hsieh, 2007; Pih & Mao, 2005), the long-term impact of this unique educational journey on individuals and families (e.g., Lee & Friedlander, 2014; Lee et al., 2020), as well as potential interventions (Lee & Wentz, 2019a). Interestingly, there is very little discussion in the literature around prevention of psychological, behavioral, and academic problems for parachute kids. Also, most of the literature focuses on the experiences of the minors and their

Hsin-Hua Lee, Ph.D., Department of Psychology, Arcadia University. Ariel Virk, M.A., Department of Psychology, Arcadia University  
Correspondence concerning this article should be addressed to Hsin-Hua Lee, Department of Psychology, Arcadia University, 450 S. Easton Road, Glenside, PA, 19038 Boyer Hall# 129 (e-mail: leec@arcadia.edu)

parents, but there is little to no discussion of the perspectives of host parents or other entities that work with these families. In other words, there is a lack of comprehensive guidelines for working with these minors. Therefore, the goal of this paper is to (a) review the limited amount of literature on parachute kids in terms of host parents, and (b) discuss best practices for working with these minors, their parents and host parents, and educational agencies.

### **Why Do Parachute Kids Come to the U.S. and Where Do They Stay?**

As reported by Shyong (2016), approximately 9 million students annually fight for 7 million spots in universities and colleges within China. About one million of those who are rejected end up attending schools overseas, with the U.S. being one of the most popular destinations. Due to this fierce competition, as well as a desire for higher social standing for the family, many Chinese and other Asian parents are now sending their adolescents, and sometimes younger children, overseas earlier and earlier (Larmer, 2017), even though more recent studies have shown that parachute kids' employment rate and job compensation are not significantly higher than those who grew up and were educated in China (Yang, as cited in Shyong, 2016). Some adolescents also reported that the increased ability to engage in a variety of extracurricular activities is another important factor in their decision to leave the Chinese educational system (Shyong, 2016).

According to Lee and Wentz (2019a), parachute kids often reside with relatives or host families. Some of them live alone or with older siblings, and some of them attend boarding schools. While many of them possess student visas, some of them were born in the U.S., returned to their native countries with parents for various reasons, and later came back to the U.S. by themselves. The latter are technically U.S. citizens, but their experiences may be more similar to those who identify as international students or young immigrants based on the first author's clinical experiences. There is also a group of minors whose families have permanent residency status in the U.S., but they decide not to accompany their children/adolescents to the U.S. due to various reasons. Minors from these families are therefore

eligible to attend public secondary schools and to apply for citizenship when they reach adulthood.

### **Risk and Protective Factors for Psychological Issues**

Over the years, a handful of researchers have examined the risk and protective factors for parachute kids' adjustment and development of psychological issues. For example, earlier literature suggest the negative impact of not having parental supervision on these minors' functioning (e.g., Hsieh, 2007; Pih & Mao, 2005). Difficulties associated with acculturating to a new culture and school system had also been found to be a major contributing factor in the development of psychological, behavioral, and academic problems for these adolescents (Hamilton, 1993; Zhou, 1998). All of this early literature was either based on correlational data or participants' narratives; therefore, it was impossible to establish, scientifically, the causal relationships between the aforementioned risk factors and outcomes. Moreover, it is especially confusing when there is research that shows contradictory results. For example, Chiang-Home (2004) found that parachute kids displayed problematic behaviors at the same rate as other immigrant youths, suggesting that a lack of parental supervision and being separated from their homeland, could not fully explain why these minors developed behavioral issues. Therefore, we argue that there are some protective psychological factors that might mitigate, or act as buffer for, some of the acculturative stress and the negative impact of not having parents around.

In a study examining the adjustment of international exchange high school students, researchers found that perceived social support had a positive impact on the mental health of these students and the association was mediated by coping styles (Furukawa et al., 1998). Specifically, those who reported a more task-oriented strategy when faced with difficult circumstances, had a more positive outcome as compared with those with a more emotion-oriented coping style. Ra and Trusty (2015) also examined how varying coping styles mediated the relationships between acculturation and acculturative stress among 220 Asian international students, and found that a task-oriented coping style helped minimize perceived acculturative stress; whereas, emotion-oriented

coping strategies often involved some form of self-deprecation and led to increased stress. Ra and Trusty's findings echo those reported by Furukawa (1997) in another study that examined the role of neuroticism in adjustment; that is, higher levels of neuroticism were found to contribute to adjustment difficulties as well as development of mental health diagnosis both during transition to the new culture and when young international students return to their homeland. Furthermore, Cheng (2009) found that those who were more proactive in making adjustments and had the opportunity to participate in the decision-making process of studying overseas tended to have an easier transition than the other parachute kids. Overall, based on these studies, how these minors *internally* respond to the difficulties facing them and whether they have any agency in the process seems to shape their development and experiences of studying abroad.

Interpersonally, certain traits also seem to allow for better psychological adjustment for parachute kids. For example, Lee et al. (2020) surveyed a group of former parachute kids, who came from relatively high-functioning families, about their experiences of culture-based family conflict, and found that many of them reported feeling closer to their parents after being separated from them and became more appreciative of their support over time. In contrast, Mok (2015) documented her experiences of working with a former parachute kid whose relationships with parents were strained since early childhood; however, the separation did not seem to enhance their closeness. In her conceptualization, Mok (2015) discussed how early contextual vulnerabilities had potentially laid the foundation of the client's future mental health struggles, and how the acculturation difficulties then exacerbated these vulnerabilities and led to the onset of psychological issues. Indeed, there seems to be a connection between the parachute kids' relationship with primary attachment figures and their ability to cope (e.g. reaching out for support). This argument was further supported by a study conducted by Chen et al. (2002). In their study, Chen et al. (2002) found that higher levels of secure attachment among adult international students from East Asian countries predicted higher levels of perceived support from family and friends back home, perceived support from international students' office on campus, and perceived support from new social networks in the U.S. The support from new friends was especially

effective in buffering acculturation related stress and perceived racism. In summary, this small subset of literature suggests that relationship quality prior to moving abroad might be a good indicator of parachute kids' capacity to cope with the transition to a foreign culture.

Aside from their temperament, coping styles, and interpersonal capacities, Kim and Kkasaki (2014) also offered some valuable insights (i.e., the importance of preparation) regarding the wellbeing of parachute kids. Based on an in-depth interview of ten South Korean early-study-abroad students in the U.S., Kim and Okazaki (2014) found that greater ambivalence and more unrealistic expectations of the U.S. culture predicted higher levels of vulnerability and longer duration of adjustment upon arrival among these youths. This finding is particularly important because, as stated earlier, there is virtually no discussion of prevention strategies for these youths in the literature, and the results of this study show us how important it is to adequately prepare the minors and their families prior to their journeys. Therefore, we argue that this is something that *can* and *should* be done for families, irrespective of the minors' internal and interpersonal resources.

### School-Based Interventions

For school interventions, the literature is scant. To date, there is one intervention study conducted specifically for parachute kids (i.e., Lee & Wentz, 2019a). In this study, Lee and Wentz (2019a) tested whether a school-based psychoeducational/support group was effective for a group of 17 Mandarin-speaking students at a private high school in the northeastern region of the U.S. Results showed that the group was helpful for the students' transition to studying and living abroad. However, the study did not include a standardized questionnaire to measure mental health outcomes, and the results did not include those who stopped coming to the groups due to a variety of reasons. It was possible that some of these students did not find the group useful, but the authors were not able to collect their feedback.

Due to a lack of literature on interventions for parachute kids or Mandarin-speaking minors, we reasoned it would be appropriate to draw from studies that focused on international students who are in colleges and universities, particularly those with samples of older adolescents (i.e., 18 and 19

years old). For example, Montgomery (2017) conducted an in-depth interview with 6 Chinese international undergraduate students who were in their first year of study at a large university in the southeastern region of the U.S. Even though the target population was undergraduate students, there were many recommendations that were applicable to parachute kids. First, Montgomery (2017) suggested that there should be a systemic orientation process that included collaboration between all relevant stakeholders and the orientation should occur *prior* to students' arrival, again when they first arrive, and at an on-going basis. This author also suggest schools can do a better job of creating opportunities for students to interact with domestic students, and role play how to problem-solve everyday situations (e.g., interacting with teachers, peers, managing bureaucratic processes, etc.). Schools should also play a more active role in students' housing arrangement, including screening domestic students who are willing and interested in rooming with and assisting international students. Finally, the school should not assume that international students would reach out when they need help; instead, school staff should play a more proactive role in ensuring that these students' needs are met.

Tsai and Wong (2012) conducted a qualitative study involving two group discussions with nine Taiwanese and Chinese international college students. Participants expressed how important it was for them to belong to some social organizations; they stated that these group experiences provided them with an outlet for recreation, an opportunity to receive important information, some reduction in loneliness and homesickness, and a buffer for racism. Based on these findings, the authors recommended that schools should have more coordinated efforts in order to create opportunities for international students to engage with some social organizations and to expand their counseling services to include support groups and workshops.

Smith and Khawaja (2014) tested a pilot program called STAR: Strengths, Transitions, Adjustments, and Resilience, for a group of international students in Australia. The sample was small (16 participants) but the majority of them (12) identified as Asian. The program consisted of four weekly two-hour sessions that targeted coping strategies, adaptation, and acculturation. The results showed that participants improved in their

psychological adaptation and their efficacy in coping from pre- to post-test. Moreover, Kanekar et al. (2019) tested an online intervention to see whether it was effective in combating mental health issues for a group of Indian international students at a large Midwestern university. The online intervention included psychoeducation about social support and acculturation, and was found to be effective in increasing positive mental health outcomes.

Altogether, the above literature on international students seems to emphasize the importance of culturally sensitive interventions (e.g., Carr et al., 2003; Lee & Wentz, 2019a) and the role of stigma in international students' help seeking behaviors (e.g., Montgomery, 2017; Smith et al., 1999). Further, the literature also stresses the positive impact of social support (e.g., Tsai & Wong, 2012) and highlights the therapeutic effect of increasing positive coping strategies (e.g., Smith & Khawaja, 2014). Finally, there appears to be a consensus around the importance of a more systematic orientation process (e.g., Montgomery, 2017) and the utilization of interventions such as peer support groups, outreach, and web-based interventions (e.g., Andrade, 2006; Kanekar et al., 2019).

### **What is the Role of Host Parents?**

As discussed earlier, host parents' roles are often neglected in the literature. The lack of literature is astounding since these individuals are the guardians of many parachute kids. The host parents are generally in charge of these minors' housing, transportation, food, and/or other essential activities, and they are often the first people to observe problematic changes in these minors' physical and mental health. To date, we have located two academic papers that focused on host parents' relationships with international students. Even though they surveyed only older adolescents/college-aged international students outside of the U.S., we believe the information is relevant for the current population.

According to a qualitative study conducted by Ng et al. (2017) in Australia, whether international students (ranged from 17 to 21 years old) successfully integrate into the host society may depend on how much host parents are willing to support this process. Specifically, some participants reported that their host parents took them out to social gatherings and encouraged them

to join family dinners; being connected with their host parents helped improve their language fluency. Another qualitative study conducted by Rodriguez and Chornet-Roses (2014) showed that the relationships between host parents and the international students could be categorized in four ways: family, friends, guest-host, and tenant-landlord. While the participants in the study identified as American college students studying in Luxembourg, not parachute kids, this study helped highlight how the differences in expectations could cause difficulty in students' emotional adjustment and affect how satisfied they were with their host family. Together, these findings echo the first author's clinical experiences with parachute kids; that is, relational problems with host parents are often one of the main complaints, or a serious exacerbating factor for these youths' pre-existing mental health issue. Differences in habits, communication styles, and/or expectations can often trigger these relational problems.

### Experiences of Host Parents

It is also important to understand the perspectives of host parents when designing any intervention programs. Frist and colleagues (2005) surveyed parents and host parents of roughly 1500 high school aged exchange students in nine countries, and the results showed that students who had only one host family placement were perceived to have greater host-culture language fluency as compared to those who lived with two or more host families, suggesting that getting along with their host families and consistency in the students' housing arrangement helped increase their learning of the new language. However, the authors of this study did not explain why some of the participants switched host parents.

Additionally, host parents who hosted American students abroad reported that students who (a) were more mature, (b) had a more open personality, (c) were not overly connected with family and friends back home via technology, and (d) had more knowledge about the host culture tended to adjust better to living with their host family in the new culture (Knight & Schmidt-Rinehart, 2002). Interestingly, the lack of the above qualities was reported by host parents to be more predictive of adjustment issues than linguistic ability. These host parents also reported that the biggest adjustment for them was the preparation of meals (e.g., wanting to diversify the

options of food for the international students), and there was little to no orientation for them from the school or the educational agencies that assigned them to the students. Finally, Knight & Schmidt-Rinehart (2002) recommended an orientation to include the following elements: stereotypes, homestay families, sibling issues, country-specific information, safety issues, culture shock and the adaptation process, cultural practices and perspectives (including food, clothing, etc.).

In a more recent survey of 30 host parents of Chinese and Taiwanese international students who were minors, it was found that the majority of these participants (63.33%) became host parents due to the financial compensation as well as interests in foreign culture and language. The two major challenges that they experienced included difficulty communicating and trouble adjusting to students' cultural backgrounds and behaviors (Lee et al, 2019b). Specifically, almost all of the participants (93.33%) reported that they did not cook for their international students, and most of them did not have regular communication with the biological parents in China or Taiwan. The trend that most host parents did not cook for their students is concerning, because sharing of food and eating together is usually one of the main avenues for cultural exchange and opportunities for the host parents to learn about those minors. Finally, 48.4% of these host parents reported receiving little to no training before becoming a host parent; 6.5 % had a one-time orientation/meeting; and only 12.9% reported receiving ongoing training. Notably, 53.3% of the host parents reported that the training they received was helpful because they received support from others, information about the cultural context of their students, support in communicating with students and their parents, and information about general expectations. When asked what other support would be helpful, participants listed the following: having more organized meeting and contact with other host families/parents; making it clear to the adolescents and their parents that this is a cultural exchange and that host families are not staff to their adolescents; being able to communicate with the students' family; and finally, having more training in general.

In sum, stable housing arrangement and quality relationship with host parents seem to predict better language acquisition, overall adjustment to the host culture, and psychological health among



parachute kids. Host parents also seem to agree that more orientation and support along the way help them become better cultural ambassadors and custodians for these minors.

### Recommendations

Based on the literature review, we argue that some parachute kids are more susceptible to developing psychological problems and relational issues with families because of their individual vulnerabilities *prior* to their departure from home; these vulnerabilities coupled with environmental stressors (i.e., acculturation, conflict with host parents, separation from friends, and/or a lack of emotional support from parents) may lead to the onset of serious short-term or long-term psychological issues. Furthermore, there seems to be (a) a lack of preparation for parachute kids and their parents prior to the youths' journeys, (b) no empirically supported guidelines for schools and educational agencies, and (c) little to no orientation and ongoing support for the host parents; therefore, we hope the following recommendations will serve as a beginning step of a more comprehensive understanding and services for parachute kids.

### For Parachute Kids and Parents

First of all, many parachute kids are currently sent to the U.S. without a choice. The lack of personal agency can place these children and adolescents at a more psychologically vulnerable state (Cheng, 2009), and feeling forced by their parents could be perceived as a relational rupture by the minors. More specifically, some minors may see the parents' decision to send them away as a way to reduce the shame that was brought upon their family due to their lack of educational accomplishment in their home country. Therefore, we believe it is important that the minors should be more involved in the process, and expectations should be realistic and openly discussed.

Second, while we understand that cultural norm plays an important role in most families' decision to send their minors abroad, we cannot emphasize enough that some minors are more likely to develop symptoms or show worsening of symptoms when placed in an unfamiliar environment *if* they were already struggling psychologically prior to their departure. It is important to clarify that we do not mean to say that

these minors should never go abroad to study; however, we strongly recommend that the decision should be made with caution and that parents should consider measures that will mitigate the impact of acculturation. That is, for those who were already showing symptoms of psychological issues (anxiety, depression, behavioral issues) prior to leaving home, parent should consult with mental health providers and to have frank conversations with their minors to determine the timing (now vs later) and location of studying abroad (whether the destination has adequate support and resources), as well as the specific resources that the minors might need during their transition.

For those who do not meet any full criteria of psychological conditions, but seem to demonstrate a more anxious attachment style, a more emotionally oriented problem solving strategy, an unwillingness to seek support from others, and/or a generally more anxious demeanor, parents could encourage their minors to seek help from mental health professional to strengthen their problem solving abilities and social skills in preparation of their journeys abroad. The families may also want to consider delaying the plan to study abroad until these minors show enough maturity and skills for more independent living. Finally, the parents should remain communicative with host parents, schools, and other coordinators to ensure a smooth transition for the minors.

Third, parents and minors should receive some psychoeducation on mental health issues and acculturation processes, irrespective of their symptomatology, prior to leaving their home countries: *What are mental illnesses? What are the common symptoms of psychological issues? What types of changes in mood and behaviors should trigger a concern? How to seek support and treatment in the host country?* Moreover, the psychoeducation should include some discussion about acculturation processes, the common acculturative difficulties, how to address these difficulties, and how to seek help.

Fourth, parents and minors should be clear with each other about their expectations in terms of academic achievements and the type of relationships that they want with their host families. These expectations should be clearly communicated with host parents, school, and other coordinators. This can reduce the chance of the

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minors being caught in the middle and not knowing who to go to for problems and support. For example, it is often up to the host parents and parents to decide what services would be included in the monthly fee that the parents pay the host parents. With a higher monthly payment, minors might be fed twice a day instead of once by the host parents. If not negotiated clearly, minors may feel confused and mistreated by their host parents. Of course, language is often the biggest barrier for parents and host parents' communication. We recommend that parent should not rely completely on the agents/coordinators (those who help connect them to the host parents) for interpretation, they should be more proactive about asking questions, clarifying the terms and conditions of their contract, and seeking their own language interpretation if needed.

Fifth, information is power. We argue that it would be tremendously helpful if the parents and the minors could learn about the educational system and practices of the host culture together. It might be also helpful if they could role-play some everyday scenarios with individuals who are familiar with the host culture. Again, the more preparation the families have prior to their journeys abroad, the more success the minors are likely to have after leaving home.

### For Schools in the U.S.

Given the limited amount of literature that we have on interventions for parachute kids, we tentatively offer the following recommendations. To begin, high schools that admit Mandarin-speaking minors, or parachute kids, should hire or appoint a person who is skilled in working with this particular population. This person ideally would have a birds-eye view of all the services available to these minors, is effective in building relationships with them, and can act as a liaison for all the offices and individuals who work with the minors. Another important step the school can take is to create groups and/or organizations that would encourage international students to get to know each other and help them interact with domestic students in order to create positive, intercultural experiences (Lee & Wentz, 2019a). For example, some parachute kids choose to study abroad because they are interested in participating in more extracurricular activities (Shyong, 2016). If schools can actively encourage these students to participate in different sports and recreational

activities, it would certainly help their integration with the campus community. Again, schools should not expect international and domestic students to be naturally interested in *and* able to interact with one another effectively; international students often need more encouragement and support in the process of integration.

The importance of additional academic and emotional support cannot be overly emphasized. As stated earlier, these minors' primary goals for coming to the U.S. are often related to educational attainment (Hsieh, 2007; Zhou, 1998). Clinically, the first author also noted that many parachute kids would cite academic related stress as the primary reason for seeking psychological help. Therefore, schools should be prepared to offer tutoring, writing support, and counseling in Mandarin. If there is no Mandarin provider nearby, schools should help connect the students with providers in other region via telehealth.

We also believe that schools are in a particularly strong position to advocate for parachute kids. Specifically, many schools do not advertise or work directly with families in China and Taiwan. Instead, schools sign contracts with agencies that help them recruit students from agencies abroad; these U.S.-based agencies also help the students find host families. Similarly, the families in China and Taiwan would usually go to an agent in their home country to begin the process of finding a school and host family. Therefore, there are usually two *middle persons* (i.e., agencies) between the families and the school, which can complicate the communication. As a client, the schools could demand their partnering agencies in the U.S. to provide more screening of, training for, and ongoing supervision of host parents. The schools should also demand that their partnering agencies only work with foreign companies that are reputable and would provide orientations for parents and minors prior to their journeys.

### For Host Parents

To begin, it is important that host parents continue to reflect on their intentions and goals for hosting international students, as well as their reactions throughout the process; such self-awareness may help them manage any frustration that might arise and therefore increase their ability to seek help in a timelier fashion. For example, many host parents in the study by Lee et al. (2019b) reported that they

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took on the responsibility of hosting due to financial benefits and their curiosity about foreign culture. However, it is unclear which one is the more influential factor. We would argue that when the sole motivation is monetary, it is harder for host parents to demonstrate the level of warmth and involvement needed for hosting younger international students, especially if these minors have the expectation that host parents would act as their pseudo-parents or friends. In other words, we recommend that host parents be clear about why they are hosting. If it is mostly for monetary gain, they should refrain from hosting those who are minors. Furthermore, host parents should consider seeking external support (support groups on social media, local cultural organizations, etc.) throughout the process because minor frustration and difficulties are a natural byproduct of hosting younger students.

Second, we believe that intrinsic interests about parachute kids' cultures would help build rapport with these minors. In other words, instead of having the attitude of *'I'm here to teach you about the U.S. and you will acculturate to our way of living,'* an attitude of *'I'm here to learn from you or we are learning from each other'* will help the minors feel more welcomed and valued. The sense of feeling valued will then help the students open up to their host parents and in turn makes it easier for the host parents to support the students and feel rewarded by the process. According to the first author's clinical and research experiences, many host parents complain about having communication difficulties (e.g., Lee et al., 2019b). While some of the difficulties are due to language barrier, the majority of them are about a lack of mental adjustment and preparation within the host parents. To maintain a curious stance and to prepare mentally for their role as host parents, we recommend that host parents engage with students' culture in other formats. These may include (a) reading fictions from the students' native culture, (b) taking a language or other cultural classes to learn about their students, and (c) having regular conversation with others who are familiar with the student's cultural background.

Relatedly, it is important for host parents to be educated about the process of acculturation so they are prepared to manage their students' emotional reactions and behaviors. For example, it is typical for someone who is new to the U.S. to want to seek social support from their own cultural background.

This is a normal reaction to acculturation and not necessarily a resistance to learning about the U.S. Host parents should support this practice while encouraging and creating opportunities for their students to also engage with the new environment and people. In other words, acculturating into the U.S. and maintaining a sense of belonging with one's native culture are not mutually exclusive.

Finally, host parents should screen agencies based on the type of orientations they offer (or if they offer any at all) and the type of support they provide along the way. It would also be important for the host parents to know whether they could have regular contact with their students' parents, schools, and agents. Prior to the students' arrival and throughout the process, there should be discussions about expectations. For example, *does the student expect the host parent(s) to make all or some of the meals? What types of food do they prefer? How often can the student go out and is there a curfew? Who is responsible for transporting the student for various school and extracurricular activities? What type(s) of host parent-student relationship is expected by everyone in the equation?* By asking these questions, host parents would know, more clearly, if they are ready to take on the role and whether a particular student may be a good fit for them.

### For Host Family Placement Agencies

According to Lee et al.'s (2019b) survey, it appears that many agencies do not provide orientation, training, or any formal ongoing support for the host parents. In other words, once the students arrive in the U.S., the agencies' primary function is to *react* to problems when they arise. We argue that a more proactive stance would help the students, their biological parents, and the host parents. To this end, we recommend that, at a minimum, there should be a workshop or orientation for parents prior to their adolescents' departure from home. Such a workshop and orientation should focus on providing information about the U.S. culture and school systems, potential challenges associated with acculturation, and strategies that could be used during students' transition.

In addition, the host parents should be screened and trained prior to becoming a host parent. For example, agencies should investigate, using

multiple methods if possible, as to why host parents are interested in taking on this responsibility, whether there is any concerning history (criminal and others), if they are financially secure, and their expectations for this intercultural experience. An orientation could also provide host parents with the opportunity to grasp the scope of responsibility they are undertaking, to understand the potential challenges, and to be equipped with resources to support their students. On a regular basis, agencies could also host workshops and other social events to help host parents create a social and support network, to exchange information and resources, and to learn about culturally sensitive ways to communicate and problem solve.

Lastly, we argue that it is important for agencies to establish a framework for regular check-ins among the students, their biological parents, schools, and the host parents. These are meant to increase their communication about changing expectations and policy. Also, adolescence is a particularly challenging period of one's development; early coordinated response may help reduce the negative impact of any psychological and behavioral problems.

### Directions for Future Research

As stated above, there is little research on parachute kids; therefore, we recommend that there should be more systemic investigations of the risk and protective factors associated with leaving one's motherland during various points of childhood and adolescence to more accurately determine who might be at risk and how to better support these youths. Also, we made several recommendations in terms of preventions (i.e., workshops at school, orientations for parents and minors prior to departure, and ongoing orientations and trainings for host parents). While these arguments made theoretical sense, empirical evidence is needed to support them.

### Conclusion

As more Mandarin-speaking adolescents, or even younger minors, arrive in the U.S. each year from China, Taiwan, and other Asian countries, it is concerning that there is little coordinated effort to support this vulnerable population as well as those who work closely with them (host parents and

schools). We hope that this paper will serve as a springboard for more targeted clinical discussions and research among the various stakeholders.

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# Burnout among New Mental Health Counselors: Applying the Indivisible Self Model of Wellness

Adam F. Stephens, Joel F. Diambra, Daniel Shirley, & Brittany L. Pollard-Kosidowski

Burnout is common amongst professionals working within the helping fields (Paris & Hoge, 2010). This study sought to capture the experiences of clinical mental health counselors who left the counseling profession as a result of burnout. Using directed content analysis methodology, we explored participant burnout experiences through the lens of Myers & Sweeney's (2004) Indivisible Self Model of Wellness. Data analysis yielded five key findings and provides important implications for counselor educators and clinical supervisors.

*Keywords: attrition, wellness, burnout, new professionals, mental health counseling*

The attrition rate for mental health professionals currently sits at approximately 60 percent (Paris & Hoge, 2010). While there is no doubt a miscellany of explanations for high turnover and attrition among the helping professions, this study examines a singular experience commonly recounted among those who have left the clinical field: professional burnout. Maslach and Jackson (1981) detailed the concept of burnout using a three-dimensional view of its precipitating factors, including: emotional exhaustion, depersonalization (i.e., absence of empathy and therapeutic presence), and feelings of diminished accomplishment. Kottler (2010) described burnout as “the single most common personal consequence of practicing therapy” (p. 180), pointing to its pervasiveness in the field of counseling. This study seeks to illuminate experiences of counselor burnout (CB) and outline implications for supervisors and counselor educators to better help students and supervisees prevent and address CB.

## Counselor Burnout

While there exists no unified scholarly definition of CB, Lambie (2006) defined burnout as “a psychological syndrome embedded in the context of a complex interpersonal relationship involving the person's concept of both self and others in which chronic stress leads to an emotional depletion and then to cynicism and a detachment response” (pp. 32-33).

Although Maslach and Jackson's (1981) aforementioned tri-dimensional model aligns with this definition, Lambie's (2006) conceptualization expands burnout to apply in a wider range of contexts, emphasizing the impact of interpersonal interactions. Lambie (2006) explored organizational structure, populations served, inter- and intra-personal dynamics, and counselor preparation to develop a systemic view of burnout and to situate it within a variety of relevant contexts (Paris & Hoge, 2010; Lawson, 2007; Wallace et al., 2010; Yager & Tovar-Blank, 2007). These expanded definitions provide a greater context to the experience of burnout that goes beyond simply that of client-counselor interactions.

Paris and Hoge (2010) conducted a meta-analysis of 145 articles focused on the topic of CB and found that only 38 were published within the United States between 1990 and 2009. They noted that rather than providing any new scholarly understanding of burnout, much of this literature was solely anecdotal or observational. A further complication of defining CB is the myriad of closely-related terms such as compassion fatigue, secondary traumatic stress, and vicarious trauma, which are often confused with the concept of burnout as a standalone experience (Thompson et al., 2014). The complexity of this problem, particularly within the counseling profession, makes it imperative to identify and distinguish concepts that fit within the burnout

Adam F. Stephens, SUNY New Paltz; Joel F. Diambra & Daniel Shirley, University of Tennessee; Brttany L. Pollard-Kosidowski, Indiana University of Pennsylvania. Correspondence concerning this article should be addressed to: Adam F. Stephens Department of Psychology, SUNY New Paltz 1 Hawk Drive New Paltz, NY 12561 E-mail: stephena@newpaltz.edu

“umbrella” and take a nuanced approach to understanding the phenomenon (Newell & MacNeil, 2010). As field researchers build awareness of the manifestations of CB, we can establish a more nuanced definition, explore how it presents, and consider how we might be more proactive in addressing it (Newell & MacNeil, 2010). One such avenue involves conceptualizing the role of wellness in the counseling profession.

### **Wellness as a Theoretical Framework**

To better understand CB, it is imperative for counselor educators, supervisors, practitioners, and trainees to understand the critical role that wellness plays in counseling practice and counselor development (Wolf et al., 2012). As wellness models have become increasingly researched and formalized, they allow for greater depth in understanding CB and assists educators and supervisors in better preparing counselors for the realities of the profession (Lenz & Smith, 2010). The following sections outline current norms associated with teaching wellness in counselor education programs, as well as those associated with counselor development.

#### **Teaching Wellness in Counselor Education Programs**

Conceptualized as the inverse experience of CB, wellness offers a framework for combating and sometimes preventing CB through effective self-care and a general orientation to holistic health. Myers et al. (2000) defined wellness as “a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community” (p. 252). Wolf et al. (2012) pointed to the need for applying evidence-based concepts of wellness to the process of counselor training. They recommended an adaptation of the Indivisible Self Model of Wellness (IS-WEL; Myers & Sweeney, 2004), derived from the Wheel of Wellness model developed by Hattie et al. (2004), as a means by which to establish consistent terminology among field professionals.

Lawson & Myers (2011) asserted the essential nature of clinician wellness and its effects on client treatment outcomes, noting that “well” counselors are more effective as agents of change for their clients. As such, teaching and addressing burnout can also be

understood as an ethical imperative for those who train new professionals. Emphasizing the link between counselor wellness practices and client outcomes helps counselor educators and supervisors to support students in developing foundational wellness beliefs and practices before entering the field (Roach & Young 2007; Yager & Tovar-Blank, 2007).

#### **Counselor Personal and Professional Development**

The Integrated Developmental Model (IDM) of supervision for counselors-in-training posits that all new counselors enter the profession lacking skills associated with awareness of self and others, motivation, and autonomy, placing them at the novice level (Stoltenberg, 2005). New counselors commonly enter the field without effective foundational wellness practices to build upon as they engage in professional practice. While many developmental models of supervision offer guidance for building clinical skills and behaviors, supervisors currently lack a model for evaluating new counselors’ capacity to maintain healthy professional behaviors that support their own wellness (Lenz & Smith, 2010; Lambie, 2006; Stoltenberg, 2005).

#### **Purpose of the Study**

Typically, research aimed at further exploring burnout and attrition uses a quantitative approach and has focused on the experiences of doctoral students in counselor education programs (Stephens, 2016). There is a gap in current research regarding the experiences and professional contexts that increase the likelihood of attrition in counselors who have recently entered professional practice. As such, this study qualitatively explored participants’ counselor attrition narratives in an attempt to better understand the common experiences and factors that ultimately resulted in counselors leaving professional practice. Our research question was: What experiences culminate in CB and attrition for new clinical mental health counselors?

#### **Method**

The researchers utilized a semi-structured interview protocol and a directed content analysis methodology to apply Myers & Sweeney’s (2004) IS-WEL (Appendix A) domains to the personal narratives of new counselors in an attempt to better understand the factors that ultimately influenced them to leave the



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counseling profession. Pre-existing wellness categories from the IS-WEL were used to code transcripts from participant interviews, as opposed to the more inductive approach of assigning codes based on the researchers' examination of the data (Hsieh & Shannon, 2005; Ryan & Bernard, 2000). To better account for contextual variables, we limited participation to individuals who had graduated with a degree in clinical mental health counseling less than two years prior to participating in this study.

## Trustworthiness and Validation Strategies

Creswell and Miller (2000) identify eight distinct validation strategies for promoting a study's trustworthiness. Although it is unnecessary and often impractical to utilize all eight strategies, the thoughtful application of several techniques demonstrates adequate scholarly rigor. For this study, we used four of Creswell and Miller's (2008) eight strategies: (1) providing a rich, thick description of employment contexts and professional responsibilities from participants' interviews, (2) member checking through clarifying interview themes with research participants, (3) engaging in peer review of transcribed data, and (4) maintaining clear documentation of decision-making for coding purposes throughout data collection and analysis.

## Participants

This study's participants were all trained clinical mental health counselors who had left professional practice of their own volition within the first two years of post-graduate practice. We used two strategies to identify eligible participants. First, we published an invitation to participate through CESNET, a professional listserv for counselor educators who might further disseminate the request for participation among previous students or other potentially eligible individuals. The second method used snowball sampling to reach potential participants who might otherwise be difficult to contact (Creswell, 2013). Our strategy for identifying potential participants relied on sources of mutual contact, given that those who met the study's inclusion criteria were unlikely to be members of CESNET themselves.

Participant interviews were conducted via Skype to ensure the inclusion of subtleties observed during in-person interaction. Each interview lasted for approximately one hour and utilized a semi-structure interview protocol focused on participant experiences

of CB and the IS-WEL domains. This study consisted of five participants (four females and one male) who had graduated from CACREP-accredited clinical mental health counseling programs. All participants identified as Caucasian and ranged in age between 26 and 31.

## Data Analysis

The researchers transcribed the interviews using NVivo qualitative software where all participants were assigned chosen pseudonyms to help protect their identity. Transcripts were coded according to the various domains and sub-constructs within the IS-WEL, following a directed content analysis approach (Hsieh & Shannon, 2005; Ryan & Bernard, 2000). In accordance with the IS-WEL model, we established high-level (creative, coping, social, physical, and essential self) and low-level (thinking, emotions, control, work, positive humor, leisure, stress management, self-worth, realistic beliefs, friendship, love, spirituality, gender identity, cultural identity, self-care, exercise, and nutrition) codes, following methods identified by Carspecken (1996) and differentiating codes in accordance with the visual guide of the Indivisible Self (Appendix A). When a clear fit for the low- and/or high-level codes was not self-evident, we used a peer review approach to make decisions about the most appropriate coding strategy. Following Hsieh & Shannon's (2005) recommendations for minimizing researcher bias, we also included specialty codes in data analysis that were not sourced from the IS-WEL model. We attained data saturation within these five participants' responses.

## Results

We first present findings applicable to each of the five themes within the IS-WEL (Myers & Sweeney, 2004), which include the "Coping Self", "Social Self", "Essential Self", "Physical Self", and "Creative Self." What follows is an exploration of participant data through the IS-WEL lens, with participant quotes illuminating personal experiences.

### Theme 1: "Coping Self"

This theme was the most expansive finding, as participants spoke at length about their efforts to grapple with personal experiences of CB. Particularly salient topics within this theme were stress management and perceptions of self-worth. Sub-categories within the "Coping Self", as drawn from

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the IS-WEL, included: leisure, stress-management, self-worth, and realistic beliefs. ‘Coping’ is defined on a personal basis, with no specific set of behaviors or strategies that equate to health. For the purposes of this study, this theme incorporated self-directed therapeutic activities, beliefs about personal efficacy, and effective professional values and boundaries.

**Leisure.** Few participants explicitly identified leisure as a strategy used to cope with CB, so no noteworthy findings were associated with this sub-theme. The majority of participants explicitly mentioned, however, a glaring absence of life activities outside of work. Experiencing a lack of leisure time was often coupled with descriptions of mental and physical fatigue at the end of a taxing workday or week. Amanda noted that decreased participation in previously enjoyed activities made her burnout more apparent. The single exception, Alex, noted that while engaging in a variety of activities was helpful to promoting his wellness and interpersonal connections, it ultimately did not help him to avoid burnout. While he reflected, “[My friends and I] would stay busy on the weekends. We went camping, went to concerts, traveled when we could, and were generally always into something,” Alex noted that even high-level social engagement that improved his well-being failed to serve as a CB deterrent.

**Stress management.** This sub-theme was especially salient, as each participant described the specific strategies and actions they undertook to manage CB and general work stress. Amanda spoke of the pressures of clinical documentation, stating, “I remember every vacation I went on last year, just like a trip or a wedding, I was just always doing notes ... like that’s all I remember. I don’t feel like I ever stopped working at that job.” Similarly, Alex described poor boundary decisions as a significant source of occupational stress. He described feelings of bitterness toward the profession and frustration with himself after setting overly demanding work hours to accommodate clients. Riley noted that specific attempts to manage stressors actually contributed to her burnout: “I tried rearranging my schedule – didn’t work. I tried to space my clients out – didn’t work. I tried to force my way into doing more parts of the job that I really enjoyed – didn’t work. Nothing worked!”

**Self-worth.** All participants reported relating their feelings of self-worth to their overall professional effectiveness. One recurring theme involved the negative effects CB had on their personal perceptions of the quality of their work. Anna recalled, “I didn’t

feel like I was doing the job very well ... and, um, I’m a prideful person, so I like to do things well... and it didn’t feel like I was doing that.” Riley was mystified by experiencing high levels of CB not long after entering the professional field: “I know a lot of practitioners who have practiced for 30 years and they still love it. I felt like something was wrong with me.”

**Realistic beliefs.** This sub-theme encompassed participants’ shifting perceptions of mental health counseling and the seeming inescapability of work-related struggles. Anna described the juxtaposition between her beliefs before and after entering professional practice. She shared having “no idea” what the real work of mental health counseling would be like and posited that the complexity of agency work had to be experienced to be understood. Amanda stated, “I left the job in December with 74 people on my caseload. You don’t even have 74 slots per week! So, I don’t know how it’s even a realistic expectation.” Riley shared a wish for increased dialogue related to burnout inevitability during her training: “I think stressing the importance of not getting sucked into stigma and embarrassment is critical. Maybe discussing it as somewhat inherent would help ... I don’t really know. But maybe it would help those who burn out to feel less isolated and shameful.”

### Theme 2: “Social Self”

Contained within this theme were participants’ use of social support systems and CB’s effect on these supports. The IS-WEL (Myers & Sweeney, 2004) outlines two specific sub-themes within this thematic area: ‘friendship’ and ‘love.’ Each of these sub-themes centers primarily on the ways in which outside-of-work relationships are affected by new counselors’ experiences of CB.

**Friendship.** All five participants identified professional relationships with those who understood the pressures of the field as being particularly important and helpful to their experiences. Three participants shared about the essential nature of professional relationships outside of the work environment. Anna reflected on the importance of continued friendships with other counselors whom she met during graduate school, sharing, “So that was helpful to an extent, to talk to friends . . . my counseling friends, about what was going on.” All participants reported experiencing support and understanding from their relationships with other clinicians. Likewise, all participants experienced

difficulty in navigating relationships with others not involved in clinical work, which resulted from the challenges of CB. Anna shared, “It kinda took away from other things going on in the world that were not related to my job... and so I wasn’t talking about those things with other people.” Alex experienced feelings of dissonance as he neglected to talk about his clinical work with friends outside the profession, even though it was a major component of his identity at the time.

**Love.** All participants described romantic relationships impacted by CB. Anna and Riley talked about relying on their partners as a sounding board for work frustrations, and both reported stress in their relationships as a result of this dynamic. Riley recognized that her sole reliance on her boyfriend for CB support led to his frustration within their relationship. Anna added, “[My boyfriend] unfortunately did have to listen to a lot... and I think he... there was a big part of him that just checked out because (a) he didn’t know how to fix it... and (b) that’s all I wanted to talk about... like how miserable I was. And so, it makes it hard on a relationship for sure.” Joy shared how burnout affected her relationship with her husband: “Well one big [impact] that really urged the decision for me to quit was that me and... my husband were fighting constantly.” She recalled the realization that she could not provide “emotional connection or conversation” in the relationship, noting: “[My husband] was like, ‘Something has to change ...’ And I was like, ‘Yeah, I agree.’”

### Theme 3: “Essential Self”

This theme examines how personal beliefs, practices, and sources of identity offer a helpful perspective when dealing with CB. The IS-WEL identifies four sub-themes relevant to the “essential self”: spirituality, gender identity, cultural identity, and self-care. This study used a broad interpretation of the ‘cultural identity’ sub-theme to include participants’ self-perceptions as mental health counselors and the influence these perspectives had on personal experiences of CB.

**Cultural Identity.** We sought to understand culture through participants’ beliefs regarding clinical mental health counseling. Some participants identified their graduate training as the origin of these beliefs and values, while others simply noted beliefs compatible with their own personal experiences. All participants remarked on the significance of understanding counselors’ duties and their potential for making a

positive impact on clients. Alex talked about feelings of dissonance between his reason for entering the field and the realities of the work, noting “I come from a very helping-oriented family, so it seemed like a natural fit with how I was raised and how I see myself as a person... But I started to feel like I was ineffective in a lot of ways. I was spending a lot of time trying to please administration and insurance – things clients wouldn’t even necessarily know about... which didn’t feel like the kind of helping that was most effective or what I wanted to be doing.” Some participants identified this lack of harmony as a major factor in deciding to leave the counseling profession, as well as in experiencing its long-term effects. Amanda said, “I feel like I was not really myself last year. At all. And I think it’s honestly taken me until like... last month to feel more of myself again.”

**Gender Identity.** While many participants’ stories indirectly touched on this sub-theme as it related to other parts of life, only Alex specifically attended to the ways in which gender impacted his professional experience. Alex shared, “I wish I had been more active about getting help through supervision or talking to others. I think a part of why I didn’t was because... growing up in a family with male figures who held on to masculine norms, I was indirectly taught to kind of ‘tough it out’ rather than showing weakness and getting help. While I knew that was important from what I learned in graduate school, it was hard for me to understand that on an emotional level and put it into practice.”

**Self-Care.** The role of self-care in participants’ lives proved to be the most salient sub-theme of this section. Many participants talked about the self-care component of their graduate training. Riley noted a lack of depth in this aspect of her training: “And I feel like self-care is kind of glossed over. It was like, ‘Self-care is important. Make sure you’re running every day and eating healthy and seeing your friends and you’ll be fine!’” Said Amanda, “I feel like constantly in graduate school we were always told, ‘Burnout prevention,’ and like... I think I had all these great ideas for how I would prevent it...”. Although she remembered gaining a conceptual understanding of burnout and self-care in graduate school, Amanda noted that it was not until she entered the field that she developed a true understanding of it in practice. As such, she believes it would be best taught in a more “holistic, realistic, and individualized sense.” Some participants identified a desire to practice improved self-care as a factor in their decisions to leave professional practice. Amanda commented, “I

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feel like a lot of times you're told you can't take care of clients if you're not taking care of yourself. There's no time to take care of yourself!" Joy felt frustrated by the encroachment of work upon her personal life: "I think a lot of times it's easier to talk about setting boundaries than it is to do it in practice."

**Spirituality.** Neither spirituality nor religion were directly mentioned as part of participants' overall experience of CB. Still, personal fulfillment was clearly a salient topic for all participants. After sharing that he initially felt guilty upon leaving professional practice, Alex reflected, "I'm at peace with my decision now. It's taken me a while to get there, but I did the right thing for me."

### Theme 4: "Physical Self"

This theme includes subthemes of exercise and nutrition, two specific areas of health behavior that are often associated with personal wellness. Here, participants shared about physiological symptoms they encountered as a result of their experience of stress and CB. An additional sub-theme related to adverse health outcomes as consequences of CB was also identified.

**Exercise.** Anna was the only participant to note the impact of exercise on her overall physical health. She described the decrease and eventual absence of exercise from her lifestyle as an indicator of CB severity, stating, "I wish I had worked out more because that's a good de-stressor for me. I think I tried . . . I just couldn't." Riley remembered the concept of exercise being "preached" in her master's degree program but admitted that it never became grounded as a concrete part of her personal experience.

**Nutrition.** Three participants saw signs of their own CB through changes in their nutritional habits. Alex chuckled as he remembered, "There were days where I would be leaving work and I would have to consciously think if I had eaten lunch that day!" Amanda's workload often included back-to-back sessions, and she described rarely having time to eat during the workday. She shared the consequences of this schedule: "I really felt like I gained 15 pounds just working the last year because I never had the time to eat, and when I did, I was starving, so I would just grab food on the way home."

**Additional findings.** An additional category was established to account for the CB health consequences participants reported that did not fit within the

constructs of exercise and nutrition. Riley shared how her physical health became compromised by CB: "I was always tired and I got sick all the time! That really was a significant clue to me that something was wrong." Joy, who conducted in-home visits, similarly shared of the toll on her overall health: "So I would, like, park at grocery stores and sleep in my car for like an hour and nap... and then kinda wake up... and try to get more awake for the next client." Amanda experienced disruptions to her sleep hygiene, which had negative consequences for her mental and physical health: "Pretty much until I started this job, like even through grad school, I never had problems sleeping. But I would say probably from like a couple months in... I still don't sleep through the night. Like I usually wake up every two hours and I felt myself having like... these horrible nightmares, not even about clients, but just about like not finishing my notes."

### Theme 5: "Creative Self"

The final theme is comprised of the ways in which participants used creativity to cope with stress and to manage CB. In this model, creativity describes flexibility in modes of practice and the use of problem-solving to achieve improved work-life balance and overall wellness. The IS-WEL (Myers & Sweeney, 2004) identifies five subthemes related to the "creative self": thinking, emotions, control, work, and positive humor.

**Thinking.** Several participants expressed difficulty clearly identifying and understanding the presence, severity, and impact of CB. Joy said, "While I was being burnt out, like I knew that something was different... but it took me a while to figure out that I was so different... like, really different. The energy I was putting out there was so negative. And I didn't even really notice as much." Riley stated, "Looking back, it feels much more intense and convoluted than I can recall from that time. Maybe I just wasn't in a place to understand it then... or even try to make sense of it." Riley's experience of CB eventually led to pervasive negativity about her work: "I had negative thoughts about my work all the time. I just didn't want to be there – dreaded every client. Sometimes I prayed my clients would cancel their sessions. It was ugly... and it made me feel terrible about myself as a professional."

**Emotions.** Participants talked about the ways their emotions affected their professional self-image. Amanda expressed feeling guilty regarding her work

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quality: “There were so many sessions where I would walk in or go to grab a client from the lobby and I was like... ‘I didn’t even get to do what I said I would do for them the last time.’” Anna struggled to find balance in an agency where she perceived service quality to be of secondary importance to documentation: “I also felt like there was just this intense fear that... all of us therapists had in our office... like ‘Oh my gosh, I hope I wrote that note right, because they’re going to audit this and do all these things.’”

Some participants felt a subconscious sense of guilt, shame, and embarrassment due to their struggle with CB so early in their new careers. Riley remembered feeling as if she “had this shameful secret to hide.” Amanda laughed as she reflected, “And so, I don’t know if it’s like my guilt of, ‘Well, I just spent millions (not really millions) of dollars and I’m not doing therapy!’ Is that why I want to do therapy? Or do I want to do therapy because I like it?”

**Control.** This sub-theme centered on participants’ efforts to recognize, accept, and cope with feelings of imbalance, stress, and CB in their day-to-day lives. Most participants shared experiences of being micromanaged by administration or striving for control in difficult circumstances. Alex stated, “I feel like I got really good at putting on a poker face... and it probably looked like to others that I was approaching the workday with a lot of energy. Maybe a part of me was hoping I could trick myself into believe that also.” Likewise, Riley shared, “I was going to ‘will’ myself out of burnout... I was a great ‘faker,’ which is scary to admit. I knew that someone who wanted to be there could’ve helped so much more.”

**Positive humor.** Several participants noticed changes in the way they used humor to cope with difficult client cases, stress, and frustration. Anna reflected, “So, you know, if someone said something, like one of my coworkers, or one of my counselor girlfriends ... if they said something negative about [frustration with management] then we would kind of commiserate in it ... and it would just kind of go further and further down the rabbit hole until the point where it wasn’t productive.” She added, “Some of it I needed, but I don’t think I would have complained as much. I would have tried a little harder to focus more on the positive things... and try to be more in the moment.”

**Work.** This sub-theme served as a microcosm for the study overall, as participants’ wellness was compromised as a result of the stress of the workplace and their experiences of CB. All participants remarked on the excitement and passion they felt for counseling at the beginning of their work. Alex reflected, “Part of me really misses the excitement I had in graduate school for counseling. It felt like it was so much easier to empathize... whereas now I feel like I have to really work at it. That’s a change I don’t really like.”

### Key Findings

An analysis of participant reflections yielded five key findings related to counselor burnout: administrative and systemic factors; impact of relationships; impacts on physical health; complicated emotions; and the progression of burnout. Application of the IS-WEL model (Myers & Sweeney, 2004) reveals these five findings as important to better understand the situations and experiences that lead to CB and, eventually, to professional attrition. Following is a discussion of these findings as they emerged through data analysis.

#### Administrative and Systemic Factors

Agency administrators and clinical supervisors were highly impactful on participants’ sense of self-worth and their overall morale as new counselors. Participant narratives suggest that the mental health delivery system in which new counselors practice has a significant impact on their self-worth, happiness, and sense of professional fulfillment. Specific to this point, participants experienced conflict between their personal counseling philosophies and those of agency administrators, as well as disillusionment with the realities of mental health work.

Specific circumstances that led to participants feeling unsupported included: high caseloads, an emphasis on session quantity rather than quality, fear-based enforcement of deadlines, being overlooked for promised positions, focusing on liability rather than on wellness and coping, poor agency organization, and suggestions that were either unhelpful or unrealistic. Common thoughts and feelings that arose in response to these experiences included: feeling unsupported, having concerns dismissed by others, and anger. For example, after being passed by for a promised position without even a chance to interview, Joy felt betrayed, as if her hard work and loyalty had been exploited.

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Across all participants, a lack of supportive and engaged clinical supervisors, the difficulties of interfacing and interacting with other agencies, and administrative teams that focused on the bottom-line at the expense of client care were situations that resulted in new counselors feeling unsupported, undervalued, and, occasionally, less than effective. This finding is in line with seminal literature concerning the importance of attending to the professional needs of counselors (Figley, 1995; Paris & Hoge, 2010) as systemic components are often cited as influencing overall counselor wellness and workplace satisfaction.

### Impact of and on Relationships

Relationships and relational dynamics played major roles in all participants' experiences of CB. Both professional and personal relationships served as vehicles for participants' increased understanding of CB, feelings of catharsis, processing difficult experiences, and, at times, heightened distress as their CB intensified. All participants viewed friendships as important components of wellness after friends noticed their growing discontent and dissatisfaction with work. Three participants identified coworkers as the primary composition of their friend group. Anna talked about relying on agency peers who seemed better able to empathize with her experiences.

The second consistent pattern was distress in romantic relationships while experiencing CB. Participants struggled with a lack of time with their partners, as well as their partners' unfamiliarity with the work of counseling, and, as a result, problems in communicating their needs. Growing dissension with partners seemed to culminate in participants' acknowledgement that CB was negatively impacting the relationship and that, as Amanda said, "Something has to change." Participants consistently communicated their desires to talk openly about CB but were often hampered by either physical/emotional fatigue and/or their partner's inability to empathize with counseling-related stress.

### Impacts on Physical Health

Without prompting, all participants shared stories of how their physical health was affected by CB. Multiple participants offered information on changes in their physical health after being asked about the steps they had taken to manage CB. Anna was the only participant to directly mention exercise. She began to

notice the heavy toll CB was taking when she had no motivation for this wellness activity, which she had once enjoyed on a regular basis.

Conversely, all participants discussed physical symptoms and health-related issues not contained within sub-categories like 'exercise' or 'nutrition.' Physical and mental fatigue were described consistently through each participant's interview, while sleep disruption and increased instances of sickness also emerged as salient themes. No participant directly related their career attrition to health-related concerns, but physical discomfort and negative health outcomes constituted factors that contributed to all participants' decisions to leave the field.

### Complicated Emotions

Emotional experiences before, during, and after making the decision to leave the field comprise our fourth key finding. All five participants mentioned specific ways in which their emotions alerted them that they were ready to leave the field of counseling. One participant shared feelings of pervasive dread regarding her counseling work. All five participants reported that their skills for empathy, being present, and emotional intelligence were dulled by CB. Feelings of shame concerning CB was another common theme.

All five participants experienced a similar arc in their emotional experiences of CB. First, most were surprised or upset after becoming aware of their CB, with many expressing guilt after acknowledging the experience. Second was a sense of shame regarding their personal decisions to leave the profession, mostly due to the investment required for training and entering the field. Lastly were mixed emotions post-attrition that involved appreciation for the opportunity, relief at moving on, and the lack of belongingness experienced as counseling professionals.

### Progression of Burnout

The final key finding of this study is the progressive nature of burnout experienced by participants. The first feelings of burnout were not met with a cognitive awareness of what was happening. Only after lengthy experiences of CB and the appearance of additional symptoms such as fatigue, general detachment, dread of work, and a decreased ability for client empathy did

participants begin to realize they were experiencing significant burnout. Additionally, several participants described not being fully aware of their growing discontent until they noticed changes in their own behavioral patterns, such as sleep disturbances, poor communication with romantic partners, and dietary changes. This finding demonstrates that CB is experienced systemically and holistically, rather than as the result of any individually identifiable circumstance.

### Discussion

Data analysis using the IS-WEL (Myers & Sweeney, 2004) offered insight into the ways in which participants related wellness to burnout and burnout to attrition. Participants reflected a general reliance on specific components of wellness, most commonly in the form of personal relationships. Conversely, themes concerning the absence or decline of other essential aspects of wellness, such as nutrition and exercise, were also identified. Many participants pointed out the ways in which their lack of understanding of counselor wellness led to gaps in personal wellness practices and, ultimately, to their desire to leave the counseling field altogether.

The IS-WEL (Myers & Sweeney, 2004) helped to capture the nuances of participant experiences. For example, the ‘Social Self’ domain (sub-constructs: friendship and love) highlighted participants’ shared reliance on coworkers and field colleagues, as well as the difficulties they encountered with significant others. This points to the complicated contexts of individual experiences, even within a specific shared aspect of their lives. The model offers further nuance by exploring constructs across various domains of personal functioning, from nutrition to spiritual identity.

### Implications for Counselor Educators and Clinical Supervisors

This study’s first implication focuses on the type of employment common to all five participants: community mental health agencies. All participants reported experiencing conflict with agency management related to supervision, resources, and/or caseload. As field professionals work to decrease stigma and promote treatment for clients, we must also help counselors-in-training to meet the expected demands of this work. Doing so will help promote the welfare of clinicians navigating the daily challenges

of emotionally demanding work. Our ethical and professional duties encompass the clients our students and supervisees serve, meaning that effective advocacy for self-care and wellness will enhance the innate link between counselor and client welfare.

A second implication attends to the needs of counselors-in-training from program enrollment through independent licensure. While most participants had difficulty pinpointing changes that would have improved their graduate training, most shared a desire for supportive supervision tailored to the unique experience of being a new counselor. Counselor educators should provide opportunities for students to develop a personalized understanding of wellness in order to promote their buy-in. Furthermore, counselor educators can discuss the realities of balancing self-care practices while working with clients. This might take the form of structured interventions, integrating wellness habits within counseling curriculum, and being more intentional in fostering wellness in supervision (Lenz & Smith, 2010; Merriman, 2015).

Supervisors of new professional counselors can also encourage open, ongoing conversations about self-care as it relates to job performance so that work-related issues can be addressed proactively. All participants reflected on a delayed awareness of accumulating CB due to stigma, which often resulted in shame, guilt, and/or embarrassment upon recognizing its presence. Supervisors must seek to humanize the concept of CB through frequent dialogue and promote the realistic understanding that the taxing combination of engaging in clinical work and navigating personal life stressors will affect all counselors’ effectiveness at some point in their career.

### Recommendations for Future Research

One recommendation for future research is a replication of the current study including a larger, more diverse participant pool in terms of geographic area, age, and gender identity. Secondly, investigating setting-specific experiences is a necessary component of understanding the ways in which work environment contributes to CB. This study lends itself to replication, focusing on specific subsets of professional practice and environment.

Lastly, as this study was predominantly conceptualized through the lens of counselor educators and clinical supervisors, additional research might seek to understand effective instruction and

supervision practices as they relate to burnout and wellness. While we hoped to increase counselor educators' ability to proactively humanize CB, we cannot ignore the fact that the majority of work concerning CB will continue to be a reaction to students and supervisees experiencing CB. Addressing the ways in which counselor educators proactively teach and explore CB could better inform the structure of contemporary counseling curriculum.

### Limitations

The first limitation for this study regards data interpretation through directed content analysis. By using the Indivisible Self Model of Wellness (Myers & Sweeney, 2004) we hoped to provide a viewpoint of CB from a transposed, polar construct. This decision was due in large part to the, as of now, somewhat elusive construct of burnout as compared to empirically-based models of wellness (Wachter et al., 2008). Although this model offered a relatively simple way to analyze a wide range of data, this approach came with its own inherent limitations. Hsieh and Shannon (2005), described three specific limitations of the directed content analysis approach, including: (1) researcher bias, (2) unintentionally leading interviewees, and (3) overreliance on theory at the expense of contextual information.

The second limitation is this study's small, relatively homogenous participant sample, although these five participants allowed for data saturation and yielded a rich description of individual experiences. All participants identified ethnically as Caucasian, were situated at similar developmental periods (ages 26-31), and were residents of one southeastern state. Participant differences in employment, client populations, and supervisory experiences offered variance that provided nuance and variability across the data set. Another limitation of note is the challenge of investigating a broadly defined construct like CB without losing the individual voices of study participants to the volume of the whole. We took care to help each participant retain what Robinson (2014) called a 'locatable voice' by including participant quotes throughout our reporting of analyzed data. While there were some overlapping themes expressed by multiple participants, their unique journeys all provide important information that led to a better understanding of the CB phenomenon overall. Lastly, while providing for a nuanced and personalized viewpoint of wellness, the IS-WEL (Myers & Sweeney, 2004) brings its own challenges

to the research process. Our study experienced its greatest difficulty in capturing elements of the 'Essential Self' domain, specifically the sub-constructs of spirituality, gender identity, and cultural identity. While these factors are pervasive throughout most individuals' lives, participants did not characterize their experience through a particular cultural lens; however, we can make a reasonable hypothesis that personal values and beliefs are a major factor in one's professional self-concept and fulfillment. This high level of nuance resulted in limited data for this specific domain due to the difficulty it presented in the coding process.

### Conclusion

This study sought to better understand the burnout experiences of new clinical mental health counselors who chose to leave the counseling field. Using participant interview data, we conducted a directed content analysis to better understand how participant wellness was compromised, leading to burnout and attrition. What emerged were thematic findings as to the relational and emotional tolls experienced by all participants. Upon reviewing these findings, counselor educators and supervisors may better adapt curriculum and supervision sessions to explore CB in a way that seeks to destigmatize and proactively address wellness practices with counselors-in-training and new helping professionals. In doing so, developing counselors can more proactively address their own wellness, both professionally and personally, and provide a more present self for the clients they serve.

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# Invisible Women: Justice-Involved Pregnant Women Presenting with Opioid Use Disorders

Kelley McNichols & Aimee Cordero-Davis

Pregnant justice-involved women presenting with opioid use disorders (OUD) are a marginalized population. Historically, carceral settings have been based on the male experience creating an atmosphere where women are invisible. To increase the visibility, counselors are ethically obligated to address the unique needs of this rising, particularly vulnerable, subset of pregnant women. This brief report calls on counselors to advocate for gender-responsive treatment in order to enhance the visibility of pregnant justice-involved women presenting with OUD.

*Keywords:* pregnant women, opioid use disorder, evidenced-based treatment, medication for opioid use disorders, criminal justice

Some of the most neglected, misunderstood, and unseen women in our society are those who are justice-involved. Although incarceration rates for women have increased exponentially within the last few decades, programs for those who are justice-involved continue to be based on the male experience (Bone et al., 2018; Kajstura, 2018; Winkelman et al., 2020). As a result, resources available to women in carceral settings are not able to adequately meet or address their needs.

With limited to no support to address issues related to women, justice-involved women are at increased risk for recidivism and relapse. Women that are justice-involved, pregnant, and present with opioid use disorders (OUD) are at greater risk of recidivism and relapse. If incarceration is necessary for this vulnerable population, the criminal justice system must provide an opportunity to connect justice-involved women to evidence-based treatment. This brief report explores the need for counselors to advocate for gender-specific treatment and evidence-based therapeutic interventions for pregnant women who are incarcerated and present with opioid use disorders.

## The Face of Justice-Involved Women

Incarceration rates for women have more than doubled the pace of growth among their male

counterparts in recent decades, growing 834% over nearly 40 years (Sawyer, 2018). Although reasons may include pre- and post-conviction barriers, there is a shortage of timely, gender-specific data to explain the increase (Kajstura, 2019). What is known however, is that most justice-involved women are poor, uneducated, unskilled, single mothers, and are disproportionately women of color (The Sentencing Project, 2019). Black and lesbian or bisexual women are also incarcerated at disproportionate rates (Kajstura, 2019). In fact, in 2019 the imprisonment rate for African American women (83 per 100,000) was over 1.7 times the rate of imprisonment for white women (48 per 100,000) (The Sentencing Project, 2019).

Although there has been an increase in women arrested for violent crimes, less than half of those charged with violent offenses have been convicted, with most justice-involved women serving sentences for non-violent offenses such as property and/or drug related infractions (The Sentencing Project, 2019). Furthermore, nearly half of all incarcerated women are disproportionately placed in local jails instead of prisons, with 60% of women incarcerated in local jails not yet convicted of a crime and awaiting trial (Kajstura, 2019). Although time served in jail is often shorter than time served in prison, there are many challenges for justice-involved women in jail, including limited access to proper mental health care and the ability

Kelley McNichols & Aimee Cordero-Davis, Waynesburg University. Correspondence concerning this article should be addressed to Kelley McNichols, Department of Counseling, Waynesburg University (e-mail: [kelly.mcnichols@waynesburg.edu](mailto:kelly.mcnichols@waynesburg.edu)).

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to stay in touch with their support systems and family (Kajstura, 2019).

Given that justice-involved women experience difficulty staying in touch with family, children of justice-involved women are particularly vulnerable. Of women incarcerated in state prisons, more than 60% have a child(ren) under the age of 18 (The Sentencing Project, 2019). Furthermore, 80% of women in jails are mothers and are often the primary caregivers of their children (Kajstura, 2019). This year alone, over 2.3 million incarcerated mothers will be separated from their children (Sawyer & Bertram, 2018). With the increase of female prisoners, there is a need for counselors to be aware of and prepared to address the special needs of justice-involved women, especially those who are mothers.

The call to social justice tasks counselors with advocating for gender-responsive treatment for justice-involved women. Counselors must also be prepared to treat justice-involved women presenting with substance use disorders. A large proportion of justice-involved women engage in criminal behavior while under the influence of mood-altering chemicals and/or engage in criminal behavior in order to support their substance use. As such, 26% of women in prison have been convicted of a drug offense compared to 13% of their male counterparts (The Sentencing Project, 2019). Likewise, more than two-thirds of women in state prisons meet the criteria for substance use disorders, with about half of them using drugs at the time of the offense for which they were incarcerated (Sawyer, 2018).

The underlying cause of many women's substance use and criminal behavior are distinct from men. Approximately 50% of female offenders are likely to have histories of physical or sexual abuse and women are more likely than men to be victims of domestic violence (National Institute on Drug Abuse [NIH], 2014). Some women have also been incarcerated solely for the alleged crime of substance use during pregnancy (Jessup, 2019). Because many justice-involved women have a history of physical and sexual abuse (Collington, 2001), they may self-medicate to escape the pain associated with victimization and trauma. Since substance use affects both the brain and behavior (Mayo Clinic, 2021), the individual's mood, perception, and emotional state can be altered over time with repeated use. Furthermore, when an

individual is under the influence of mood-altering chemicals, their decision-making and rational thought process are often impaired. Although substance use can be a maladaptive coping mechanism, substance use and the adverse consequences associated with drug use, can lead to justice system involvement (Sawyer, 2018). This pattern can perpetuate trauma and prevent justice-involved women from obtaining adequate support to address their underlying needs.

As more women are incarcerated, correctional facilities are struggling to respond to their unique needs (Shafter et al., 2019). Female offenders are more likely to need medical and mental health care services; however, treatment, research, and recovery in jails and prisons have historically been based on the male experience (NIDA, 2014). Many justice-involved women have little access to gender-responsive substance use, mental health, and reproductive health care services while they are incarcerated (Sawyer, 2018; Pendleton et al., 2020). As a result, fewer than one in four women with severe psychiatric disorders will receive mental health care services and less than half of the women in state prisons with a history of substance use disorders will receive treatment (Sawyer, 2018). The lack of options available to women significantly impacts their treatment, recovery, and ability to reintegrate into their communities upon release.

Compared to men, women also progress more quickly from using or abusing mood altering chemicals to developing a substance use disorder (Areas-Holmblad, 2016). In regard to opioid use, women are more likely than men to report a history of opioid use; yet, are more likely to be prescribed opioids for pain at higher doses (29.8% compared to 21.1%) contributing to gender-specific trajectories associated with the development of an opioid use disorder (OUD) (Preis et al., 2020; Wright, 2020). Women are also more likely to develop medical or social consequences faster than men (Areas-Holmblad, 2016). Consequently, women often find it more difficult to quit using mood altering chemicals and are more susceptible to relapse compared to their male counterparts (Areas-Holmblad, 2016). As the female prison population continues to increase, another issue on the rise is women presenting with substance use disorders who are incarcerated while pregnant.

### **Pregnant Justice-Involved Women with OUD**

Pregnant women with OUD are a marginalized population with distinct needs; however, their unique needs are often undetected and untreated. Pregnant women with OUD often have a history of trauma that includes childhood abuse and neglect, sexual abuse, and intimate partner violence. In fact, it has been estimated that 50% to 80% of women with substance use disorders have experienced trauma (Preis et al., 2020). The complex intersection between trauma and substance use disorders can have devastating implications for pregnant justice-involved women, implications that cannot afford to go undetected or untreated.

Pregnant women with substance use disorders are struggling and many are dying. A recent review of maternal causes of death identified opioid overdose deaths as a significant contributor to maternal deaths. In fact, between 11% and 20% of all deaths during pregnancy were found to be a direct result of an opioid overdose (Vestal, 2018). Although recent studies have reported that opioid overdose deaths decline during pregnancy, they peak in the years following pregnancy and are now one of the leading causes of mortality among women during that period (Vestal, 2018; Whiteman et al., 2014).

Although systematic data on pregnancy in prisons is limited and not routinely collected, a recent study estimated that 3.8% of newly incarcerated women in United States prisons are pregnant (Sufrin et al., 2019). Three quarters of imprisoned women are considered to be in their prime childbearing years of 18 to 44 years old (Carson, 2018). Thus, 80% of women who will be incarcerated this year are mothers with approximately 150,000 women being pregnant at time of incarceration (Sawyer & Bertram, 2018). According to the American College of Obstetricians and Gynecologists (ACOG), at any given time, approximately 6% to 10% of incarcerated women are pregnant and many women first learn they are pregnant when they enter a correctional facility (Ghidei et al., 2018). Even though some of these women are released before giving birth, each year an estimated 1,400 women in the United States will give birth while incarcerated (Sufrin et al., 2019).

Documentation and data surrounding incarcerated pregnant women with opioid use disorders is even more sparse. Available statistics report that incarcerated individuals with substance use disorders are 100 times more likely to die by overdose within the first two weeks following their release compared to the general public (National Council for Behavioral Health, 2020). Furthermore, in the United States, the number of newborns with neonatal abstinence syndrome (NAS) has increased 433% from 2004 to 2014 (Syvertsen, 2021).

Opioid use disorder (OUD) during pregnancy is associated with adverse outcomes that can have lifelong negative consequences for women and their infants. Unmanaged and abrupt withdrawal from opioids can cause pregnancy complications that could include miscarriage, poor fetal growth, preterm birth, and neonatal abstinence syndrome (NAS). In addition to affecting the physical and mental health of both mother and baby, not having adequate support during the prenatal period can be associated with high costs of health care (Shafter, 2019). Proper care and medical management of OUD during pregnancy for incarcerated women can help reduce health care costs and mitigate the risks.

It is evident that there is an increased need for counselors to advocate for gender-responsive treatment in carceral settings, including the development and implementation of programs that meet the unique needs of incarcerated pregnant women (Sufrin, 2017). Expansion of gender-responsive programming needs to include adequate obstetric and gynecological services, prenatal and post-natal care, evidenced-based behavioral health treatment, as well as access to medications for opioid use disorders (MOUD) which is deemed a best practice for pregnant women presenting with an opioid use disorder.

### **Medications for Opioid Use Disorders**

Pregnancy offers a unique opportunity for counselors to incorporate substance use interventions, as pregnant women may be more willing to seek care and may be more motivated to remain in treatment than at other times in their lives (Whiteman et al., 2014). When incarceration is necessary, the criminal justice system has an opportunity to play a crucial role in connecting the most vulnerable populations, specifically justice-

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involved pregnant women presenting with OUD, to the helping professions and evidence-based treatment programming. Evidence-based treatments that are indicated for pregnant justice-involved women presenting with OUD include medications for opioid use disorders (MOUD).

The Federal Drug Administration (FDA) has approved three medications for the treatment of opioid use disorders, otherwise known as MOUD, or medication-assisted treatments (MAT). The three FDA approved medications include methadone, buprenorphine, and naltrexone. Methadone and buprenorphine have been proven safe and effective for pregnant women with OUD; however, naltrexone is not recommended. Naltrexone, or vivitrol, is not recommended for pregnant women because people are required to either withdraw from opioids or to be free of all opioids for seven days prior to naltrexone induction which could put the mother and baby at grave, and unnecessary, risk. Consequently, there has been little research on the effects of naltrexone on fetal development.

Of the three FDA approved medications for the treatment of opioid use disorder, buprenorphine is generally preferred. Buprenorphine is more readily accessible than methadone. For example, individuals prescribed buprenorphine are not required to be in an opioid treatment program (OTP). Adhering to OTP requirements behind the walls of institutions is unequivocally fraught with challenges and can exacerbate barriers to accessing treatment in a system that is already challenged to provide adequate behavioral health services. Additionally, buprenorphine, and all products containing buprenorphine, are considered schedule III drugs indicating a moderate to low potential of physical or psychological dependence, whereas methadone is a schedule II drug indicating a higher potential for abuse with an elevated risk of severe physical or psychological dependence (Drug Enforcement Administration [DEA], 2019). Lastly, when comparing buprenorphine to methadone, research has shown that pregnant patients prescribed buprenorphine have lower risk of preterm birth and have a greater birth weight with little to no associated increased risk (Zedler et al., 2016).

Despite this information, the criminal justice system does not consistently offer MOUD to incarcerated females. “According to a survey of medical

directors of state and federal prison systems, 55% offer methadone to inmates in some situations, and a handful offer buprenorphine treatment” (Bruce, 2010, as cited in Bone et al., 2018, p. 269). Even more troubling is the fact that only 50% of pregnant women receive MOUD (Winkelman et al., 2019). Some of the reasons for inconsistent implementation of MOUD within correctional facilities include funding, staff objections, stigma, and cultural perceptions of MOUD (Bone et al., 2018; Syvertsen et al., 2021).

### **The Intersectionality of OUD, MOUD, and Justice-Involved Pregnant Women**

In general, people with OUD are disproportionately involved in the criminal justice system. A review of the literature has identified pregnant incarcerated women as invisible women; however, such women can become very visible with effective treatment protocols. Pregnant justice-involved women who have had the opportunity to receive MOUD have yielded significant results, noting reduction in drug use, criminal activity, recidivism rates, infectious diseases, withdrawal symptoms, cravings, as well as decreased rates and severity of neonatal abstinence syndrome (NAS) (Preis et al., 2020; Sufirin et al., 2019; Wright, 2020). Pregnant justice-involved women on methadone or buprenorphine have experienced a 70% reduction in overdose deaths (Wright, 2020). Moreover, this vulnerable population has experienced improved pregnancy related outcomes, improved adherence to treatment for substance use disorders at time of reentry, improved quality of life, improved prenatal care, and increased rates of in-hospital deliveries (Zedler et al., 2016; Winkelman et al., 2019). The fact is pregnant justice-involved women engaging with MOUD, an evidenced-based treatment, are gaining increased visibility. Subsequently, the helping professional is encouraged to enhance their skill set in order to cultivate change and connect with this marginalized, vulnerable population in a gender-responsive manner.

### **The Phenomena of Prisoner Reentry**

Knowing that the rate of incarceration for women continues to soar and that women have distinct treatment needs compared to their male

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counterparts, counselors are ethically obligated to support the reentry needs of the increasing number of justice-involved women. The reentry experience is a critical time for the 1.9 million women released from prisons and jails each year (Sawyer, 2019). To reduce the likelihood of fatal overdose deaths, recidivism, and relapse for the 1.9 million women experiencing reentry each year, counselors must advocate for gender-responsive treatment.

Counselors must obtain the training, education, and supervision needed to adhere to the core professional values of the counseling profession in order to effectively treat justice-involved women while in carceral settings, during the reentry experience, and beyond. Counselors are in an exceptional position to help support the unique needs of women transitioning from the carceral institution into the community setting. To do so, counselors must be familiar with post-conviction barriers to reentry that women face.

Stigma is at the core of the opioid epidemic (Smyser et al., 2021; Valuck et al., 2021). Stigma that is manifested across a women's pregnancy journey creates yet another unique challenge for this marginalized population. Although Csete (2019) identified a number of criminal justice barriers to treatment of opioid use disorders in the United States and called for public health advocacy, the pervasive and drug-related stigma surrounding women with opioid use disorders is amplified during pregnancy creating substantial barriers to treatment (Syvertsen et al., 2021). Some of the identified barriers for pregnant, justice-involved women presenting with opioid use disorders include, but are not limited to, shortages of mental health providers, potential criminalization of substance use during pregnancy, lack of transportation, limited supply of medications, lower levels of education, limited work-related skills, lack of childcare, and limited access to ancillary resources. Subsequently, Crawford et al. (2015) reported that expectant mothers with addiction issues seek substance use disorder treatment less often than their male counterparts.

As Winkelman et al. (2019) have shown, women referred by criminal justice agencies to substance use disorder treatment facilities are less likely to get MOUD than those referred by other sources. "Among pregnant women with OUD referred by criminal justice agencies, treatment without

medications for OUD was more common than treatment with medications for OUD" (p. 6). Given reentry is already a time of acute relapse risk, this is an especially precarious situation for pregnant women with OUD. This also has long term implications for women and their children. It is recommended that new mothers remain on MOUD once their pregnancies have ended to improve their chance of recovery; however, if they are less likely to get MOUD upon reentry then they are most likely to experience increased barriers to recovery.

Furthermore, there is a lack of education and job training opportunities that are geared toward women while incarcerated. According to Preis, Inman, and Lobel (2020) the "majority of pregnant women with OUD earn less than \$20,000 per year and are unemployed" (p. 854). Women are often ill prepared to rejoin the workforce upon reentry. Their lack of education and job training is further aggravated by childcare and housing obstacles for women experiencing reentering the community after a period of carceral incarceration. Women are more likely to need access to childcare services, assistance in finding housing, and support in securing employment than their male counterparts (NIH, 2014). However, specialized resources are scarce.

Pregnant women (and women with children) experiencing reentry are a particularly vulnerable group. Coupled with OUD and limited access to MOUD, their reentry experiences are further compromised. The specialized, gender-responsive, services offered in the criminal justice system tend to be the exception rather than the rule; therefore, services for justice-involved women are typically inadequate to address both their unique needs while incarcerated, as well as at the time of reentry and beyond.

### Gender-Responsive Care

Despite the staggering increase of pregnant justice-involved women there is limited literature on the topic of gender-responsive care for this marginalized population. Counselors are ethically obligated to treat substance use disorders in carceral settings (Bone et al., 2018) and shall advocate to ensure that justice-involved women become visible. To increase visibility while providing gender-responsive care, counselors need to advocate for universal screening tools that are valid and reliable. Knowing that the vast majority

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of incarcerated women are of prime childbearing years, and that a number of women may be pregnant upon intake, universal and culturally sensitive screening tools are necessary (Maruschak, 2006, 2008).

The multiculturally competent counselor is well positioned to implement gender-responsive best practices that support the unique needs of justice-involved pregnant women presenting with OUD (Peeler et al., 2019). Counselors are ethically obligated to be advocates and encourage corrections to implement brief and validated universal screening tools (Barnett & Johnson, 2018). Screening should be performed at intake to identify behavioral and physical health treatment needs as early as possible. It would behoove counselors to become familiar with validated screening tools, such as the NIDA quick screen 4Ps Plus (Coleman-Cowger et al., 2019). Other beneficial scales include the clinical opiate withdrawal scale (COWS), and the clinical institute narcotic assessment (CINA) scales. Intervention for a positive screening should include the screening brief intervention and referral to treatment (SBIRT) to support continuity of care upon reentry. As a result, women are more likely to receive the appropriate diagnosis, which shall guide the treatment episode, support interdisciplinary teaming, and better prepare women for the reentry experience.

Counselors can seize the opportunity to enhance and expand evidence-based treatments for pregnant justice-involved women. Motivation is often the key to behavioral change and women that are pregnant may demonstrate increased motivation to change. The counselor can begin to elicit and enhance motivation to change with women presenting with OUD by implementing motivational interviewing (MI). Motivational interviewing can strengthen a person's motivation and commitment to change and is empirically effective for individuals presenting with substance use disorders. The foundational principles of MI can be infused into the treatment episode with pregnant justice-involved women with OUD by expressing empathy, developing discrepancy, rolling with resistance, implementing change talk, and by supporting self-efficacy (Miller & Rollnick, 2013).

Counselors are well positioned to partner with correctional systems to enhance awareness of

prevention and treatment approaches in a gender-responsive fashion. Counselors can identify and disseminate best practices related to evidence-based treatments. For instance, Title II of the Americans with Disabilities (ADA) Act (1990) prohibits discrimination against qualified individuals with disabilities in all programs, activities, and services. Counselors can support MOUD expansion by advocating for invisible women to become more visible by having the opportunity to receive evidence-based treatment while incarcerated.

There is also a need to advocate for change at a legislative level. The U.S. Bureau of Labor and Statistics (2021) reported that the employment of substance use disorder and mental health counselors is growing much faster than that of other occupations. Actually, the average growth rate for all occupations is 4% whereas the projected growth rate between 2019 to 2029 for substance use counselors and mental health counselors is 25%. The message is explicitly clear, the field of counseling needs qualified substance use disorder professionals to meet the occupational demand. In return, aspiring counselors need the means to obtain a quality education in substance use disorder counseling. Thus, financial aid and scholarships are increasingly important and must be available to support the professional growth and development of diverse substance use disorder professionals.

In terms of shattering stigma, there are a number of misconceptions in the field about substance use disorders and substance use disorder treatment. Recovery is possible and reducing stigma makes recovery more likely (Smyser et al., 2021). Professional counselors owe it to the profession, and to those suffering from substance use disorders, to advocate for social justice. Implementation of the sequential intercept model (SIM) can be an effective ally to combat stigma. The sequential intercept model (SIM) aims to divert individuals with behavioral health issues from the criminal justice system to community-based treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021). This is a promising approach to identify points within the criminal justice system in which alternative strategies could improve care for women with OUD.



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Counselors shall implement trauma-informed care to optimize engagement in treatment. As stated above, many pregnant justice-involved women with OUD have experienced significant trauma events. Trauma-informed care is a strength-based delivery approach that calls upon counselors to understand and discern the impact of trauma while placing emphasis on safety. Creation of a safe holding space can endorse a healthy therapeutic alliance. By adhering to a trauma-informed care approach, the therapeutic alliance, which is commonly referred to as the cornerstone of an effective counseling experience, can flourish. Asking “What has happened to you?” instead of “What is wrong with you?” and perhaps more importantly “What is right with you?” to foster connection, growth, and change among this particularly vulnerable population.

The skill of attunement becomes central to a transformational experience. Attunement is a person’s ability to be present to and with, another’s lived experience. Attunement is comprised of empathy, mindfulness, active listening, experience, knowledge, and cognitive understanding. Saying “I see you,” “I hear you,” “I am here with you,” compliments attunement and empathy to further reinforce the therapeutic alliance as well as the holistic recovery process.

In conclusion, all of the aforementioned components of engagement and connection requires professional integrity, or doing what is right over what is fast, easy, or comfortable. Counselors are to identify the behavior as a symptom of the problem while providing treatment that effectively addresses the cause. The intersection between treatment and the criminal justice system demands advocacy and integrity to cultivate connection and change with justice-involved pregnant women presenting with opioid use disorders.

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# JPCA Test to Earn CE Credit

*Note:* Earn 2.0 Free Continuing Education Credits by reading selected articles in this issue. Read the articles identified below and answer 8 of the 10 questions correctly to earn 2 CE credit.

## **Hosting Mandarin-Speaking Minors and Building a Successful Cross-Cultural Experience (pp. 4-14)**

1. Which of the following is a potential risk factor for developing academic, psychological, and behavioral issues among parachute kids?
  - a. Having moderate difficulty adjusting to first grade in China.
  - b. Having an estranged relationship with a parent.
  - c. Spending more than 2 hours a day on extracurricular activities.
  - d. Preferring to socialize with other parachute kids.
2. What should be covered in an orientation for parachute kids and their parents prior to the minors' trip to the U.S.?
  - a. Learning about the common mental health issues that could be triggered by the acculturation process.
  - b. The importance of discussing expectations with host parents.
  - c. How to seek mental health services in the U.S.
  - d. All of the above.
3. Which of the following strategies should schools use when working with parachute kids?
  - a. Hiring only teachers who are bilingual.
  - b. Allowing students to take as many classes as they would like.
  - c. Systemically encourage interaction between domestic students and parachute kids.
  - d. Minimizing contact with these students' parents in China because the language barrier may lead to miscommunication.

## **Burnout among New Mental Health Counselors: Applying the Indivisible Self Model of Wellness (pp. 15-26)**

4. A common precipitating factor of counselor burnout is:
  - a. depersonalization
  - b. emotional exhaustion
  - c. feelings of diminished accomplishment in professional work
  - d. all of the above
5. From this particular study, an overarching experience leading to counselor burnout was:
  - a. the mental health delivery system in which the counselors were practicing.
  - b. the severity of issues clients presented with.
  - c. inadequate preparation for a cohesive theoretical orientation
  - d. centered around the number of clients on their caseload.
6. According to participants in this study, one reason they did not address burnout more openly and earlier was due to:
  - a. assuming it would go away after a while
  - b. not having a good relationship with their supervisor
  - c. due to stigma and feelings of guilt and shame around their experience
  - d. being unfamiliar with the term

## **Invisible Women: Justice-Involved Pregnant Women Presenting with Opioid Use Disorders (pp. 27-36)**

7. Naltrexone is recommended for the treatment of pregnant women with opioid use disorders.
  - a. True
  - b. False

8. Unmanaged or abrupt withdrawal from opioids during pregnancy is associated with adverse treatment outcomes for women and their infants, such as:

- a. Neonatal Abstinence Syndrome
- b. Miscarriage
- c. Poor Fetal Growth
- d. All of the above

9. It is recommended that gender-responsive treatment include all of the following except:

- a. Universal Screening Tools
- b. Criminalization of Substance Use Disorders
- c. Evidence-Based Practices
- d. Trauma-Informed Care

10. Buprenorphine is considered a schedule III drug indicating a \_\_\_\_\_.

- a. high potential for abuse.
- b. elevated risk of severe physical or psychological dependence.
- c. moderate to low potential of physical or psychological dependence.
- d. High risk of preterm birth.

I certify that I have completed this test without receiving any help choosing the answers.

**Feedback**

Please rate the following items according to the following scale:

5 – Superior    4 – Above Average    3- Average    2 – Below Average    1 – Poor

	Superior	Above Average	Average	Below Average	Poor
The authors were knowledgeable on the subject matter	5	4	3	2	1
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The content was relevant to my practice	5	4	3	2	1
This journal edition met my expectations as a mental health professional	5	4	3	2	1
How would you rate the overall quality of the test?	5	4	3	2	1

Comments/Suggestions?

**Instructions**

**Email:** Complete the test, sign the form, and email to: [PCA.profdev@gmail.com](mailto:PCA.profdev@gmail.com). Allow 2-4 weeks for processing.

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# Guidelines for Authors

The *Journal of the Pennsylvania Counseling Association (JPCA)* is a professional, refereed journal dedicated to the study and development of the counseling profession. The Editor invites scholarly articles based on existing literature that address the interest, theory, research, and innovative programs and practices of professional counselors. Authors submitting manuscripts to the journal should not simultaneously submit them to another journal, nor should manuscripts have been published elsewhere in substantially similar form or with substantially similar content. All submissions are blind peer reviewed and authors should expect a decision regarding a manuscript within three months of acknowledgement of receipt. Following are guidelines for developing and submitting a manuscript. Any submissions that do not adhere to the following guidelines will be returned without review.

## Specific Requirements

1. Manuscripts should not exceed 30 pages, including references.
2. Manuscripts should be typewritten, double-spaced (including references and extensive quotations) with 1" margins on all sides.
3. **Title Page:** Identify the title page with a running head. The title page should include title (not more than 80 characters), author, affiliation, and an author's note with contact information. Author's note should be formatted exactly as it appears in this example:

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Correspondence concerning this article should be addressed to Author Name, Department of \_\_\_\_\_,  
University, Street address, City, State, zip code (e-mail: xxxxx@xxxx.edu).
4. **Abstract:** Begin the abstract on a new page, and identify the abstract page with the running head and the number 2 typed in the upper right-hand header of the page. The abstract should not exceed 75 words.
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6. **Text:** Begin the text on a page 3, and identify the text page with the running head and page number 3 typed in the upper right-hand header of the page. Type the title of the article centered at the top of the page and then type the text. Each subsequent page of the text should carry the running head and page number.
7. **Tables and Figures:** No more than 3 tables and 2 figures with each manuscript will be accepted. Do not embed tables or figures within the body of the manuscript. Each table or figure should be placed on a separate page following the reference list
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12. An electronic copy of the manuscript should be e-mailed to the editor: Dr. Terence Yee (pcajournal@gmail.com).

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