THE CONCEPTUALIZATION OF SELF-CARE AND INTEGRATION OF
SELF-CARE EDUCATION IN THE COUNCIL FOR ACCREDITATION OF
COUNSELING AND RELATED EDUCATIONAL PROGRAMS ACCREDITED
CLINICAL MENTAL HEALTH COUNSELING PROGRAMS CURRICULUM:
A MULTIPLE CASE STUDY

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The purpose of this research was to explore how CACREP accredited Clinical Mental Health Counseling programs conceptualize self-care and integrate self-care education into counseling curriculum. Counselor educators in CACREP accredited Clinical Mental Health Counseling programs served as representatives to their programs and were invited to share how their counseling programs conceptualize self-care and integrate self-care education into the curriculum. In addition, the counselor educators identified a faculty member teaching a course in which the CACREP standard is met. This faculty member completed a questionnaire regarding their experiences teaching the course. The questions guiding the research were:

1. How do Clinical Mental Health Counseling programs accredited by CACREP conceptualize self-care?

2. How is self-care education integrated into counseling curriculum?

Participants included three counselor educators teaching in a Clinical Mental Health Counseling program accredited under the 2009 CACREP standards and two faculty members teaching a course in which the CACREP standard was met.
In response to the first question of how self-care is conceptualized in the program, two common themes emerged between the three individual cases: ambiguity of self-care conceptualization and an emphasis on prevention and early intervention. In response to question two which explored how the programs are integrating self-care education into the curriculum, two common themes emerged between the three cases: specific course integration and infusion throughout the program, and faculty involvement and demonstration of importance. The results and interpretations are explained; contributions to the current literature, implications, and limitations are discussed; and recommendations for future research are provided.
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CHAPTER I
INTRODUCTION AND LITERATURE REVIEW

This research explored how Clinical Mental Health Counseling programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) conceptualized self-care and integrated self-care education into counseling curriculum. The impetus for this research included the lack of a universal definition of self-care provided by the counseling profession, CACREP stipulations of self-care education integration, and the American Counseling Association (ACA) Code of Ethics’ emphasis on impairment prevention.

A primary motive for this research was that CACREP does not provide a definition of self-care for the accredited programs. Despite CACREP’s lack of a definition of self-care in the mental health profession, The World Health Organization (WHO) defined self-care as “what people do for themselves to establish and maintain health, prevent and deal with illness” (p. 2). The WHO explained that this includes hygiene, nutrition, lifestyle, environmental factors, socioeconomic factors, and self-medication.

Although CACREP does not provide a definition for self-care, self-care is described as one of the factors of wellness in the Indivisible Self Model (Myers & Sweeney, 2008). The counseling profession has a specific approach for helping others with a focus on wellness through developmental, prevention, and wellness based approaches (Myers & Sweeney, 2008). Wellness is defined in the counseling profession as “a way of life oriented toward optimal health and well-being in which body, mind, and
spirit are integrated by the individual to live more fully within the human and natural community” (Myers, Sweeney, & Witmer, 2000, p. 252). The wellness definition specific for counseling is based on multiple disciplines including Alfred Adler’s concepts of considering the whole individual or holism (Myers et al., 2000). Initially, wellness was introduced into the counseling profession in the format of the “Wheel of Wellness,” which is a theoretical model including five life tasks including: spirituality, self-regulation, work, friendship, and love (Myers et al., 2000), with spirituality in the center (Myers & Sweeney, 2005, 2008; Myers et al., 2000). Self-regulation was later renamed self-direction and included 12 areas as follows: sense of worth, sense of control, realistic beliefs, emotional awareness and coping, sense of humor, nutrition, exercise, self-care, stress management, gender identity, and cultural identity (Myers & Sweeney, 2008). These 12 areas provide guidance and direction as the person addresses the tasks of work, leisure, friendship, and love.

From the Wheel of Wellness, an evidenced based model of wellness was created called the Indivisible Self which included five second order factors that encompassed 17 components to wellness (Myers & Sweeney, 2005, 2008) including the 12 areas described in previous paragraph as part of the “Wheel of Wellness” (Myers & Sweeney, 2008). The five second order factors include: creative self, coping self, social self, essential self, and physical self. These five second order factors provide a definition to the different components of wellness, which is considered the core of the Indivisible Self model (Hattie, Myers, & Sweeney, 2004). Furthermore, when describing wellness, Myers and Sweeney (2008) took into consideration the environment including: local,
instructional, global, and chronometrical (Myers & Sweeney, 2005, 2008). The local contexts are the immediate environments in which one lives and perceived safety in these environments. The institutional contexts include social and political systems that affect one’s daily life. The global contexts include politics and culture that connect the individual to others around the world. The chronometrical contexts include any growth, movement, or change that occurs over time (Myers & Sweeney, 2005, 2008).

So in light of the absence of a self-care definition provided by CACREP and Myers and Sweeney’s (2008) definition of self-care being part of wellness which is multifaceted, the definition of self-care in the counseling profession may not be clear. Thus the purpose of this research is to explore how CACREP accredited programs are conceptualizing self-care in their programs.

**CACREP**

Originally established in 1981, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) is the counseling profession’s accrediting body which has a vision of “encouraging and promoting the continuing development and improvement of preparation programs; and preparing counseling and related professionals to provide services consistent with the ideal of optimal human development” (CACREP, 2011c, ¶1). In addition, the goal of CACREP is to develop competent counselors through “the development of preparation standards, the encouragement of excellence in program development, and the accreditation of professional preparation programs” (CACREP, 2011c, ¶1).
Currently, CACREP accredits 604 master’s level programs and 60 doctoral level programs (CACREP, 2011f). CACREP accredits the following programs: Addiction Counseling; Career Counseling; Clinical Mental Health Counseling; Marriage, Couple, and Family Counseling; School Counseling; Student Affairs and College Counseling; and Counselor Education and Supervision (CACREP, 2011b). Since the 2001 standards, there have been changes in the programs. Specific to this research, Community Counseling and Mental Health Counseling were programs in the CACREP 2001 standards. However, for accreditation of the 2009 standards, all Community Counseling and Mental Health Counseling programs must transition to Clinical Mental Health Counseling (CACREP, 2011a). CACREP accredits 26 Clinical Mental Health Counseling programs, 160 Community Counseling programs, and 57 Mental Health Counseling programs (“CACREP Directory,” 2011).

CACREP reviews the standards every seven years using feedback from individuals in the profession to make amendments (Sweeney, 1995). The standards include areas such as the structure and evaluation of the learning environment, professional identity (includes the eight core areas described later in this paragraph), professional practice, and the curriculum requirements for each of the programs it accredits (previously listed; CACREP, 2009). Currently, CACREP standards require that all accredited programs incorporate eight core areas into the curriculum. The required eight core areas are professional orientation and ethical practice, social and cultural diversity, human growth and development, career development, helping relationship, group work, assessment, research, and program evaluation. Specific to the current
research and another impetus for the current research is the 2009 standards stipulation that accredited counseling programs incorporate “self-care strategies appropriate to the counselor role” (CACREP, 2009, p. 10). Furthermore, the 2009 standards place an emphasis on self-awareness of the counselors in training which may be achieved by personal counseling. The current research has not focused on the programs that have not been awarded accreditation under the 2009 Standards. Although programs that have not yet been awarded accreditation under the 2009 standards may be already implementing the 2009 standards, they have not yet been recognized by CACREP as meeting all standards.

**Benefits of CACREP**

Since the establishment of CACREP, researchers have examined the benefits of CACREP and comparisons between CACREP accredited institutions and non-CACREP accredited institutions. Adams (2005) conducted a study examining the difference on National Board for Certified Counselors (NBCC) National Counselor Exam (NCE) scores between students from CACREP accredited institutions and non-CACREP accredited institutions. The NCE was used as a comparison between the two groups as the NCE was originally designed to measure the eight core areas in the CACREP standards (Adams, 2005). Adams found that students from CACREP accredited institutions tend to score better on the NCE in comparison to the students at non-CACREP accredited institutions.

Adams was not the only one to acknowledge the NCE as a method of evaluation or comparison. Prior to Adams’ (2005) research, Vacc and Charkow (1999) conducted a study assessing the methods used to assess the quality dimensions of educational
programs with the goal of providing improved methods for evaluation to increase the accountability of counselor preparation programs. Consequently, Vacc and Charkow shared that the NCE could be an instrument used to assess students’ gain of knowledge in counselor education programs as well as serve as a summative evaluation tool.

Additionally, Hollis (1998) explored differences between CACREP accredited and non-accredited institutions to determine if CACREP accreditation is making a difference in the preparation of mental health counselors. Hollis compared accredited and non-accredited programs in six areas: admission requirements (GRE and undergraduate GPA), number of students in program, graduation requirements (academic hours and clinical experience), and placement of graduates the first year after graduation. Hollis found that despite a similar number in enrollment, accredited programs do graduate more students than non-accredited programs. In regards to GRE and undergraduate GPA scores, GRE scores were similar between accredited and non-accredited programs; however, the required undergraduate GPA for admission was higher for accredited programs than non-accredited programs. Hollis also found that accredited programs had higher requirements for academic hours, practicum clock hours, and internship clock hours. Accredited programs required on average 30% more clinical practicum hours than non-accredited programs. Finally, Hollis found that accredited and non-accredited programs had similar job placements after the first year of graduation.

Adams’ (2005) and Hollis’ (1998) findings of perceived benefits in CACREP standards were consistent with previous research exploring the perceived benefits of the standards (Bobby & Kandor, 1992; Smaby & D’Andrea, 1995; Vacc, 1992). Due to the
perceived benefits of CACREP, the researcher of the current study determined it would be important to explore how counselor education programs are interpreting the new addition of the required integration of self-care strategies into the curriculum.

**Ethics**

In addition to there being a lack of a universally accepted definition of self-care in the counseling profession and CACREP mandating the integration of self-care education, it is important that counselors address the issue of impairment prevention in order to adhere to the American Counseling Association (ACA) Code of Ethics, the third impetus for the current research. All licensed counselors are expected to adhere to the ACA Code of Ethics. One of the primary purposes of the code of ethics is to protect clients and members of the profession from unethical practices (Gladding & Newsome, 2010). For these reasons, it is important to examine the role of the code of ethics in the current research. In regards to self-care, the ACA Code of Ethics (2005) stipulates that:

Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or
supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients. (ACA, 2005, Standard 2.g)

Furthermore, the impairment awareness is not only a focus of professionals but also for counselors-in-training.

Counselors-in-training refrain from offering or providing counseling services when their physical, mental, or emotional problems are likely to harm a client or others. They are alert to the signs of impairment, seek assistance for problems, and notify their program supervisors when they are aware that they are unable to effectively provide services. In addition, they seek appropriate professional services for themselves to remediate the problems that are interfering with their ability to provide services to others. (ACA, 2005, Standard F.8.b)

In addition to ACA’s Code of Ethics, ACA has made additional strides to address counselor impairment. For example, ACA created a Task Force on Counselor Impairment in 1991 (ACA, 2010). In 1994 CACREP proposed the 1994 ACA Model Legislation for Licensed Professional Counselors, which was endorsed by ACA and included a section describing remediation of impaired counselors (Glosoff, Benshoff, Hosie, & Maki, 1995). A second Task Force on Impaired Counselors was created in 2003 focusing on impairment prevention and intervention for counselors (ACA, 2010). In 2004, ACA conducted a study of the prevalence of impairment among ACA members, which concluded that 63.5% of counselors were aware of another counselor who they would consider to be impaired (ACA, 2010). Of the participating counselors, 75.7% stated that they felt that an impaired counselor was a potential risk to the counseling
profession (ACA, 2010). Due to these results, the Task Force focused on three avenues to address counselor impairment including impairment prevention and resiliency education, resources, treatment, and intervention for counselors, and advocating at the state and national level (ACA, 2010). One way of accomplishing the goal of impairment prevention and resiliency education was through the development of a section on Counselor Wellness and Impairment on the ACA website. Resources specific to self-care included on the website were: “Self-Care Assessment, Self-Care Strategies Worksheet, Self-Care Life Pie Worksheet, and Self-Care Social Support Worksheet, and Combined References for Traumatic Stress, Impairment and Self-Care” (ACA, 2010, ¶2).

Problem

Despite the importance of self-care education and prevention of impairment being addressed in CACREP and the ACA Code of Ethics respectively, CACREP does not define self-care and as previously stated, the definition of self-care provided in Myers and Sweeney’s (2008) multifaceted conceptualization of wellness is not clear. Without a provided definition, it may be difficult for counselor education programs to conceptualize self-care and adhere to CACREP’s stipulated integration of “self-care strategies appropriate to the counseling profession” into the curriculum (CACREP, 2009, p. 10). Thus, the researcher explored how CACREP accredited programs conceptualize self-care and integrate self-care education into the curriculum.

In addition to the importance of adhering to the 2009 CACREP standards and the ACA Code of Ethics, ensuring appropriate client care is a third impetus to explore and determine how self-care is conceptualized and how self-care education is integrated into
the curriculum. As mentioned earlier, ACA conducted a study in 2004 exploring how prevalent impairment was in the profession and found that, of the 770 participants in the study, approximately 63.5% reported they were aware of an individual who was impaired (ACA, 2010). Additionally, in approximately 54% of these cases, supervisors were aware of the impaired counselor and, in approximately 64% of the cases, colleagues were aware of the impairment. Impairment is a prevalent issue in the profession, which Emerson and Markos (1996) shared is a reason it is pertinent that counselors find ways to balance caring for themselves in addition to their clients. Thus, it may be beneficial for counselors and counselor educators to gain insight into the conceptualization of self-care as well as strategies for the integration of self-care education into the curriculum. Consequences of not providing self-care education could lead to counselor impairment potentially causing harm to counselors and clients (Frame & Stevens-Smith, 1995; Roach & Young, 2007). Impaired counselors may be overwhelmed by their own personal emotions, thus inhibiting them from attending to the client’s emotions, missing important information from a client, or not being able to demonstrate empathy to clients (Lawson, Venart, Hazler, & Kottler, 2007). In more extreme cases, impaired counselors may establish inappropriate relationships with clients, foster dependence, or violate the trust of clients.

**Purpose**

The purpose of this research was to explore how CACREP accredited Clinical Mental Health Counseling programs conceptualize self-care and integrate self-care education into the curriculum. The researcher interviewed six to eight counselor
educators, each representing their respective program, exploring the counseling programs’ conceptualizations of self-care and how the programs integrated self-care education into the curriculum.

**Rationale**

In addition to the educational and ethical requirements regarding self-care and self-care education previously described, counselor self-care is important for both counselors’ and clients’ well-being (ACA, 2010). When a counselor is experiencing impairment they have a reduced ability to provide the appropriate care for clients (ACA, 1991, as cited in ACA, 2010). However, when counselors are psychologically and physically well they are best able to provide high quality therapeutic services (Lawson et al., 2007). Furthermore, self-care is important for the prevention of burnout and impairment (Venart, Vassos, & Pitcher-Heft, 2007) to ensure counselors are providing competent and effective services so the counseling profession maintains a reputation of trust (Lawson et al., 2007). Thus, for these reasons, as well as the lack of a universal definition of self-care (Richards, Campenni, & Muse-Burke, 2010) and lack of specific strategies to integrate self-care education in the counseling profession, the rationale of this research was to glean an understanding into how CACREP accredited Clinical Mental Health Counseling programs conceptualize self-care as well as how self-care education was integrated into the curriculum. Furthermore, the findings contributed to the literature on self-care in general and established a conceptualization of self-care for counselors as well as developed the literature on the understanding of self-care and self-care education specific to counseling and counselor education.
**Research Questions**

The research questions addressed by this research were: 1) How do CACREP accredited Clinical Mental Health Counseling programs conceptualize self-care? 2) How is self-care education integrated into the curriculum?

**Definition of Terms**

In this section, terms pertinent to the research are defined.

Burnout: “The result of a decreased ability to attach with the next client because of the emotional depletion accumulated over a period of caring for others” (Skovholt, Grier, & Hanson, 2001, p. 171).

CACREP: “An independent agency recognized by the Council for Higher Education Accreditation to accredit master’s degree programs in: addiction counseling, career counseling, clinical mental health counseling, marriage, couple, and family counseling, school counseling, and student affairs and college counseling” (CACREP, 2011d, ¶1). “CACREP also accredits doctoral programs in Counselor Education and Supervision” (CACREP, 2011d, ¶1).

CACREP accreditation: A peer review system to assure quality programs in which the programs voluntarily submit a self-study that is reviewed against the CACREP standards by counselors and counselor educators to ensure that students receive a quality educational experience (CACREP, 2011e, ¶1).

Clinical Mental Health Counseling program: Clinical Mental Health Counseling programs prepare graduates to work with clients across a spectrum of mental and emotional disorders, as well as to promote mental health and wellness. Clients may be
seen individually, in couples, families, or group settings. Clinical Mental Health Counselors are knowledgeable in the principles and practices of diagnosis, treatment, referral, and prevention and often work in interdisciplinary teams with other health professionals (e.g., psychiatrists, social workers, MDs). Employment opportunities may include private practice, community-based mental health centers, hospitals, and other treatment centers (CACREP, 2011b, ¶4).

Community Counseling program: A program designation that existed before the CACREP 2009 standards were implemented where the standards for Community Counseling programs and Mental Health programs were combined to create the Clinical Mental Health Counseling program designation. Once a program has completed its next full accreditation review, all program names will be changed to Clinical Mental Health Counseling (CACREP, 2011b, ¶11).

Counseling: “Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (ACA, 2011, ¶10).

Counselor educators: Educators preparing students enrolled in counseling programs.

Impairment: Therapeutic impairment occurs when there is a significant negative impact on a counselor’s professional functioning which compromises client care or poses the potential for harm to the client. Impairment may be due to: substance abuse or chemical dependency, mental illness, personal crisis (traumatic events or vicarious trauma, burnout, life crisis), physical illness, or debilitation (ACA, 2010, ¶2).
Mental Health Counseling: A program designation that existed before the CACREP 2009 standards were implemented where the standards for Community Counseling programs and Mental Health programs were combined to create the Clinical Mental Health Counseling program designation. Once a program has completed its next full accreditation review, all program names will be changed to Clinical Mental Health Counseling (CACREP, 2011b, ¶14).

Professional counselor: A counselor who has received a master’s degree or higher from an entry-level program in counselor education matching the standards outlined by CACREP in addition to state licensure requirements. A professional counselor remains active in the counseling profession by participating in professional development and seeking appropriate licensure and certification (CACREP, 2009, p. 62).

Wellness: “A way of life oriented towards optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully within the human and natural community” (Myers et al., 2000, p. 252).

**Review of the Literature**

Individuals in the helping profession spend the majority of their education, training, and professional time helping other individuals and often neglect to take care of themselves (Skovholt, 2001). In addition to counselors integrating self-care strategies into their practice, counselor educators also have the responsibility to integrate self-care education into the curriculum to encourage self-care to become a part of the counselors’ identity and repertoire (Roach & Young, 2007; Witmer & Young, 1996; Yager & Tovar-Blank, 2007). This literature review examines the potential consequences of not
engaging in self-care (burnout, vicarious trauma, compassion fatigue, secondary traumatic stress, and impairment), self-care in other helping professions (medicine, nursing, social work, and psychology), wellness and self-care in the counseling profession, and integration of self-care education in the counseling profession.

**Self-Care**

Self-care is not a behavior to be engaged in once in a profession but instead is a lifelong process for counselors in order to promote wellness (Venart et al., 2007). Despite there not being one agreed upon operational definition in the counseling profession (Richards et al., 2010), Skovholt et al. (2001) shared that there are two main forms of self-care, professional and personal self-care. Examples of professional self-care include furthering education (Puterbaugh, 2008; Venart et al., 2007), engaging in peer support (Puterbaugh, 2008; Skovholt et al., 2001; Trippany, White-Kress, & Wilcox, 2004), participating in supervision (Puterbaugh, 2008; Skovholt et al., 2001; Trippany et al., 2004), participating in mentoring relationships (Skovholt et al., 2001), maximizing professional successes (Skovholt et al., 2001; Venart et al., 2007), minimizing professional losses (Skovholt et al., 2001), increasing awareness (Puterbaugh, 2008; Skovholt et al., 2001), engaging in consultation (Puterbaugh, 2008; Skovholt et al., 2001), and balancing a caseload with the number of clients with a history of trauma and clients without a history of trauma (Trippany et al., 2004).

In addition to professional self-care, personal self-care is also important for counselors. Puterbaugh (2008) conducted a phenomenological study examining the experiences of bereavement counselors and their personal self-care strategies.
Puterbaugh found that bereavement counselors reported engaging in self-nurturing including: nutrition, exercise, sleep, relaxation, and personal time, which were reported to be helpful. Additionally, Trippany et al. (2004) described specific personal self-care strategies for counselors to prevent vicarious trauma including personal coping mechanisms such as work life balance and increased spirituality or meaning.

Furthermore, Venart et al. (2007) explained that personal strategies can be categorized into four domains: physical, emotional, cognitive, and social relationships. The physical domain includes relaxation of the body, nutrition, grounding through the senses, and movement and music. The emotional domain includes understanding one’s emotions, increasing awareness and then reflecting on the emotions, and expressing emotion. The cognitive aspect includes improving cognitive thoughts, ensuring not to take on the responsibility of the client but share in the responsibility, celebrate victories at work, continue lifelong education, channel energies into activities that facilitate movement toward systematic change. Skovholt et al. (2001) recommended focusing on similar domains but incorporated a spiritual component instead of the cognitive. Skovholt (2001) further explained that there is not one way to address the spiritual component but it is for each individual to determine how to fulfill the spiritual component.

**Consequences of not engaging in self-care.** It is important for counselors to incorporate self-care strategies in order to promote wellness and prevent burnout and impairment (Venart et al., 2007) as well as for counselor educators to provide education
to counselors-in-training about the importance of self-care and examples of self-care strategies (Skovholt, 2001).

In addition to being aware of the importance of incorporating self-care strategies into the counseling profession, it is important to understand potential consequences of not engaging in self-care strategies. Potential consequences of not engaging in self-care strategies include burnout (Figley, 2002a, 2002b; Lambie, 2006), vicarious trauma (Pearlman, 1999; Pearlman & Saakvitne, 1995), compassion fatigue (Figley, 2000b), secondary traumatic stress (Valent, 2002), and impairment (Emerson & Markos, 1996; Lawson et al., 2007).

The first potential consequence of not engaging in self-care strategies is burnout which Lambie (2006) explained begins when the counselor has difficulty demonstrating caring and commitment. The counselor then struggles to give to others due to a decline in inner resources and emotional exhaustion. Lambie also shared that burnout is associated with interaction of the work environment and the counselor’s expectations of his or her professional roles. Figley (2002a) explained that burnout can manifest in a variety of ways: emotionally, physically, behaviorally, interpersonally, and environmentally. The emotional aspects of burnout could include anxiety, depression, and an inability to concentrate. Physically, the individual may experience somatic complaints or exhaustion. Behaviorally, the individual could be aggressive. Interpersonally, the individual may not have a sense of humor or may isolate from friends. Burnout’s impact on work could include absenteeism, tardiness, or a reduced work performance.
Skovholt (2001) shared that there are two types of burnout: meaning burnout and caring burnout. Meaning burnout occurs when the individual cannot find meaning in the work that he or she does and often experiences an existential crisis. Skovholt explained that an example of not finding meaning in the work anymore could be that the counselor becomes bored by the work or the work becomes routine. Additionally, if the counselor joined the counseling profession to meet his or her own personal needs and those needs are satisfied, the counselor may have lost the original meaning or purpose of the profession. If a new meaning and purpose is not discovered this could lead to burnout. A final example of not finding meaning in work could be that the counselor no longer feels as though the work he or she is doing is helpful to the client. Skovholt explained that this could occur when a counselor is working in an agency where a significant number of cases and amount of paperwork prevents the counselor from being able to counsel individuals as he or she would like.

The second type of burnout is caring burnout, which is most frequently described in the profession (Skovholt, 2001). Caring burnout occurs when an individual is unable to attach to the client and form a relationship. This, according to Skovholt, occurs because of a break in the caring cycle, which is described later.

Counselors are more susceptible to burnout and impairment, which may impact personal and professional relationships due to the constant engagement and separation which is required in the counseling relationship (Skovholt, 2001). An example of the constant engagement and separation which occurs in the counseling relationship is counselors beginning a therapeutic relationship with new clients and simultaneously
ending relationships with other clients whether the ending of the relationship would be on a mutual agreement or the client’s independent decision. The beginning and ending of relationships is constant throughout a counselor’s professional life. Burnout as well as ineffectiveness, and incompetence, according to Skovholt (2001), occur because of a break in the caring cycle (previously mentioned), which involves the following three interactions: empathetic attachment, active involvement, and felt separation. All counselors go through this cycle for each client over the course of their professional career (Skovholt, 2001). However, sometimes counselors do not complete the cycle in a productive way. With each attachment a counselor forms, the counselor must prepare for the inevitable separation (Skovholt, 2001). If a counselor can separate from the client appropriately then the counselor will be able to attach in the next relationship without any negative consequences (Skovholt, 2001). However, sometimes with each separation the counselor is drained a little bit, and over time with each separation draining the counselor a little bit at a time, it inhibits the counselor from being able to attach to the next client (Skovholt, 2001). Thus, Skovholt explained that when the counselor is not able to attach to another client burnout, defined as “disengagement of the self from the caring cycle” (p. 113), occurs.

An additional example of a break in the caring cycle that counselors may experience which could lead to burnout is too many ambiguous losses. Ambiguous losses occur when a relationship ends without either concrete results or closure (Skovholt, 2001). Skovholt provided the following as an example of ambiguous loss: a counselor establishing a relationship with a client and the client ends treatment before the
client and counselor mutually agree to end treatment. These ambiguous losses can lead to the counselor’s inability to form a relationship with another client due to fears of an additional ambiguous loss (Skovholt, 2001).

It is important to realize the number of times a counselor is expected to complete the cycle of caring due to the numerous clients to whom a counselor will provide services throughout his or her professional career (Skovholt, 2001). If the caring cycle is not completed successfully and the counselor is depleted of energy through the cycle and burnout occurs, the counselor’s expectations of the counseling process are impacted (Skovholt, 2001). The counselor may struggle with the belief that he or she is helping to make a difference in clients’ lives, struggle with the ability to deal with the ambiguity of the profession, and also struggle with the belief that individuals can become self-actualized and accomplish their goals (Skovholt, 2001).

Compassion fatigue is one form of burnout (Figley, 2002b). Figley explained that compassion fatigue is the same as secondary traumatic stress disorder which parallels the criteria of post-traumatic stress disorder with the exception that symptoms of compassion fatigue apply to the individual who has an emotional response to the trauma of another individual opposed to the individual experiencing the trauma personally as in post-traumatic stress disorder (Valent, 2002). Consequently, Figley (2002b) stated that those who work with individuals who are suffering suffer themselves. Figley further explained that individuals experiencing compassion fatigue may experience negative symptoms and reactions in their thoughts, emotions, actions, spirituality or spiritual beliefs, personal relationships, physical well-being, and work performance.
In addition to burnout and secondary traumatic stress or compassion fatigue, counselors, especially counselors working with trauma survivors, may experience vicarious traumatization (VT) (Pearlman, 1999; Pearlman & Saakvitne, 1995). VT is when the counselor experiences changes in his or her perception of helping, worldview, relationships due to working with trauma survivors (Pearlman, 1999; Pearlman & Saakvitne, 1995). Although secondary traumatic stress and vicarious trauma may appear to be the same concept, they do vary. Secondary traumatic stress is based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis of PTSD and focuses on the observable symptoms whereas vicarious trauma focuses on the meaning counselors assign to experiences and relationships as well as the whole person (Pearlman & Saakvitne, 1995). Despite a different focus, VT does not ignore the observable symptoms but instead places the symptoms in context of meaning. VT views the individual as part of a whole and explores how the individual assigns meaning to his or her experiences (Pearlman & Saakvitne, 1995).

Impairment, another potential consequence of not engaging in self-care strategies, is defined by the ACA Task Force on Wellness as occurring when the counselor’s own personal issues are impacting his or her ability to effectively interact with clients (ACA, 2010). This could be due to mental illness, personal issues (potentially burnout), physical illness or disability, or substance abuse.

Impairment, however, is not the only potential consequence of not engaging in self-care strategies, nor is a counselor’s state of wellness constant throughout his or her profession. It is important that counselors recognize that all counselors have the potential
to be well or impaired and to not underestimate the risk of becoming impaired and to maintain a wellness plan to prevent impairment (Lawson et al., 2007).

Lawson et al. (2007) further elaborated that there is a continuum ranging from wellness to impairment that may vary throughout a counselor’s professional experience. Lawson et al. explained that the following are categories on the wellness continuum at which a counselor may describe himself or herself throughout his or her professional career: wellness, stressed, distressed, and impaired. The well individual is an individual who is balanced and able to provide competent and effective care to clients. The stressed individual is the individual who experiences stress but is able to leave the stress at the door before seeing clients (Lawson et al., 2007) and does not allow the stress to impact the care of the client (ACA, 2010). The distressed individual is the individual who allows personal stress to impact the ability to work effectively with clients such as arriving late to appointments and not attending to the details of a client’s story. The impaired counselor is meeting his or her own needs through the client (Lawson et al., 2007), therefore, impacting the counselor’s ability to work effectively with the client (ACA, 2010). Thus, in order to ensure competent care to clients and ensure that the reputation of trust of counselors is maintained, it is important to learn how to prevent impairment (Lawson et al., 2007).

**Self-care in other helping professions.** Although the focus of this research was on self-care strategies in the counseling profession, it is important to explore how other helping professions, such as medicine, nursing, psychology, and social work, define and conceptualize self-care. Additionally, it is important to understand how self-care is
conceptualized to enable professionals to be able to integrate it effectively into the curriculum. I chose to explore self-care strategies in medicine, psychology, and social work as these are the three main helping professions described by the ACA Taskforce on Counselor Wellness and Impairment when describing the history of a need to address impairment in helping professionals (ACA, 2010). In addition, I decided to incorporate the nursing profession as nurses have a significant role in mental health. In the following sections, I discuss stressors experienced by individuals in each profession, potential consequences of the stressors, self-care strategies used in other professions, and how self-care is integrated into each of the professions.

**Stressors.** In order to provide and implement appropriate self-care strategies for individuals in helping professions, it is first important to gain an understanding of the potential stressors helping professionals may experience in the individual’s professional and personal areas in life.

In regards to the professional area, a unique aspect of the helping profession is the emotional demand that is required of helping professionals. It is important that individuals working in helping professions are aware of the required emotional demands as well as the fact that working in the human service profession is the largest risk factor for burnout (Newell & MacNeil, 2010).

In the medical profession, physicians must learn to be able to deal with patients’ suffering and the death of patients (Firth-Cozens, 2001). Further complicating the emotional demands of physicians, physicians may believe they need to be miracle workers and place pressure on themselves to fulfill this belief (Mavroforou, Giannoukas,
In addition to these internal pressures physicians may place on themselves, physicians may experience a need for perfection and feelings of incompetence (Rabin, Matalon, Maoz, & Shiber, 2005). Rabin et al. reported that physicians’ feelings of incompetence may be exacerbated by the vast increase in the amount of information available to patients and physicians, courtesy of the Internet. Consequently, physicians may feel challenged and stressed to keep current with the most updated literature (Shanafelt et al., 2005).

The felt importance of taking care of others before themselves and emotional demands of the job (Bednarski, 2009; Taylor & Barling, 2004) are not unique to physicians but also experienced within the nursing (Bloniasz, 2011; Hernandez, 2009) and social work (Collins, 2005) professions. Furthermore, psychologists may also experience emotional challenges when working with difficult clients (Sherman & Thelen, 1998) and when trying to determine the best intervention for a client (Mahoney, 1997; Sherman & Thelen, 1998).

In addition to the emotional demands of the helping profession, there were often stressors that were more administrative or systemic than emotional. For example, physicians reported poor management (Mavroforou et al., 2006), time pressure (Mavroforou et al., 2006), and litigation (Firth-Cozens, 2001) as sources of stress. In the nursing profession staffing levels (Gupta & Woodman, 2010), employment insecurity (Bednarski, 2009; Taylor & Barling, 2004), heavy caseloads (Bednarski, 2009; Gupta & Woodman, 2010), issues with management and the politics of the system (Bednarski, 2009; Taylor & Barling, 2004), difficulties with the nature of the work, and inadequate
resources and services (Bednarski, 2009; Taylor & Barling, 2004) were reported as systemic stressors in the profession. Furthermore, Sherman and Thelen (1998) reported that the following were systemic stressors for psychologists: excessive paperwork, lack of sufficient time, and restrictions by managed care companies.

Additionally, individuals in the helping profession also experienced stressors in their personal lives, which could potentially impact their work performance. For example, serious health conditions of a family member (Sherman & Thelen, 1998), borrowing a significant amount of money, marital and relationship issues (Mahoney, 1997; Sherman & Thelen, 1998), changes in spouses’ work outside the home (Sherman & Thelen, 1998), and a change in financial status were the most commonly reported stressors in psychologists’ personal lives (Sherman & Thelen, 1998). In addition, Ospina-Kammerer and Dixon (2001) shared that personal stressors common between family physicians and family social workers included financial stressors, family conflicts, and restrictions of free time.

**Potential consequences.** In addition to being aware of the potential personal and professional stressors, in a helping professional’s life, it is also important that individuals in helping professions recognize the potential consequences of lack of awareness and appropriate response to stressors present in the professions.

Firth-Cozens (2001) reported that if the stressors physicians experienced were not managed effectively, the stressors could potentially lead to physician impairment including stress, depression, or drug or alcohol abuse which could in turn lead to poor patient care. The primary psychological concerns experienced by physicians include
depression, anxiety (Cole & Carlin, 2009), and problems with alcohol, which are higher in the physician population than compared to the regular working population (Firth-Cozens, 2001). Furthermore, in the United States approximately 15% of physicians will be impaired at some point in their career for reasons which may include: mental health concerns or concerns with drugs or alcohol (Cole & Carlin, 2009).

Similarly, nurses experience consequences such as burnout, illness, substance abuse, and difficulty retaining nurses in the profession (Hernandez, 2009). Taylor and Barling (2004) further explained that when nurses’ stressors are not addressed appropriately, specific outcomes of their stress include: a decrease in the ability and quality of sleep, irritability, and tiredness. In addition, psychologists may also experience depression and substance abuse, and unaddressed stressors for psychologists can lead to impairment, harm to clients, lack of appropriate boundaries, depression or anxiety, or use of negative coping skills such as use of alcohol or other substances (P. L. Smith & Moss, 2009). Furthermore, social workers also may experience stress, depression, anxiety, and burnout if self-care strategies are not implemented to maintain wellness (Collins, 2005).

**Self-care strategies used in other professions.** In response to the stressors and potential consequences of stressors in the profession, individuals in helping professions developed strategies to prevent and mitigate the potential negative consequences. Some of the common strategies include increased self-awareness, maintaining personal and peer relationships, maintaining a work-life balance, and continuing education. (See Appendix A for the self-care strategies recommended by each helping profession along with the respective references for each strategy.)
The integration of self-care education in other professions. In response to the awareness of the importance of self-care strategies, many helping professionals have provided recommendations specific to the delivery of this information. One of the primary recommendations made in regards to self-care education is integrating the education into the training programs for professionals to communicate the importance and establish a culture of self-care (Barnett & Cooper, 2009). The importance of self-exploration and personal growth and development is described as a critical component of self-care education (Norræss, 2005; Saunders et al., 2007; Shanafelt, Sloan, & Habermann, 2003; Siebert, 2005).

**Medicine.** Medical school may be the best time to prepare medical students for the stress associated with practicing medicine as teaching self-care strategies to medical students may have the greatest long term benefit (Gerrity, 2001). The educators of physicians-in-training need to promote self-awareness and strategies to create a balance between their personal and professional lives (Shanafelt et al., 2003) and convey the message that self-care is an obligation rather than an option (Cole & Carlin, 2009).

Furthermore, education in school about drug and alcohol abuse as well as stress management education specific to work stress may serve as preventative tools to impairment (Mavroforou et al., 2006). Participants in DiLalla, Hull, and Dorsey’s (2004) study who received wellness education in medical school scored higher on wellness and empathy scales demonstrating support for incorporating wellness and self-care education into the curriculum.
In response to the demonstrated need for self-care of medical students, Rakel and Hedgecock (2008) conducted a study incorporating modules providing knowledge about self-care and wellness. Within these modules were topics such as exercise, healthy eating, forgiveness, journaling, meditation, breathing exercises, progressive muscle relaxation, and humor. Individuals who completed the modules were then asked to complete surveys regarding the effectiveness of the modules. Of the 500 medical students and residents completing the surveys after the modules, 89.4% stated that they felt they had an improved understanding of how to maintain personal health, 38.5% stated the modules changed behavior towards their health, and 53% reported that they had gained insights into the strengths and weaknesses of their help either much or very much.

Furthermore, Saunders et al. (2007) recommended specific strategies to help medical students cope with the challenging environment of medical school. One method the authors recommended was a Mind-Body Skills (MBS) course for first year medical students with the goal to increase self-awareness and reflection. The medical students enrolled in the MBS course reported the following experiences as a result of taking the course: making meaningful connections, gaining in self-discovery, learning MBS skills as well as increased performance in school, reducing stress, recognizing that the MBS group was a unique experience for medical education. The authors shared that these central themes support that the MBS groups used to teach these skills in this research were successful in teaching and promoting self-awareness, self-reflection, and self-care for the undergraduate medical students.
Social work. Although Radey and Figley (2007) explained that The Council on Social Work Education does not require the students to learn and practice self-care, the authors shared that social work instructors have the responsibility to not only provide students with the basic skill set and knowledge but also about the importance of social resources and good health for themselves. One response to this would be to provide an education surrounding signs and symptoms of distress and impairment (Newell & MacNeil, 2010) and self-care and burnout prevention to increase awareness of social worker’s experiences in the profession (Newell & MacNeil, 2010; Pooler, 2008) as well as educating social workers about the consequences of not engaging in self-care strategies (Newell & MacNeil, 2010; Radey & Figley, 2007). Siebert (2005) suggested that both social work students and new professionals should be encouraged to conduct personal assessments to explore personal history and characteristics, which may lead to increased risk of distress and burnout.

This education should be integrated at the beginning of professional education and training as well as integrated into the curriculum of practicums and internships, which typically occur at the end of training programs (Newell & MacNeil, 2010). During practicums and internships, field instructors have the opportunity to create objectives for how to practice self-care (Radey & Figley, 2007). This self-care practice should begin in the social work education process as students often feel overwhelmed by their responsibilities and do not feel as if they have time to take off or engage in enjoyable activities (Newell & MacNeil, 2010; Radey & Figley, 2007).
Ospina-Kammerer and Dixon (2001) shared that incorporating stress-reducing strategies into the social work curriculum is one way to facilitate students’ learning of how to address the stressors social workers experience as previously described. Specific stress reducing strategies to be implemented into the curriculum include the Respiratory One Method (ROM) which is a form of meditation when the individual focuses on one word and attaches the word to each exhale to focus on the present and let go of the negative thoughts the individual may be experiencing (Ospina-Kammerer & Dixon, 2001). Furthermore, Ospina-Kammerer and Dixon recommended Walking Meditation by Jon Kabat-Zinn, which is when an individual walks and is present in the moment and concentrating on the walking. The individual gently redirects his or her attention when becoming less focused.

Psychologists. Similar to social workers’ training and despite the awareness of the potential consequences of not engaging in self-care, psychologist training programs also lack in their education of the importance of self-care education in the curriculum (P. L. Smith & Moss, 2009).

Norcross (2005) stated that it is essential that psychologists’ training focus on both their personal development as well as the clinical training. With this expectation, Norcross explained that there are some specific recommendations including that in programs of health care psychology there needs to be an emphasis on interpersonal development in addition to items such as grade point averages and GRE scores. Furthermore, Norcross provided specific ways to place emphasis on the interpersonal development in health care psychology programs including recommendations such as:
(a) personal therapy is recommended in the descriptions of graduate programs; (b) affordable personal therapy options are made available; (c) benefits of personal therapy are integrated throughout courses; and (d) personal therapy is emphasized as a lifetime process which is modeled by the faculty.

**Wellness in the counseling profession.** As previously stated, although CACREP does not provide a definition of self-care, self-care is described as one of the factors of wellness in the Indivisible Self Model (Myers & Sweeney, 2008). Due to Myers and Sweeney (2005, 2008) providing one of the only definitions of self-care in the counseling profession within the context of wellness, the history and evolution of wellness in the counseling profession is provided in this section.

Although all of the previously mentioned professions are part of the helping professions, the counseling profession has a specific approach for helping others with a focus on wellness through developmental, prevention, and wellness based approaches (Myers & Sweeney, 2008). Wellness became the focus of the counseling profession in 1990 when the theme of the association was “Wellness throughout the Lifespan” (Myers, 1992, p. 137). This was a pivotal moment when wellness could become the foundational paradigm of counseling as opposed to a medical or illness-based model (Myers, 1991). A wellness paradigm incorporated a focus on prevention, choice, and maximizing human functioning while providing alternatives to unhealthy choices.

The concept of wellness is not new to the counseling profession as earlier definitions of guidance (a predecessor to the term counseling) included development and wellness (Farwell & Peters, 1957, as cited in Myers, 1991). However, in an attempt to
compete with other mental health professionals, counselors moved from the focus of development and aligned themselves with the pathology or medical model for treatment (Myers, 1991). As a result, the goal of professional counselors to promote optimum health and wellness as stated in the resolution of the American Association of Counseling and Development (AACD), which is now ACA, was lost or underemphasized (Myers, 1991; Myers & Sweeney, 2008). In order to support the original goal of professional counselors, Myers (1991) recommended the counseling profession commit to a wellness philosophy as well as advocate for wellness. In order to commit to and advocate for wellness, Myers suggested that there needed to be changes made within the counseling statement explaining the wellness philosophy, education, credentialing, research, and advocacy. Myers also suggested that each counselor needs to live a lifestyle of wellness to model to clients.

One of the first models of wellness was the theoretical Wheel of Wellness model which incorporated a multitude of theoretical perspectives including Alfred Adler’s (1927/1954, as cited in Myers et al., 2000) focus on holism and Maslow’s (1970, as cited in Myers et al., 2000) theory on self-actualization. In the Wheel of Wellness, there are 5 life tasks and 12 subtasks. The life tasks include: spirituality, work, friendship, love, and self-direction (Hattie et al., 2004; Myers et al., 2000). The 12 subtasks of self-direction include: sense of worth, sense of control, realistic beliefs, emotional awareness and coping, problem solving and creativity, sense of humor, nutrition, exercise, self-care, stress management, gender identity, and cultural identity. Changes in one area of wellness will impact other areas of wellness. Prior to the development of the Wheel of
Wellness, a definition for wellness was established: “a way of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully within the human and natural community” (Myers et al., 2000, p. 252).

After the development of the Wheel of Wellness, the Wellness Evaluation of Lifestyle (WEL) was developed to assess the dimensions of the Wheel of Wellness (Hattie et al., 2004). The authors then explored the factor structure of the Wheel of Wellness and found that there were 5 second order factors including: Creative Self, Coping Self, Social Self, Essential Self, and Physical Self with Wellness in the center. In addition to finding five second order factors, 17 third order factors were also confirmed by the authors. Despite the confirmation of these 17 factors, the structure of the Wheel of Wellness as well as the relationship among the variables of the Wheel of Wellness were not confirmed (Hattie et al., 2004). After reevaluation, the five second order factors were found to comprise the Indivisible Self (Myers & Sweeney, 2005).

The Indivisible Self model is an empirically based model of wellness with the center of the model being the Indivisible Self surrounded by the 5 second order factors (Myers & Sweeney, 2005). In addition to the 5 second order factors and the 17 third order factors, the context is also taken into consideration including the local, institutional, global, and chronometrical. The local contexts include families and neighborhoods, institutional contexts include education, religion, government, global contexts include politics, culture, global events while chronometrical is the recognition that through development individuals change.
Self-care in the counseling profession. As stated previously, CACREP does not define self-care and Myers and Sweeney (2005, 2008) defined self-care as a component of wellness which is a multifaceted model described below. Within the Indivisible Self Model, self-care is one of the 17 third order factors (Myers & Sweeney, 2005, 2008). The Indivisible Self Model includes one of the definitions for self-care in the counseling profession. Within the Indivisible Self Model, self-care is defined as “taking responsibility for one’s wellness through self-care and safety habits that are preventative in nature, minimizing the harmful effects of pollution in one’s environment” (Myers & Sweeney, 2008, p. 485). Three dimensions of self-care are described in the Indivisible Self Model including: behaviors that protect the individual from injury or death; having physical, medical, and dental checkups; and avoiding any harmful substances (Myers et al., 2000). Despite these specific examples provided in the Indivisible Self Model, other explanations of self-care vary. Although there are a variety of definitions and understandings of self-care there are some common overarching themes among these definitions including the physical, psychological (personal counseling), spiritual, and support (supervision/peers) aspects (Richards et al., 2010). For example, Skovholt (2001) stated that it is important for counselors to learn how to care for themselves in addition to caring for others. Furthermore, Skovholt proposed four main domains need to be addressed in regards to self-care including: physical, emotional, spiritual, and social. Eckstein (2001) added the fifth domain of focusing on mental wellness. All five of these domains are applied to six areas: fitness, adaptability, moving through loss, independence
longevity, and motivation to determine a well individual engaging in the appropriate self-care strategies. More importantly, Eckstein focused on having a plan to engage in the self-care strategies. Witmer and Young (1996) agreed that it is important not only for counselors to have a plan to engage in self-care strategies but also that counselor educators have a wellness plan to model to students. For the purpose of the current research it is important to examine different areas of self-care described by individuals in the counseling profession.

Lawson (2007) conducted a study exploring what specific strategies counselors in the ACA were engaging in and considered career sustaining behaviors. The results included having a balanced personal and professional life, having supportive relationships, and maintaining a sense of control over their caseload.

In addition to Lawson’s (2007) findings, other authors suggested the following as beneficial self-care strategies: eating well, sleeping well, exercising (Grafanaki et al., 2005; Kraus, 2005; Radey & Figley, 2007), engaging in supervision and/or consultation, and having a balanced caseload and self-awareness (Coster & Schwebel, 1997; Trippany et al., 2004). Trippany et al. explained that a balanced caseload means ensuring that not all clients on an individual’s caseload are clients who have experienced a trauma, which may reduce the potential effects of vicarious trauma for counselors.

Integration of self-care education in the counseling profession. Now that specific self-care strategies have been described, the question becomes how to integrate this self-care education and impairment prevention into the curriculum. In response to the ACA Code of Ethics, impairment prevention must be addressed to adhere to the code
Furthermore, CACREP (2009) stipulated the integration of self-care education into the curriculum of counseling training programs. Thus, Nagpal and Ritchie (2002) and Ziomek-Daigle and Christensen (2010) explained that counselor educators have a responsibility to serve as gatekeepers to the counseling profession. Other researchers also demonstrated support for the integration of impairment prevention or self-care education into the counselor education curriculum (Roach & Young, 2007; Schure, Christopher, & Christopher, 2008; Witmer & Young, 1996; Yager & Tovar-Blank, 2007). Consequently, Yager and Tovar-Blank shared that impairment can be prevented if individuals have the appropriate knowledge about wellness. However, this knowledge does not come from textbooks or sitting in a lecture hall but must be incorporated into the personal growth and development of the individual.

Yager and Tovar-Blank (2007) and Witmer and Young (1996) shared that self-care education should be integrated into the counseling curriculum at the beginning of the program, because if the education is not incorporated early in the curriculum a message may be conveyed that it is not important. The importance of self-care could be integrated early through an informed consent (Yager & Tovar-Blank, 2007) or through statements in program policies (Witmer & Young, 1996) explaining that self-awareness and personal growth and development are essential components of the curriculum. In addition, the self-care education should continue throughout the course of the program and curriculum. Williams, Helm, and Clemens (2012) explained one specific way to incorporate self-care education into the curriculum is to have students create wellness plans in courses such as practicum and internship.
In addition to incorporating self-care education into the curriculum, it is important that self-care education be connected to the ACA Code of Ethics (Witmer & Young, 1996; Yager & Tovar-Blank, 2007) and the CACREP standards (Yager & Tovar-Blank, 2007). Within the curriculum, students should be provided creative and innovative ways to engage in self-care strategies (Witmer & Young, 1996; Yager & Tovar-Blank, 2007) and required to engage in personal counseling (Yager & Tovar-Blank, 2007).

Yager and Tovar-Blank (2007) and Witmer and Young (1996) provided the recommendation of incorporating a wellness component into portfolios (as described by Carney, Cobia, & Shannon, 1996; Cobia et al., 2005). Yager and Tovar-Blank (2007) specified that the area titled “Inter- and Intrapersonal Functioning” in the portfolio would be an appropriate place to incorporate a wellness component into the portfolio. Cobia et al. (2005) explained that the “Inter- and Intrapersonal Functioning” section in the portfolio was to include self-reflection by the student. (The portfolio referenced by Cobia et al., 2005, was a portfolio for doctoral students so some adjustments would need to be made for Master’s students.) In addition to self-exploration and reflection, Cobia et al. shared that portfolios provide a way to review summative growth over the course of the program, thus allowing for faculty to be able to monitor students’ developmental progress.

In addition to portfolios, Yager and Tovar-Blank (2007) also recommended following S. L. Smith, Myers, and Hensley’s (2002) recommendations of integrating wellness into counseling curriculum. Although Smith et al. (2002) recommended this wellness integration into a career course, Yager and Tovar-Blank (2007) stated that the
concept could be incorporated into any counseling course. Smith et al. begin the wellness integration by students completing the Wellness Evaluation of Lifestyle (WEL) Inventory that measures the dimensions described in the Wheel of Wellness, previously described (Hattie et al., 2004). After completion of the WEL, the scores are interpreted in class. The students then explore how they feel about their scores, and select scores which they want to improve and activities to improve these scores. Over the course of the semester the plans are reviewed and evaluated.

Witmer and Granello (2005) also supported the integration of wellness education into the counseling curriculum and shared three possible methods of wellness education integration. They suggested either one specific course focused on wellness, infusing the wellness education into all courses, or incorporating the wellness education into every aspect of the program including curricular and co-curricular.

Finally, Yager and Tovar-Blank (2007) suggested active involvement with Chi Sigma Iota Chapters to encourage a focus on self-care and wellness of counseling students as an innovative way to incorporate self-care education into the curriculum. Yager and Tovar-Blank shared that creating mentoring relationships with a focus on self-care in Chi Sigma Iota Chapters may be an innovative way to incorporate self-care education. Consequently, Myers, Mobley, and Booth (2003) explained the importance and value of self-care education being incorporated into co-curricular activities, such as Chi Sigma Iota events, as well as curricular activities. Myers, Borders, Kress, and Shoffner (2005) explained that co-curricular events allow for “meaningful and relevant learning experiences” (pp. 91-92) that may not be able to be incorporated into typical
courses. Additionally, the authors explained that co-curricular activities can “facilitate professionalism and advocacy, create community and collaboration, and promote professional involvement and leadership development” (Myers et al., 2005, p. 92). Myers et al. (2003) further explained by encouraging self-exploration, learning, and personal growth through co-curricular activities wellness may be enhanced.

Furthermore, Witmer and Young (1996) believed that it was important that faculty provide a model of ways that students can engage in self-care strategies and prevent impairment. Thus, the environments in which the students are developing their professional identity are characterized by a focus on the importance of self-care. Likewise, Myers et al. (2003) attributed the wellness levels of the participants in their study to possibly the modeling of wellness behaviors by faculty or students. In addition to faculty, modeling self-care strategies and impairment prevention, supervisors may also be influential. Williams et al. (2012) reported that it is beneficial for students to hear supervisors’ personal experiences with self-care strategies.

So, the question becomes: how are CACREP accredited institutions doing in regards to incorporating self-care education into the curriculum? Roach and Young (2007) conducted a study exploring how counseling students perceived self-care education in their curriculum. Of the 204 participants, only two stated that they did not feel as if self-care education was incorporated enough. The other participants stated that they received self-care education in specific courses and specific activities in courses, learning about the importance of knowing yourself before helping someone else, through role plays, group work, and other assignments and in-class activities. This research also
demonstrated that the counseling students who participated scored higher on the 5F-WEL than the 5F-WEL norm group in all areas except the physical domain. The 5F-WEL is an instrument that measures levels of wellness on five domains (creative, coping, social, essential, and physical) in the Indivisible Self Model described earlier (Myers, Luecht, & Sweeney, 2004). Thus, the counselor educators have an opportunity to further develop the students’ wellness level. However, the results from this research did not suggest that the students’ wellness levels improved. One reason for this could be that the students reported that they gained the knowledge associated with impairment prevention and wellness education but did not learn how to implement the knowledge and skills.

An area not mentioned by participants in Roach and Young’s study (2007) was having an entire course focused on self-care education. Radey and Figley (2007) shared that the counseling profession is not the only profession experiencing this lack of courses in self-care. The Council for Social Work Education requires 180 hours of internship placement in addition to many other requirements; however, they do not require a course on impairment prevention or self-care.

Schure et al. (2008) conducted a study implementing a 15-week course in which students choose either quigong, hatha yoga, or meditation as a medium to increase self-awareness and increase concentration on the self. The participants then had to reflect both verbally and through journaling their responses to the course. The participants reported that they not only learned a lot about themselves but also became more comfortable with silence, had a changed perspective on the counseling process, such as
the importance of both physical and spiritual components in overall well-being, and were more patient with the counseling process.

**Summary**

With the recent mandated integration of self-care education into the curriculum, it was necessary to determine how self-care was conceptualized in the counselor education programs as well as how self-care education should be incorporated into the curriculum. This research gleaned insight into the understanding of how self-care is conceptualized and how to integrate the self-care education into the curriculum in addition to contributing to the general body of literature on self-care and more specifically to the body of literature on self-care in the counseling and counselor education professions.
CHAPTER II
METHODOLOGY

Counselors must take care of themselves to be able to work effectively with their clients (Rothschild & Rand, 2006; Skovholt, 2001). In addition to ineffective work with clients, lack of engagement in self-care can lead to burnout (Venart et al., 2007), impairment (Lawson et al., 2007; Venart et al., 2007), vicarious trauma (Pearlman, 1999), and compassion fatigue (Figley, 2002a). In order to prevent these potential consequences, researchers demonstrated support for the integration of self-care education into the curriculum for counselors-in-training (Roach & Young, 2007; Schure et al., 2008; Witmer & Young, 1996; Yager & Tovar-Blank, 2007). Thus, the research question addressed by this research was how the Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited Clinical Mental Health Counseling programs conceptualize self-care and integrate self-care education into the curriculum.

In this chapter, the methods used to answer this question are described as well as the rationale for the selected methods. Qualitative research, case studies, and multiple case studies are described in this chapter. Additionally, the research question along with the methodology used in the research are explained including: recruitment of cases, researcher experiences and assumptions with self-care and self-care education, researcher role and ethics, procedures and data sources, data analysis, trustworthiness, and delimitations.
Qualitative Research

The word qualitative refers to a focus on processes and meanings that are not measured by intensity, quantity, or frequency as quantitative references (Denzin & Lincoln, 2005). In qualitative research, the focus is on how others construct their realities or experiences and what meanings are assigned to these constructions (Denzin & Lincoln, 2005; Merriam, 1998).

During qualitative research, the researcher is the primary instrument for data collection and analysis in which the researcher goes into the field to observe in a natural setting (Merriam, 1998). In qualitative research, there are multiple themes and perspectives gained by the participants’ narratives and the researcher encouraging the participants to provide more details and elaboration on their narratives (Creswell, 2007).

Sampling in qualitative research is purposeful in that the participants are selected carefully so that the participants are individuals who can contribute to the phenomenon being studied (Creswell, 2007). In addition to studying the individuals selected in the purposeful sampling, it is important to gather additional information about the individual being studied (Creswell, 2007). In order to find an essence (Merriam, 1998) or to make sense of the phenomena (Denzin & Lincoln, 2005), qualitative researchers may collect a variety of materials such as case studies, introspections, interviews, and artifacts that are assigned meaning by individuals in the study.

The researcher then engages in interpretive inquiry to gain a better understanding of the issue (Creswell, 2007). Interpretive research is one of three orientations of research in addition to positivist and critical research (Merriam, 1998) and is the
orientation used in the current research. In positivist research, information is gained through scientific or experimental methodologies and is quantifiable (Merriam, 1998). Additionally, in positivist research, reality is perceived as stable (Merriam, 1998). In critical research, the focus is on the social and cultural structure of a phenomenon (Merriam, 1998). In interpretive research, the goal is to understand a lived experience through modes of inquiry driven by theory and inductive method, rather than a deductive method (Merriam, 1998). Despite gaining a deeper understanding, it is understood that each interpretive practice may assign a different meaning (Denzin & Lincoln, 2005). Thus, oftentimes in one study there are multiple interpretive practices used (Denzin & Lincoln, 2005) and there are multiple realities created by the interviewees (Merriam, 1998).

Due to the current researcher exploring how CACREP accredited Clinical Mental Health Counseling programs conceptualize self-care and integrate self-care education into the curriculum, the researcher selected qualitative research for the current research. The researcher used a multiple case study design, which is one of the five approaches to qualitative research and one of the preferred research methods when answering a “how” question (Yin, 2009). Yin recommended using a case study when examining a program or an implementation process that describes the current research, which examined counseling programs and implementation of self-care education into the curriculum. The other qualitative approaches include narrative research, phenomenology, grounded theory, and ethnography (Creswell, 2007).
Case Study

Case studies differ from other methodologies because a case study is not a specific methodology (Hesse-Biber & Leavy, 2011; Stake, 2000, 2005). Choosing to do a case study is not a methodological decision but is a decision of what is to be studied (Stake, 2000, 2005). There are three distinct case studies including: intrinsic, instrumental, and collective. The intrinsic case study occurs when the case study itself is the focus of interest; whereas, the instrumental case study occurs when the researcher learns about an issue or concern through the case study. Finally, the collective case study (Merriam, 1998) or multiple case study (Stake, 2000) functions the same as an instrumental case study but expands to multiple cases rather than one single case. The case does not operate in isolation but is part of a complex system including physical, economical, and ethical contexts (Stake, 2000). A holistic case study examines these complexities by paying attention to the different dimensions and nuances within the case (Hesse-Biber & Leavy, 2011).

Multiple Case Study

The present research was a multiple case study also referred to as a collective case study (Merriam, 1998). Each counselor educator in the present research represented a counseling program, which is an individual case, and the multiple counseling programs create a multiple case study. Thus, each counselor educator is not a case, but instead representatives of the cases which are the programs. Typically within case studies extensive forms are used as sources of information such as documents, interviews,
observation, and physical artifacts (Creswell, 2007; Yin, 2009). The researcher used the following data sources to examine the cases as discussed in the following paragraph:

1. interviews
2. questionnaires
3. syllabi
4. program provided campus resources for students
5. practicum and internship handbooks

The researcher conducted interviews, as well as provided questionnaires to faculty identified by the representative of the counselor education program as teaching a course in which the CACREP self-care standard was met, and examined supporting documents such as: syllabi, program provided campus resources for students, and practicum and internship handbooks. The interviews, one of the most frequently used sources of information in case studies (Yin, 2009), determined nuances of how each program conceptualized and integrated self-care into the program. The syllabi were reviewed to determine the specific self-care content integrated into the courses and how and when self-care education was integrated into the courses. The campus resources were reviewed to explore different self-care opportunities available on campus for students. The internship and practicum handbooks were reviewed to see if and how self-care was described within these courses that students take at the end of their program. The use of multiple sources of information is encouraged in case studies (Creswell, 2007). The researcher studied counselor educators’ conceptualization of self-care, the content of
self-care education, as well as the process of integrating self-care education into the curriculum.

An important feature of case studies is that the cases are bound (Yin, 2009). Binding cases means setting boundaries around cases as to what defines a case (Creswell, 2007). For the present study, the cases, which were the counseling programs, were bound by the following criteria: being a Clinical Mental Health Counseling program and being CACREP accredited under the 2009 standards. The interviewees served as a representative for the program, which is identified as the case for the present study. Based on the 2009 standards, Clinical Mental Health Counseling programs were selected due to the CACREP standards requiring the integration of self-care into the curriculum specifically for this program. The potential interviewees were representatives of CACREP accredited programs as it was necessary for the programs to adhere to the CACREP standards for the researcher to explore how the programs were implementing the required standards. Figure 1 is a flow chart demonstrating the process used for the present research.

**Recruitment**

Approval was obtained from the Kent State University Institutional Review Board (see Appendix B for IRB approval from the Kent State University Institutional Review Board) prior to approaching potential representatives of counselor education programs in the study. Once approval was granted, purposeful sampling was begun by selecting CACREP accredited Clinical Mental Health Counseling programs (Merriam, 1998). The researcher began the recruitment process by contacting Dr. Robert Urofsky (Director of
Figure 1. Recruitment and Data Analysis
Accreditation at Council for Accreditation of Counseling and Related Educational Programs, Alexandria, VA) to obtain a list of Clinical Mental Health Counseling programs that have been awarded accreditation for the 2009 standards. The researcher then determined the CACREP liaison and contact information for each of the Clinical Mental Health Counseling programs awarded accreditation for the 2009 standards by finding the universities in the CACREP Directory (2011f). The researcher then checked the CACREP liaison’s university website to determine if the liaison also fulfilled the role of academic unit leader for the program. CACREP (2009) defined an academic unit leader as a faculty member who is clearly designated with the following:

1. is responsible for the coordination of the counseling program(s);
2. receives inquiries regarding the overall academic unit;
3. makes recommendations regarding the development of and expenditures from the budget;
4. provides or delegates year-round leadership to the operation of the program(s);
   and
5. has release time from faculty member responsibilities to administer the academic unit. (p. 7)

If the individual fulfilled both the CACREP liaison and academic unit leader role of the Clinical Mental Health Counseling programs awarded accreditation for the 2009 standards, the researcher then sent a letter and informed consent form as well as the audio/video consent form to the individuals with a preaddressed and stamped envelope to determine if they were interested in participating in the research (see Appendix C for
Through this letter the researcher determined if the interested faculty member was an academic unit leader. A further explanation of the recruitment process is explained below.

The rationale for the representatives of counselor education programs fulfilling the role of counselor educator at a CACREP accredited university was due to the CACREP 2009 standards mandated integration of self-care education being the impetus for the current research. In addition, the representatives of counselor education programs must fulfill the roles of academic unit leader and CACREP liaison so the counselor educators have the perspective of working directly in the university setting as a counselor educator and are familiar with the curriculum of the program as well as experience working with the CACREP board and the standards in the role of CACREP liaison. Individuals not meeting the criteria were excluded from the study.

As previously stated, the researcher sent the initial invitation to participate via postal mail including the informed consent form and audio/video consent form and followed with a supportive e-mail a few days later (second contact; Millar & Dillman, 2011). A week later a third contact was sent reminding those who had not yet responded (Millar & Dillman, 2011). Two and a half weeks later a fourth contact was made via postal mail and included a replacement copy of the informed consent form which was followed by a fifth and final prompt sent via e-mail approximately three to five days after the fourth contact (Millar & Dillman, 2011).

This recruitment method led to one participant declining to participate and no additional responses from any of the other potential participants who were contacted.
Thus, the researcher then worked with faculty advisors to make changes to the recruitment process. The researcher then removed the inclusionary criteria of participants being an academic unit leader and Program Coordinator to increase the number of potential participants and also included programs with two year 2009 CACREP accreditation in addition to the eight year accredited programs. The researcher contacted Dr. Robert Urofsky again and requested a list of all 2009 accredited programs (both with two year and eight year accreditation). After the researcher received the updated list of programs, the researcher worked with her advisors and established a list of potential participants at CACREP accredited institutions and contacted the participants via telephone. Each potential participant was contacted via telephone twice unless they responded after the first telephone call (See Appendix L for transcript for telephone calls) and then if there was no response, an email (See Appendix M for email sent) was sent to the participant inviting the participant to participate in the research. (A maximum of two e-mails were sent and then the participants were no longer contacted to participate in the research.) The researcher received IRB approval for each of these amendments prior to the implementation.

Once a participant agreed to participate and had signed and returned the informed consent forms, the first interview was scheduled. (Participants were given the option of completing the interview via Skype or telephone call and all three participants selected a telephone interview.) During the first interview the participant was asked to identify a faculty member in his or her program who teaches a course in which the self-care integration standard is met. The researcher then contacted these identified individuals by the method indicated as best by the participant recommending that individual. The
researcher then sent the informed consents via e-mail or postal mail per the participant requests. Once the informed consent was returned to the researcher, the questionnaire was sent to the identified faculty member for completion and returned via e-mail. (Each identified faculty member was provided the option of receiving the informed consent form via e-mail or postal mail depending on the individual’s preference.) Program A and Program C’s identified faculty member responded and completed the questionnaire. The identified faculty member for Program B did not respond or complete the questionnaire. Therefore, only two identified faculty members participated.

Cases

Each counselor educator interviewed in the present research is referenced as a representative to the case. The participant alone does not serve a case but as a representative to the case. In this section the cases are described in general and then the components of each case are described in detail.

The representative grid (See Table 1) provides the demographics for the participants of the study. Each representative selected a pseudonym to be used to maintain confidentiality. Additionally, the researcher refers to each program as Program A, Program B, or Program C to further protect the identity of the representatives and the programs they represented.

Three representatives in total were interviewed including two female representatives and one male representative. The representative represented each level of faculty rank. One representative was an Assistant Professor, one an Associate Professor, and one Full Professor. All three representatives identified as Caucasian. Additionally,
all three representatives reported that they had earned doctoral degrees in Counselor Education from CACREP accredited institutions.

Each representative served as a representative to the affiliated counseling program, which was the case for the present research. Please see Table 2 for the relationship between each representative and the program.

Table 2

Case Grid

<table>
<thead>
<tr>
<th>Representative</th>
<th>Program</th>
<th>Faculty member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheryl</td>
<td>Program A</td>
<td>Faculty member A</td>
</tr>
<tr>
<td>John</td>
<td>Program B</td>
<td>Faculty member did not respond</td>
</tr>
<tr>
<td>Ellen</td>
<td>Program C</td>
<td>Faculty member C</td>
</tr>
</tbody>
</table>

Case A. Case A included the representative for the Clinical Mental Health Counseling program, Cheryl; the questionnaire completed by the faculty member Cheryl
provided who teaches a course in which the self-care standard is integrated; practicum and internship handbooks; syllabi; and program recommended resources. The university for case A is a public university in the Southern region of the United States that considers itself a metropolitan university with approximately 11,000 students (Retrieved November 25, 2012, from university website). A metropolitan university is defined as a university with great involvement and leadership within the community, a focus on the needs of the residents, as well as a focus on public service and applied research (Retrieved November 25, 2012, from university website).

The university for Case A is a Master’s only program and offers a Master’s in Education with concentrations in Clinical Mental Health Counseling and School Counseling. The Clinical Mental Health Counseling program and the School Counseling program are part of The College of Health, Education, and Professional Studies (Retrieved November 25, 2012, from university website). The Clinical Mental Health Counseling program was originally the Community Counseling program and received CACREP accreditation in 2003 and received accreditation as a Clinical Mental Health Counseling program in January 2012 (CACREP, 2012). Additionally, the Master’s in Education with a concentration in School Counseling is also CACREP accredited (Retrieved November 25, 2012, from university website).

The Clinical Mental Health Counseling program is a 60 semester hour program that prepares students to obtain a state licensure as a Professional Counselor (Retrieved November 26, 2012, from university website).
Case B. Case B included the representative for the Clinical Mental Health Counseling program, John; syllabi which were not referenced as they did not provide contributory data for the current research; and program recommended resources. The questionnaire from the faculty member identified as teaching a course in which the standard is integrated was not included as the identified faculty member did not respond to the researcher’s multiple contacts.

The university represented in Case B is a public institution in the Eastern region of the United States with approximately 35,000 students on the main campus where the counseling programs are located (Retrieved November 26, 2012, from university website).

The university offers Master’s in Education with concentrations in Elementary School Counseling, Clinical Mental Health Counseling in Schools and Communities, Rehabilitation Counseling, Secondary School Counseling, and a Doctorate in Counselor Education and Supervision programs in the College of Education. The Clinical Mental Health Counseling in Schools and Communities program, the School Counseling program, and the doctoral program in Counselor Education and Supervision are CACREP accredited. The Clinical Mental Health Counseling in Schools and Communities program is a 60 credit hour master’s degree with the goal for students to be eligible for state licensure as a Professional Counselor and National certification as a Professional Counselor (Retrieved November 26, 2012, from university website).

Case C. Case C included the representative for the Clinical Mental Health Counseling program, Ellen; the questionnaire completed by the faculty member Ellen
provided who teaches a course in which the self-care standard is integrated; syllabi; and program recommended resources. The university represented in Case C is a public institution in the Midwest region of the United States with approximately 14,400 students (Retrieved November 26, 2012, from university website).

The university offers a Master’s in Science and a Master’s in Education in Clinical Mental Health Counseling and School counseling as well as a PhD in Human Development (Counselor Education track) through the School of Education. All three programs are CACREP accredited. The Clinical Mental Health Counseling program was originally a Community Counseling program and originally received CACREP accreditation in 1997 (CACREP, 2012). In July 2012, the program became a Clinical Mental Health Counseling program and received accreditation. The School Counseling program and the doctoral programs have been accredited since 1997 (CACREP, 2012). All three programs are accredited until 2020.

The Clinical Mental Health Counseling Program, which is the focus of the current research, is a 60 semester credit hour program that prepares students for national certification as well as state licensure as a Professional Counselor.

**Researcher Experiences and Assumptions With Self-Care and Self-Care Education**

The researcher is a Caucasian female and a Doctoral Candidate in the Counseling and Human Development Program at Kent State University. The researcher is also licensed as a Professional Clinical Counselor with supervisory designation in the state of Ohio. The researcher has had an interest in self-care and wellness since working in her CACREP accredited Community Counseling master’s program. Since her master’s
program, the researcher has presented on the topic of self-care and wellness at professional conferences, in master’s level courses, and for corporations and businesses through her current position in an employee assistance program. The researcher has also completed a study on how students in a counseling program experienced the integration of self-care education into the curriculum. The researcher has gained her interview skills through qualitative courses in the doctoral program as well as completing a previous study.

Due to the researcher’s potential biases, it is important that the researcher is aware of her own assumptions. The researcher makes the following assumptions regarding the conceptualization of self-care and the integration of self-care education into the curriculum.

1. Self-care education will not be incorporated into courses through lecture, discussion, assignments, or exams until the practicum and internship experiences.

2. Self-care will not be conceptualized as a lifestyle integrated into all components of the representatives’ lives but will be incorporated into only the professional or work aspects.

3. There will not be specified activities or lectures of how self-care education is integrated into courses but general topics incorporated in the syllabi or general lectures from the assigned textbook for the course.
4. Faculty members who personally engage in self-care will incorporate self-care education into the curriculum of their courses more than faculty members who do not personally engage in self-care.

5. Faculty who chose to participate in this research may possess characteristics different from those individuals who met criteria to participate in the present study but decided to not participate. Faculty who participate in this research may choose to participate in the study because they value self-care more in comparison to faculty who choose not to participate.

6. Faculty will choose faculty members who best represent the best practice of self-care integration into the program to complete the questionnaire.

7. The researcher assumed the definition of self-care would be strategies individuals used to maintain their overall wellness.

To enhance the researcher’s awareness of personal biases, prior to beginning data collection and during data analysis and assumptions, the researcher engaged in reflexive writing to ensure that her own biases did not impact the research. The researcher is aware that although self-care is a passion for her it may not be a passion for others. For this reason it was important to ensure these opinions did not influence representatives from the program or faculty filling out questionnaires in any way during communication and interviews.

**Researcher Role and Ethics**

The researcher was sure to adhere to the ACA Code of Ethics when conducting this research. The researcher first gained approval from the Kent State University
Institutional Review Board. After receiving approval, the researcher then provided the representatives with an informed consent explaining the benefits and risks of the study and explaining that they are free to withdraw from the study without penalty or consequence at any time. To maintain confidentiality and anonymity, the researcher allowed each representative to select a pseudonym that was used during the entire research process and in any publications or presentations after the research. The programs were also given pseudonyms by the researcher (i.e., Program A, Program B, etc.).

**Procedures and Data Sources**

This research included six primary data sources including a demographic form, documents (syllabi, practicum and internship handbooks, and recommended resources on campus), interviews, and a questionnaire, as multiple data sources are typically used in a case study (Creswell, 2007; Swanborn, 2010). Each of these data sources is described below.

**Demographic Form**

All representatives completed a brief demographic form (see Appendix G for the Brief Demographic Form). The form was used to collect background information about each of the representatives of the counseling education program and the counseling program they represented. The demographic form included information such as name, age, gender, ethnicity, race, rank of professor, years as a counselor educator, number of years at current institution, and the representatives’ perceived level of involvement in the integration of the self-care standard into the curriculum. In addition, the demographic
form also included information specific to the program including the number of students in the program.

**Documents**

In addition to the demographic form, the researcher also collected and reviewed additional documents including items such as: syllabi, practicum and internship handbooks, and program recommended campus resources for students. The recommended campus resources were information the program provided to the students regarding personal counseling services in the community provided by professionals other than faculty members (CACREP, 2009, Section 1G). The documents were collected after the individual had been identified as a representative but prior to beginning interviews. Representatives were requested to provide the documents via e-mail. If the representative was unable to send the documents via e-mail then the researcher sent a pre-addressed stamped envelope to the representative in which to return the documents.

**Interviews**

After completing the demographic form, each program representative completed interviews with the researcher. However, prior to beginning the interview process, it was important to build a rapport with the representatives to create an environment in which they feel safe to communicate openly. In order to facilitate open communication, the researcher began by sharing professional background information about the researcher and engaging in professional dialogue. In order to build this rapport with the representatives, the researcher contacted the representatives via e-mail to collect necessary documentation and to begin communication between the researcher and the
representatives. Within the e-mail communications, the participants were given the option of interviewing via Skype or over the telephone. The researcher used both an open-ended style (Moustakas, 1994) and conversational style interview (Rubin & Rubin, 2005) as the researcher views the interviewee’s active role in the research process as invaluable.

During the interview the researcher asked two main questions:

1. How does your program conceptualize self-care?
2. How is your program integrating self-care education into the curriculum?

The researcher then allowed the representative to answer, and continued the interview by having the representatives describe their conceptualizations and program integration. Although the researcher allowed the representatives to guide the interview, the researcher had structured questions prepared if more structure was required to obtain additional information. It is important to note that due to the nature of differences among programs, there may have been nuances of the programs that were not evident until the data were beginning to be gathered, which may have necessitated additional questions in the interview.

The following are examples of more structured questions that were used only when more structure was necessary in the interview:

1. What does your program explain to students about self-care?
2. Do you try to monitor students’ integration of self-care as they progress throughout the program?
3. Is self-care integration a component of retention?
4. Does your program explore how students engage in self-care during the interview process?

5. At what point in the curriculum is self-care introduced?

6. In what courses is self-care incorporated into the curriculum?

7. Which mediums are used to incorporate self-care? (lecture, anecdotal, group activities)

8. Is self-care incorporated in other aspects of your program besides courses? (i.e., CSI [Chi Sigma Iota] events, etc.)

9. Do you feel that self-care is modeled in the program by faculty?

10. If so, how specifically do you feel it is modeled?

11. Do you have a specific course where self-care is integrated?

12. Is self-care education infused throughout the program or focused in a specific course or portion of the program?

13. Who is responsible for self-care education in your program?

14. How do students respond to self-care education?

15. What is your role in self-care education?

16. If you have a direct role in the integration of self-care education into the curriculum, how has your experience been with the integration?

17. Are there other ways in which you feel self-care could be integrated into the curriculum in which they are not currently?

18. Do you believe that faculty members’ personal beliefs on self-care influence the way it is incorporated into the curriculum in their courses?
The interviews took place over the phone on speaker, due to the majority of representatives living out of state, and were digitally recorded so that the researcher could review the interviews at a later time for transcription and analysis. The representatives of the counseling education programs were provided the option of interviewing via telephone or Skype. (In both cases the interviews were audio recorded.) The researcher used a private office to conduct the interviews. The first interview was approximately 60 minutes long, the follow-up interview was approximately 20 minutes long, and follow-up e-mails were sent, if necessary. After each interview, the researcher provided the representatives with two pages of the transcripts, the analyses from that portion, and the interpretations of the interviewed portion to check for accuracy (Creswell, 2007). This technique is called a member check and is considered the “most crucial technique for establishing credibility” (Lincoln & Guba, 1985, p. 314). The researcher then made the necessary changes and adjustments provided by the representatives prior to completing the follow-up interview. After the member checks were complete and the necessary changes and adjustments made, the researcher contacted the representative to complete the second interview. In addition, a peer reviewer reviewed a portion of the transcript after the first and second interviews to check the categories and themes found by the researcher. Follow-up e-mails were sent after the second interviews were completed, analyzed, and interpreted, if saturation had not occurred. Saturation occurs when the researcher does not find any additional information (Creswell, 2007).

Throughout the process of data collection, the researcher maintained a diary in which the researcher logged all steps of the research process (Swanborn, 2010). The
diary allowed for the researcher to engage in a consistent way with each representative and allowed the researcher to demonstrate the steps in allowing the researcher to come to her conclusions from the data (Swanborn, 2010).

The researcher completed the transcription to allow a closer review of the data. Initially, the researcher planned on the Kent State University Bureau of Research and Training Services for transcription and included this in the informed consent but then decided to complete transcription herself.

**Questionnaire**

As previously explained, in addition to completing interviews, the counselor educators representing the counseling programs were asked to identify a faculty member who taught a course in which the CACREP standard mandating the integration of self-care education was met through the course. The researcher then followed the previously explained procedures to recruit the identified faculty members to complete the questionnaire.

**Data Analysis**

As is true for all qualitative research, collection and analysis of data occur simultaneously (Baxter & Jack, 2008; Casey & Houghton, 2010). The researcher was reflecting on the data as they were being collected prior to beginning data analysis (Hesse-Biber & Leavy, 2011). The researcher wrote reflective memos for each interview focusing on what the interview meant in relation to the questions being asked. The researcher documented thoughts, reflections of the interview, and potential self-care categories after each interview to be reviewed at a later time. Furthermore, for data
analysis the researcher used a holistic analysis of the entire case (Yin, 2009). To complete a holistic analysis, the researcher integrated all of the data sources rather than focusing on each individual piece of information independently (Baxter & Jack, 2008).

In order to begin analysis, the researcher reviewed the interview transcriptions, documents, the questionnaire completed by the identified faculty member, and previous reflection memos and identified units of data in each case which were labeled by making marginal notes (Merriam, 1998), using color coding, and underlining (Stake, 2006). A unit of data is a piece of data that is meaningful or is potentially meaningful and can be as small as one word or several pages of notes (Merriam, 1998) and will ultimately serve as a basis for defining the categories (Lincoln & Guba, 1985). The researcher used different colored markers to categorize and color code similar units of data (Merriam, 1998).

When constructing a unit of data, there are two important criteria to which the researcher was cognizant. The first is that the unit of data is heuristic, meaning there is a focus on the understanding or action that the researcher must have or take (Lincoln & Guba, 1985). Second, the unit of data must be the smallest piece of information that can stand by itself (Lincoln & Guba, 1985).

The researcher then assigned a meaning unit to each unit of data. The meaning unit was a label or a code for the unit of data. Once a meaning is assigned to the units of data, the researcher reviewed the data and constantly compared the data to be able to place into categories with similar meanings (Merriam, 1998). Once the meaning units were placed into categories, the researcher named the categories to reflect what was seen in the data. Once these categories were named, the researcher continually reviewed the
categories to ascertain the data was in the correct category. To ensure efficacy of categories the researcher ensured that the categories (a) reflected the purpose of the research, (b) were exhaustive, (c) were mutually exclusive, (d) were sensitive to what the data in the categories, and (e) were conceptually congruent (Merriam, 1998).

Once coding was complete, a sample of the transcript and transcript analysis (including units of data, meaning units, and categories) was sent to the interviewee for member checks. The feedback from the interviewee was incorporated into the data analysis process if the feedback changed the analysis or provided further explanation. In addition, a sample of the transcript and transcript analysis (including units of data, meaning units, and categories) was sent to the peer reviewer for feedback. (The peer reviewer is described later in the trustworthiness section.) The researcher completed the individual case analysis prior to beginning the cross case analysis (Stake, 2006).

After completing and coding categories for each case using the methods previously described, the researcher reviewed the categories for each case and compared similarities and differences with the other cases to develop overarching themes between the cases (Merriam, 1998). The cross case analysis allowed the researcher to explore if the categories were similar across all cases or if one case reported a unique experience. The researcher then explored how each theme related to the research question.

The researcher then completed a 20-minute (approximate) telephone interview with the representative. (The representative was given the option to complete the interview via Skype or an audio recorded telephone call.) The researcher then repeated the same data analysis steps for the 20-minute follow-up interview as was completed for
the 60-minute interview. Additionally, the researcher sent a follow-up e-mail after the analysis of the 20-minute interview, if necessary, for clarification. An e-mail was sent if the researcher had additional questions for the interviewee to elaborate further on responses from either interview. If a follow-up e-mail was necessary, the researcher would then use the same data analysis steps that were used for the interviews and other documents.

After analysis of the interview transcriptions, documents, questionnaires completed by the identified faculty member, follow up e-mails, and other documents were complete, the researcher then reviewed the related literature and connected the information learned through the sources listed above with the literature.

**Trustworthiness**

To ensure the credibility of the research, the researcher engaged in memo writing (Rubin & Rubin, 2005) prior to beginning research and throughout research as a strategy for Epoche. Epoche is the process in which the researcher sets aside his or her own judgments and biases to examine the research from a non-biased perspective (Moustakas, 1994). The researcher wrote these self-reflective memos (Creswell, 2007) to ensure awareness of personal experiences with the data and personal reactions to the interviewees’ responses. This reflective memo writing was different from the diary (Swanborn, 2010) that was also kept throughout the data collection and analysis processes to log the actions taken by the researcher. The reflective writing allowed for the researcher to process her personal experiences with the topic and interviews and consider if her biases were impacting the process. This process of reflexivity through
writing is important as even unconscious feelings about the topic may influence the researcher’s process (Hesse-Biber & Leavy, 2011).

The researcher also engaged in triangulation (Lincoln & Guba, 1985), which is when the researcher uses multiple sources of information to ensure credibility (Creswell, 2007). The researcher used the literature, collected documents, questionnaires, and interviews for this research as Swanborn (2010) recommended using specific data sources in triangulation.

In addition, the researcher engaged in peer debriefing (Creswell, 2007), which is discussing with colleagues topics such as methodology, analyses, and processing any emotions or thoughts regarding the research to ensure that it did not influence the research. The peer reviewer was an individual with a doctorate and experience in qualitative research. The peer reviewer reviewed portions of the transcripts and analysis of the first interviews and provided feedback as well as after the second interviews. After the first interview, the peer reviewer examined the meaning units and categories gleaned from the transcripts. The peer reviewer was also consulted after the second interviews for the same reasons as for the first interview. In addition to consulting with the peer reviewer during the interview process, the peer reviewer was also consulted to ensure that the researcher’s biases did not impact the interview process as well as the data analysis process.

Finally, and most crucial (Lincoln & Guba, 1985) in regards to trustworthiness, the researcher engaged in member checking (Lincoln & Guba, 1985). Each representative was provided two pages of transcript from their initial interview and asked
to review for accuracy and clarity, and to indicate areas that were not clear to the participant. Each representative was also provided two pages of his or her transcript from the second interview to review for accuracy and clarity, and to indicate areas which were not clear to the representative.

**Delimitations**

Due to the requirement of self-care integration being new to the CACREP 2009 standards, programs may be new at integrating this requirement and may still be in the process of clarifying how they want to integrate self-care into the curriculum. An additional delimitation is that the requirement of self-care strategies being integrated into the curriculum is one small piece of the CACREP 2009 standards and thus may not receive as much attention as other areas. Furthermore, the researcher examined only CACREP accredited programs that have been awarded accreditation under the 2009 standards. Programs that are not CACREP accredited or programs that have not yet been awarded accreditation under the 2009 standards may have different or additional experiences regarding self-care conceptualization and the integration of self-care education into the curriculum. Additionally, because only 2009 accredited programs were used in this research this was a very small population to draw from as the standards are new and many programs will not be up for reaccreditation during the time data was being collected. Thus this led to a smaller sample size.

**Summary**

Chapter 2 described the multiple case study as an appropriate method of inquiry regarding the conceptualization of self-care and integration of self-care education into the
counseling curriculum. Participants were three counselor educators serving the roles of both CACREP liaison and academic unit leader at a CACREP accredited institution that was awarded accreditation under the 2009 Standards and two faculty members identified by the counselor educator as teaching a course in which the CACREP standard related to the integration of self-care education was incorporated. Each counselor educator representing the accredited program participated in two interviews, the first lasting approximately 60 minutes and the second lasting approximately 20 minutes. The researcher engaged in procedures to ensure trustworthiness throughout the research process (e.g., member checks, peer reviewer, reflective memo writing). Data analysis was consistent with methods for multiple case studies.
CHAPTER III

RESULTS

In this chapter, the analysis from the interviews with counselor educators who are representatives for each case, the counseling programs, as well as the questionnaires completed by faculty members identified by the representatives as teaching a course in which the self-care standard is integrated, and the collected documents that contribute to the answers for the following two questions are reported.

1. How does your program conceptualize self-care?

2. How is your program integrating self-care education into the curriculum?

Additionally, the categories and themes that emerged from analysis of the interviews, member checks, peer reviews, and collected documents are described.

As a result of a limited number of programs currently accredited under the 2009 CACREP standards, the researcher had only three participants. The researcher acknowledges that three participants are fewer than may be included in a multiple case study but after multiple recruitment attempts, three participants were the most that could be recruited.

In the following discussion of the results, the counselor educators are referenced as program representatives as each counselor educator is a representative of a case, the program. Each counselor educator does not represent a case as an individual but instead each program is a case and the counselor educator serves as a representative for each case. Following is a detailed explanation of the individuals and sources that comprise each case for this study and how wellness is integrated overall in the program.
Case A

Case A included the representative for the Clinical Mental Health Counseling program, Cheryl; the questionnaire completed by the faculty member Cheryl provided who teaches a course in which the self-care standard is integrated; practicum and internship handbooks; syllabi; student handbook from university website; and program recommended resources provided by the representative.

In addition to the integration of self-care education into the Clinical Mental Health Counseling program curriculum, the concept of wellness is also incorporated into other areas of the program. The focus on student well-being in this program is evident from the beginning of a student’s engagement with the program.

The emphasis on student well-being is demonstrated in the student handbook, which is available on-line, where there is a focus on not only the academic expectations of students but also the non-academic expectations relating to students’ well-being and personal growth and development. In the student handbook it is explained that students should “be committed to personal growth and professional development” (Student Handbook, 2011, p. 23) and “demonstrate emotional and mental fitness in their interactions with others” (p. 23). Furthermore, there is constant evaluation of students’ abilities to perform the roles of a counselor, and faculty meet on a regular basis to discuss students’ abilities to perform these roles. Faculty assess students using the “Professional Fitness Review Form” which is included in the Appendix of the student handbook. This form includes five areas on which students are assessed: “professional responsibility, competence, comportment, integrity, and performance in coursework” (p. 45). An
example provided in the student handbook as potential problematic behavior is “interpersonal behaviors and interpersonal functioning that impairs one’s professional functioning” (p. 14). When potential problematic behavior is noticed, the faculty engage the students and facilitate students getting the support that they need to be successful (Student Handbook, 2011). If these attempts are unsuccessful faculty may require extra supervision, clinical experience, or course work, recommend withdrawal from the program, or formal probation or termination from the program (pp. 14-15).

Although there is an evident focus on wellness in the program, the current research explored specifically how self-care is conceptualized in the program and how self-care education was integrated into the curriculum. Below the emerging categories for the two research questions are explained.

**Research Question One**

After analysis of the interviews, questionnaire, and associated documents, the categories of ambiguity and prevention and early intervention emerged for Case A for research question one, which explores how self-care is conceptualized in the program.

**Ambiguity.** Ambiguity was the first category that emerged for Cheryl (representative for Case A) when discussing self-care conceptualization. Cheryl’s initial response to the request to conceptualize self-care included “Wow. I don’t know” (Cheryl, II, 40).

When asked if self-care and wellness were the same concept or two different concepts, Cheryl explained that “maybe wellness is a part of self-care” (Cheryl, II, 36). The participant then described self-care as being holistic and including areas such as
spiritual, physical, and social, with an emphasis on putting self first, taking time for self, and taking care of oneself.

Despite the representative’s difficulty in providing a conceptualization of self-care in the Practicum and Internship Handbook, wellness is discussed in the context of Myers and Sweeney’s (2005, 2008) wellness model, which demonstrates further ambiguity as the representative used the terms self-care and wellness interchangeably.

In Case A’s Practicum and Internship Handbook, the wellness plan that fulfills CACREP’s requirement for the integration of self-care education into the curriculum and that all students must complete is a holistic wellness plan with a “bio-psycho-social-spiritual perspective” (Counseling Program Practicum and Internship Resource Handbook, 2011, p. 7). More specifically, the students are required to include the following areas into their wellness plan “physical health and nutrition, leisure, relationships, school/work pursuits, and spirituality” (Counseling Program Practicum and Internship Resource Handbook, 2011, p. 8). These concepts are similar to the concepts in Myers and Sweeney’s (2005, 2008) wellness model, which focuses on wellness and addresses self-care as a component of wellness.

Although the representative did not provide a specific conceptualization of self-care, the representative did mention the importance of a social aspect as well as a physical aspect of wellness when referencing Myers and Sweeney’s model (2005, 2008). (As previously mentioned, the representatives used the terms self-care and wellness interchangeably.)

In reference to the importance of the social component, Cheryl explained,
You know getting together with peers and that sort of thing. I don’t know if that is specifically on anyone’s wellness plan but I think that certainly contributes to people’s wellness. We usually have a back to school kind of kick off picnic and then there is usually some sort of mixer around the holidays and then usually one or two events during the spring semester as well. (Cheryl, I, 155)

Cheryl further elaborated, “CSI does host a few social events throughout the year which I think certainly could be part of people’s wellness plan” (Cheryl, I, 153).

Cheryl also shared that there tends to be a focus on the physical aspect of wellness in addition to the social aspect of wellness and that individuals who already incorporate a physical aspect into their lives may be able to integrate it more easily. Cheryl explained,

The people who implement [self-care] typically it’s in an area they are drawn to who tend to be kind of health nuts. There is a lot of hygiene there, kayaking, it’s a very outdoorsy community and certainly people who are already into that lifestyle are the ones that have the easiest time implementing it. (Cheryl, I, 287)

**Prevention and early intervention.** In addition to discussing self-care in the context of Myers and Sweeney’s (2005, 2008) wellness model, self-care was also discussed in terms of prevention and early intervention. Cheryl explained,

We talk about self-care in that very first class and how counselors have such a high rate of burnout and that it is really important to take care of yourself in that process and recognize when you’re not taking care of yourself. This is also linked to if you have a good wellness plan yourself you are more likely to identify that
with your client and when they are not taking care of themselves and whatever it is that is causing their problems. (Cheryl, I, 12)

Additionally, Cheryl also discussed how the program recommends students seek personal counseling, which could be a proactive step for many students. Although this was not a requirement for students in the program, the program provided a campus counseling center as an on campus resource for the students to use if interested in personal counseling. However, if students presented with concerns that were not addressed, personal counseling could then become a requirement.

Cheryl explained that personal counseling is offered on campus and this resource and other campus resources are easily accessible to students. Cheryl explained, “that information is in the student handbook” (Cheryl, I, 218). In addition, she explained that the resources can be found on the “student internal website on blackboard that has links to resources on the campus so that would have a link to the counseling center, and the writing lab” (Cheryl, I, 220).

**Research Question Two**

The second question addressed was how the program integrates self-care education into the curriculum. Cheryl discussed both curricular and co-curricular mediums for the integration of self-care education as well as faculty involvement in the integration of self-care education.

**Curricular integration.** Cheryl provided a very detailed account of how the information is integrated into the curriculum.
In that class [introduction course] there is a lecture. There are a total of four classes in our program where we would talk about self-care and the wellness model. And in that intro class it would be discussed through a lecture without any sort of call to action. (Cheryl, I, 16)

Cheryl continued that “the other course it would be introduced is our counseling skills course” (Cheryl, I, 18) “and so in the skills class the students are taught specifically about the wellness model and they are expected to develop a wellness model” (Cheryl, I, 24). Cheryl further explained,

In practicum, we are much more at that point they are actually counseling and that this is an integral part (Cheryl, I, 34). . . . So in the practicum class, they are expected to bring in their wellness plan that they developed when they were in the skills course or if they fine-tuned it since then to bring in whatever their current wellness plan is (Cheryl, I, 38). . . . and so we talk again about the importance of self-care and the wellness plan and they are asked to go and refine their wellness plan, thinking that now you have two and half years under your belt in this program and now you are carrying a bigger load because you are in practicum and you are going to now start hearing people’s problems and carrying that weight as well and so what are the things that you are going to do to take care of yourself.

(Cheryl, I, 40)

Cheryl explained that the fourth class that self-care education is integrated into is the internship. However, “there are only three official classes in our assessment plan, we say that we are looking at self-care and wellness in the skills class, the practicum class,
and the internship” (Cheryl, I, 50) “but we address it in the intro class as well” (Cheryl, I, 52).

The wellness plan that Cheryl discussed is created and amended throughout the course of the program and is based on the wellness model provided in the practicum and internship manual and student handbook. Furthermore, a rubric for grading the wellness plan is provided to students in advance to allow them to understand the expectations and how they will be graded. This rubric assesses the students’ goals in each of the five domains included in the wellness plan based on how well written the goals are and if the goals are clear, relevant, measurable, and bound to time (Counseling Program Practicum and Internship Resource Handbook, 2011, p. 9). The five domains are physical health and nutrition (also referenced as physiological), leisure (also referenced as psychological), relationships (also referenced as social), school/work pursuits (also referenced as vocational or professional), and spirituality (Counseling Program Practicum and Internship Resource Handbook, 2011). Students are expected to create goals in each of these domains for the present, within a year, and within five years (Counseling Program Practicum and Internship Resource Handbook, 2011).

In regards to how the self-care education information is specifically integrated into the courses discussed by Cheryl, the faculty member identified at Program A as teaching a course in which the self-care standard is integrated for CACREP by the representative shared in the provided questionnaire that self-care education is integrated throughout the entire course and is integrated through the following mediums: lecture, activities, discussion, and anecdotal examples. In addition, the faculty member shared
that the self-care content is incorporated in the class in a way that figures into the
student’s grade and is presented in a similar way to other course content.

When asked when the representative felt that the students were actually able to
grasp the concepts of self-care, the representative shared that the students were able to
grasp the concepts in the final classes of the programs such as practicum and internship
class due to the following reasons, as explained by Cheryl.

Now you have two and half years under your belt in this program and now you
are carrying a bigger load because you are in practicum and you are going to now
start hearing people’s problems and carrying that weight as well and so what are
the things that you are going to do to take care of yourself. I would say that this is
the place where they really start to figure out what are the realistic goals to set
because sometimes they come in and are setting goals that are not obtainable and
you know that. (Cheryl, I, 40)

**Co-curricular integration.** When asked if self-care was integrated into the
program beyond the curriculum, Cheryl shared that self-care education is integrated in
multiple different ways beyond integration into the courses. “Our university has a
wellness day” (Cheryl, I, 147) “and usually our CSI chapter has a tent where they go
down and participate in the wellness day” (Cheryl, I, 149). Cheryl elaborated that “we
usually have a back to school kind of kick off picnic and then there is usually some sort
of mixer around the holidays and then usually one or two things during the spring
semester as well” (Cheryl, I, 155).
**Faculty involvement and demonstration of importance.** In addition to incorporating self-care education into the curriculum and co-curricular activities for students as previously discussed, Cheryl shared that faculty also spent time discussing or exploring their own personal self-care. The involvement of the faculty may convey the importance of self-care and the value placed on self-care in the program. Cheryl explained that each faculty member has a personal wellness plan and that “we do bring our wellness plans in and talk with the students about what is on our wellness plan” (Cheryl, I, 58). Cheryl also explained that “it helps them see the importance of it and the realness of it. We are very real about our struggles with our wellness plan” (Cheryl, I, 65). Cheryl further elaborated that “

The biggest thing that has been helpful [in regards to integrating self-care into the curriculum] for us has been faculty buy in which didn’t happen overnight. But I think once the faculty all got on board and were willing to do their own wellness plan and were able to talk to the students about that I think that was when it was truly integrated. (Cheryl, I, 226)

In addition to faculty creating their own plans for wellness or self-care, participants reported that faculty took active roles in facilitating the development of wellness plans with students beyond what was integrated into the curriculum. As previously mentioned, one way that this may occur is by faculty recommending personal counseling which could be part of the wellness plan.

In summary, the following categories were evident after analysis for question one for Case A: ambiguity and prevention and early intervention. Specific to the second
question for Case A the following categories were evident after analysis: curricular integration, co-curricular integration, and faculty involvement and demonstration of importance. The findings from Case B are discussed in the following section.

**Case B**

Case B included the representative for the Clinical Mental Health Counseling program, John; syllabi; and program recommended resources. The questionnaire from the faculty member identified as teaching a course in which the standard is integrated was not included, as the identified faculty member did not respond to the researcher’s requests.

Program B does not have a practicum and internship handbook and does not have a student handbook posted on their website. Although the program’s mission statement does not include reference to students’ well-being it does focus on teaching students how to be effective clinicians to enhance client wellness (Retrieved November 28, 2012, from university website).

The emerging categories for the two research questions are explained below. The first research question explored how self-care was conceptualized in the program. The second research question explored how self-care education was integrated into the curriculum.

**Research Question One**

The categories of ambiguity and prevention and early intervention emerged for Case B for the first research question. These categories are discussed in detail below.
**Ambiguity.** Ambiguity was the first category that emerged for John (representative for Case B) when discussing self-care conceptualization. When asked how self-care was conceptualized in his program, after a long silence, John was able to provide the following definition for self-care: “Recognizing what you need and trying to do it to yourself” (John, II, 22), and he explained that due to the overlap between self-care and wellness, it can be difficult to operationally define.

When asked if there is a difference between self-care and wellness, John responded, “I don’t know. My first sense is that self-care is consciously taking care of yourself and wellness is kind of a thing you do” (John, II, 10). “But I don’t know that I know or could say there is a big difference there” (John, II, 12). John further explained,

> The definitions overlap and the research talks about them in different ways. I am sure in many of those ways they talk about self-care as wellness and wellness as self-care. So I think there is an overlap and I think wellness has a variety of ways it can be defined. One way is: are you well? Now that’s a state. (John, II, 72)

Wellness can be a process but it can also be specific things you do. And if you’re not doing them then maybe you need to do them as self-care but maybe doing those things is self-care. But I think if you wanted to try to define the terms you’d be saying that people do a wellness thing for themselves it is a self-caring thing. Are they doing consciously? Sometimes yes, sometimes no. But then sometimes we do self-care things specifically to overcome an illness or overcome a change or create more wellness. You know there are fine differences in here. (John, II, 74)
When discussing the small differences between self-care and wellness, John explained the reason he believed that CACREP chose to use the term self-care opposed to wellness in the standards, “My guess for CACREP would be if they were going to use one term they might use self-care because their criteria have become action criteria. I don’t know that wellness is a clear action criteria but self-care certainly is” (John, II, 86). John further explained,

I think if you looked at the literature and you saw self-care in the article you were reading I would expect that you would see more in the article about problems people are having than if you looked at the wellness articles where wellness was being the primary term. (John, II, 14)

John explained that “health” (John, II, 16) would be the key focus when wellness is the primary topic in the literature. When asked if his program uses a wellness model, John explained that although their program does not tie wellness directly to a specific model, “the most likely one you are to see would be the Sweeney Myers wellness model” (John, I, 34). John further elaborated that the physical components of the wellness model are evident with the students. When asked about which components of self-care John felt that students focused on, he elaborated, “They look for the physical components” (John, II, 36). “They look for the mental and emotional components and maybe third spiritual components” (John, II, 38). Additionally, John explained that the tangibility of the physical component may be the reason that the physical component is focused on; “You can feel it; you can see it” (John, II, 62). John elaborated,
There is also physical self-care in that keeping yourself strong enough so you can do the work here but also as a professional so you can give your clients the best each day and it all is not as easy as it sounds because there is personal involvement, commitment and highly emotional things going on. (John, I, 8)

**Prevention and early intervention.** Despite the ambiguity of the conceptualization of self-care, one part of this conceptualization that emerged was prevention and early intervention. John explained the importance of engaging in self-care as a preventative strategy,

The one direction is looking at [taking care] of yourself and you might as well start here in your program because you are going to have a lot of work, you are going to be asked to do some things as a counselor and a student in groups and working with individuals that are pretty personal that are going to tap into things that go on with you. You are going to need to be ready to deal with them and seek the sources of help that you need. (John, I, 8)

Additionally, John shared that the faculty use the time a student is in their program as an opportunity to help facilitate the students’ abilities to seek the needed sources. John explained, “if there is an issue that is seen by faculty we try to use conversation about this to prevent it from potentially going to a remedial problem” (John, I, 23). John elaborated, “There are remediation programs but we have lots of students who have a death in the family, they’re overly stressed out, they are finding out they have some emotional problems they have not dealt with. We work with them” (John, I, 24). John discussed how burnout can potentially lead to unethical behaviors and how the
program uses the opportunity to teach students how to be healthy to avoid burnout, “You really have to pay attention to both sides and the starting place is to keep yourself healthy and part of what you are doing in this program is learning how to keep yourself healthy” (John, I, 8).

One way the program for Case B encourages students to be preventative and to keep themselves healthy is by recommending students seek personal counseling, which could be a proactive step for many students. Although this was not a requirement for the program, the program provided a campus counseling center as an on campus resource for the students to use if interested in personal counseling. If students presented with concerns that were unable to be addressed by the student, personal counseling could then become a requirement. John shared

We encourage all of them [students] to seek out [counseling] services here on campus. If they [the concerns] are serious enough we might require it but that is fairly rare . . . So, I think we use all those kinds of things but it’s less rare that it is a part of an official remedial plan and more likely that it is some advising, some listening, and perhaps some encouraging to seek help here on campus. (John, I, 22)

**Research Question Two**

The second question addressed was how the program integrates self-care education into the curriculum. John discussed both curricular and co-curricular mediums for the integration of self-care education as well as faculty involvement and demonstration of importance.
Curricular integration. John explained that beginning in spring 2013 an “intro course to clinical mental health counseling” (John, I, 44) will be developed and implemented and this is the specific course where self-care will be integrated into the curriculum. Furthermore, John explained that although self-care will be integrated into a new course in spring 2013, it is currently infused throughout the program. When asked how specifically self-care is integrated, John explained that

I don’t think there is a specific medium. It certainly comes up but we don’t have a given here’s the stuff you have to say about it for faculty. We don’t have a video per se about it. But what we like to do is to get in touch with the kinds of things they are feeling and the frustrations they are having and it is those critical kinds of times that the talk of self-care needs to be reinforced opposed to just talking about it any given time. It’s when they are struggling with something, when they feel stressed those are the times they will say this is new to me this is something I need to pay attention to. So we try to integrate it when the situation arises. Certainly whenever you are talking about ethics it comes up as a piece of those issues. (John, I, 20)

John elaborated that practicum was one place where students could grasp the concept of self-care. He continued to explain it as one of

The places where the stresses of helping someone, doing things that they thought were going to be easy but they’re not, where you can make mistakes, where the pressure is increasing so those are the places where once you talk about it there...
they hear it in other places. But, it has a whole lot more meaning, personalized meaning to them at those places. (John, I, 144)

**Co-curricular integration.** When asked if self-care was integrated into the program beyond the curriculum, John shared “Our Chi Sigma Iota group regularly gets together or tries to get people together for both academic things and for social kinds of things” (John, I, 22). John explained,

Certainly I think another thing we do is try to connect them with each other and connect them with the current students so that those communications and involvement with others is feeling like a group and that they are not in competition with other people is a key part of what we try to encourage and promote. (John, I, 18)

John further elaborated,

And while social may or may not be considered exactly self-care it’s really about connecting them with other people and reducing the likelihood of people isolating themselves and identifying issues. So we do have a department picnic in the fall. And then what happens is we do all we can to encourage those cohorts to become collaborators in working with each other professionally and personally. They tend to find out within themselves when there is a problem with someone and work with them to the extent they are concerned about it. They then come to faculty and say we are concerned about so and so. So, I think there is a team, a collaboration part of the cohort that is a key piece in the self-care model. (John, I, 30)
**Faculty involvement and demonstration of importance.** In addition to incorporating self-care education into the curriculum and co-curricular activities for students as previously discussed, John shared that faculty also spent time discussing or exploring their own personal self-care. The involvement of the faculty may convey the importance of self-care and the value placed on self-care in the program. John explained that faculty sharing their investment in self-care is beneficial for students to see “when they get a sense of a real person they appreciate that a great deal and hear it and listen to it more” (John, I, 161).

In summary, the following categories were evident after analysis for question one for Case B: ambiguity and prevention and early intervention. Specific to the second question for Case B the following categories were evident after analysis: curricular integration, co-curricular integration, and faculty involvement and demonstration of importance. The findings from Case C are discussed in the following section.

**Case C**

Case C included the representative for the Clinical Mental Health Counseling program, Ellen; the questionnaire completed by the faculty member Ellen provided who teaches a course in which the self-care standard is integrated; syllabi; handbook on program website; and program recommended resources which include personal counseling resources for students.

Similar to Case A, the university represented in Case C also emphasized the importance of the counselor trainees’ well-being in the program. Although the program does not specify self-care strategies to be incorporated by students, there is an emphasis
on students’ well-being and how faculty monitors student well-being. The importance of student well-being as well as the monitoring process is outlined in the student handbook.

The students are expected to be “emotionally stable and well adjusted (personally and professionally)” (Retrieved November 27, 2012, from university website). Additionally, students are expected to continue personal growth and development throughout the course of the program (Retrieved November 27, 2012, from university website). Faculty monitors students’ personal development as well as academic development to ensure that the students are meeting the expectations. At the end of each semester, students are evaluated using the Professional Performance Standards Evaluation (PPSE; Retrieved November 27, 2012, from university website). The PPSE consists of 12 components on which the students are evaluated. The 12 components listed in the Student Handbook are: (a) Openness to new ideas (b) Flexibility (c) Cooperativeness with others (d) Willingness to accept and use feedback (e) Awareness of own impact on others (f) Ability to deal with conflict (g) Ability to accept personal responsibility (h) Ability to express feelings effectively and appropriately (i) Attention to ethical and legal considerations (j) Initiative and motivation (k) Attention and sensitivity to diversity issues (l) Professionalism and professional identity

Although these components may not be linked directly to self-care, the components do demonstrate that the program evaluates students on personal factors rather than just academic performance. This focus on personal factors is also demonstrated in the program’s mission statement where there is a focus on personal growth in additional to academic and clinical skills (Retrieved November 28, 2012, from
university website). Additionally, the learning expectations referenced in the program’s mission statement focus on the affective component of learning as well as the intellectual and experiential aspects.

The sources for the case listed above were analyzed to answer the two research questions. The first research question explored how the Clinical Mental Health Counseling programs conceptualize self-care. The second research question explored how the Clinical Mental Health Counseling programs integrate self-care education into the curriculum.

**Research Question One**

For the first question addressing how the program conceptualizes self-care the categories of ambiguity and prevention and early intervention emerged.

*Ambiguity.* The theme apparent during the interview with the Program C representative was that self-care was difficult to conceptualize and the conceptualizations provided were ambiguous. When asked to conceptualize self-care, Ellen’s initial response was “I think it would be doing. I don’t know.” (Ellen, II, 120). Ellen then provided a definition but followed it with the clarifier, “That’s not a very good definition” (Ellen, II, 122). When asked if self-care and wellness were the same concept or two different concepts, Ellen shared “to me it seems that self-care is a part of wellness and that you couldn’t have wellness if you weren’t taking care of yourself” (Ellen, II, 112). Ellen elaborated,

For each individual, self-care would look different but it would be basically doing what you needed to do to maintain the physical wellness, mental wellness,
and wellness in other areas of your life (Ellen, II, 120) . . . such as friendships, romantic relationship, and family. (Ellen, II, 122)

Despite the difficulty in providing a conceptualization of self-care, the program based its conceptualization of wellness on Myers and Sweeney’s (2005, 2008) wellness model. For example, Program C (the program Ellen represents) assigns required readings from Myers to discuss self-care and wellness in the course lectures. Consequently, the students are expected to use the assigned readings as the basis for the development of their wellness plan.

**Prevention and early intervention.** Despite the ambiguity of the conceptualization of self-care, prevention was a theme that emerged when Ellen discussed her conceptualization of self-care. Ellen shared a specific and intentional method of being preventative:

If issues come up we proactively address them and we have proactive conversations and so that’s one way we are modeling: more assertively addressing things, not avoiding them, and it’s not punitive then. So we are addressing those things. We have what needs to happen before we get to a remediation plan.

(Ellen, I, 148)

Additionally, Ellen shared,

We can see when students are struggling. The first agenda item in every faculty meeting is students. So we just talk about how students are doing and if anyone seems to be struggling and so even before it gets to remediation plan we might have a conversation with them. (Ellen, I, 89)
Furthermore, Ellen explained what this conversation would look like.

    Self-care is definitely part of that [conversation]. This is not meant to be a punitive conversation but we are worried about you and want you to take care of yourself and if you cannot do that now when you are practicing that is going to be a concern. And so, I don’t think we say this is because it is wellness but it is definitely coming from a supportive and self-care point of view. (Ellen, I, 91)

    Specific to the integration of self-care education—in all three cases, self-care was discussed in the context of burnout prevention or introduced to students as important for burnout prevention.

    Ellen explained that “we also talk about it [self-care] as resilience and burnout prevention” (Ellen, I, 18). Ellen also provided the following example of how self-care (referred to here as wellness) is introduced in terms of prevention: “in orientation to Clinical Mental Health we talk about wellness in burnout prevention and we have speakers from our local rape and abuse crisis center and we ask them to specifically address that” (Ellen, I, 35).

    Another preventative recommendation in the program is student participation in personal counseling. Ellen explained, “we also as a program recommend, strongly recommend, that our students get personal counseling just in general” (Ellen, I, 8) “and then we specifically ask certain students to do that as well” (Ellen, I, 10).
Research Question Two

The categories of curricular integration and faculty involvement and demonstration of importance emerged for research question two which addressed how self-care education was integrated into the curriculum.

Curricular integration. Similar to students in Program A (Cheryl’s program), students in Program C create a wellness plan. As explained in the Professional Orientation and Ethics syllabus, the creation of a wellness plan for Program C is the second assignment in the Professional Orientation and Ethics course related to self-care. It is further explained the syllabus that students in Program C are required to create a wellness plan to implement consistently for 28 days during the Professional Orientation and Ethics course. Additionally, it is explained in the syllabus that the students are to focus on the positive and negative aspects of their wellness, personal growth, and how this plan assisted the student in determining self-care strategies that they need to implement for their overall well-being.

In regards to how the self-care education information is specifically integrated into the courses, the faculty member identified at Program C as teaching a course in which the self-care standard is integrated for CACREP by the counselor educators who completed the interviews shared in the provided questionnaire that self-care education is integrated throughout the entire course and is integrated through the following mediums: lecture, activities, discussion, and anecdotal examples. In addition, the faculty members shared that the self-care content is incorporated in the class in a way that figures into the
students’ grades and is presented in a similar way to other course content. Furthermore, the faculty member identified at Program C shared that

I incorporate self-care as an objective in every course, although it may not always manifest itself as an assignment but as a behavioral expectation. I find that projects such as mindfulness activities with focused reading, doing journaling, and assessment components to be useful. Small self-led groups seem to be the key to making these assignments work. Group members journal each week on their individual and group progress. (faculty member questionnaire response)

In the Professional Orientation and Ethics course for Program C, in addition to the wellness plan previously discussed, students are expected to complete a self-care journal article critique and a self-reflection which is part of the evaluation method for the course. Additionally in Program C in the development course, two activities incorporate self-care as explained the syllabus for the course. Furthermore in the syllabus for the development course, it is explained that the first activity focused on self-care is a journal that encourages students to write about how others’ experiences from assigned readings affect personal growth and wellness and some things of which the student may want to let go.

When asked when she felt that the students were actually able to grasp the concepts of self-care, Ellen shared that “they talk about it more in practicum.” She further elaborated, “I am not sure that they understand” (Ellen, I, 68), “but I think maybe in internship” (Ellen, I, 72) they have a better understanding.

Ellen also stated that self-care is integrated into specific courses as well as infused throughout the course of the program. Ellen clarified that “in our human development
class which is also a class that people take early in the program, they have wellness
groups” (Ellen, I, 14) “that they are a part of and that they work on personal goals and
keep each other accountable” (Ellen, I, 16).

Faculty involvement and demonstration of importance. In addition to
incorporating self-care education into the curriculum and co-curricular activities for
students as previously discussed, Ellen shared that faculty also spent time discussing or
exploring their own personal self-care. The involvement of the faculty may convey the
importance of self-care and the value placed on self-care in the program. Ellen stated that
faculty in her represented program also placed value on the importance of the self-care
integration and created personal self-care goals at their faculty retreat.

In addition to faculty creating their own plans for wellness or self-care,
participants reported that faculty took active roles in facilitating the development of
wellness plans with students beyond what was integrated into the curriculum. As
previously mentioned, one way that this may occur is by faculty recommending personal
counseling. Additionally, faculty may help students set boundaries if the students are
unable to do this on their own. Ellen provided the example of “saying you can’t take 12
credits you need to take nine credits and we’ll help you set boundaries for your own
wellness until you are able to do that on your own” (Ellen, I, 93). In addition, Ellen also
explained the following is sometimes done to help set boundaries for students: “We will
have a student who is completely stressed out and give them permission to miss a class”
(Ellen, I, 274).
In summary, the following categories were evident after analysis for question one for Case C: ambiguity and prevention and early intervention. Specific to the second question for Case C the following categories were evident after analysis: curricular integration, and faculty involvement and demonstration of importance. The similarities between the three cases are discussed in the next section.

**Similarities**

After review of the three representatives’ interview transcripts, the questionnaires from the identified faculty member teaching a course in which the CACREP standard is integrated, and the associated documents, the themes emerging between the cases were evident.

**Research Question One**

In response to the first question of how self-care is conceptualized in the program, two common themes emerged between the three individual cases: ambiguity of self-care conceptualization and an emphasis on prevention and early intervention.

**Ambiguity of self-care conceptualization.** All three representatives demonstrated difficulty in providing an explanation of their program’s conceptualization of self-care. This is evidenced by each representative either not being able to provide their program’s conceptualization of self-care or attempting to provide a conceptualization and then questioning if it was correct as explained in the section above. Additionally, the representatives shared that it is difficult to delineate between self-care and wellness. Consequently, the representatives used the terms self-care and wellness interchangeably.
In addition to the representatives sharing the difficulty in delineating between self-care and wellness during their interviews, the lack of distinction between the two was also evident in the associated documents and on the websites. In the practicum and internship handbook for Program A, the way that self-care is integrated to meet the CACREP standard is called a wellness plan and its components (physical health and nutrition, leisure, relationships, school/work pursuits, and spirituality) align more with the wellness model of Myers and Sweeney (2008) than self-care as defined in the model.

Due to the wellness plan being an assignment in the course that meets the CACREP standard for self-care, the interchangeability of the two concepts is further encouraged. In addition to discussion of the self-care integration in the practicum and internship manual for Program A, it is explained in the practicum course syllabus that the CACREP standard requiring the integration of self-care integration is met in four classes throughout the semester, and for three of the four weeks, the wellness plan is addressed, and for the fourth class, “counselor wellness” is the class topic.

In Program A’s Internship course, it is explained in the syllabus that the personal wellness plan is revised in this course. In addition to the integration in the practicum and internship syllabi for Program A, in the Introduction to the Counseling Profession syllabus, the CACREP standard of integrating self-care strategies into the curriculum is considered a learning objective for the course and the topic for the class meeting the course objective is “Personal and professional aspects of counseling.” Additionally the wellness plan is a part of the counseling skills course. Despite the different ways that wellness is integrated into the curriculum in each of the previous mentioned classes
(Practicum, Internship, and Counseling Skills), a commonality is an inclusion of a professional and personal fitness statement, which explains that students are evaluated on “academic, professional, and personal qualities.” Additionally, the statement includes that students must demonstrate “technical and interpersonal skills” as well as “professional character.”

The syllabus for Program B’s practicum course does not specifically address CACREP’s requirement to integrate self-care education as Program B just recently received 2009 accreditation and has not fully integrated the standards at this point. However, the syllabus for the practicum course does incorporate self-care component in an assignment. The first paper that is required in the course is an evaluation paper in which students assess their personal strengths and weaknesses they have discovered in their role as counselors-in-training as well as personal concerns they may have that could impact their ability to function as a counselor-in-training. However, it is not delineated as self-care or wellness.

For Program C, the CACREP standard is incorporated into three syllabi including professional orientation and ethics, the human growth and development courses, as well as the practicum course. Similar to Program A, in the human growth and development course for Program C, it states that the self-care standard is met in the course but wellness and personal growth summaries and a wellness and personal growth paper are considered the assessments for this standard. Despite this lack of distinction between self-care and wellness in the human growth and development course, in the professional orientation and ethics course, the assignments that fulfill the self-care standard (self-care journal
article critique and self-reflection) include the consistent use of the term self-care. Despite the consistency of the use of the term self-care in the professional orientation and ethics course, there is inconsistency between the courses that use the terms self-care and wellness interchangeably when fulfilling the CACREP standard.

**Emphasis on prevention and early intervention.** Despite the representatives’ difficulty in providing their program’s conceptualization of self-care, a common theme among the representatives description of the program’s self-care conceptualization was the focus on prevention and early intervention. The representatives discuss prevention and early intervention in two contexts. The first was preventing potential issues that could necessitate remediation and the second was teaching students how to prevent burnout as a counseling student and in their future role as a counselor. In regards to preventing potential issues that could necessitate remediation, the three representatives explained that at faculty meetings students’ progress and performance are discussed to intervene before an issue develops. The representatives then explained that if an issue does arise the faculty discusses the concerns with the student to seek resolution.

Additionally, prevention and early intervention is supported by the associated documents such as in the counseling handbook. For Program C, it is clearly stated that any concerns are brought to faculty attention in faculty meetings (program handbook retrieved from university website). Furthermore, to be proactive students are monitored during each course by the instructor, and at the end of the semester, students are evaluated by all faculty based on the Professional Performance Standards Evaluation (PPSE) which assesses the students on 12 areas discussed previously (p. 12). The
students are evaluated on a Likert scale from 1 (poor) to 5 (excellent) for each of the 12 areas. If a student has a score of a three or lower in one or more area the concerns will be discussed during the faculty meeting and a remediation plan will be put in place.

Similarly, Program C included an explanation of how students are evaluated during the faculty meetings in the student handbook and provide the review form used to rate students’ performance. Additionally, the representative for Program C further explained that if there is an issue the faculty will engage in a dialogue with the student to attempt to find resolution to the concern before the issue leads to a remediation issue.

Furthermore, Program A also included in their Student Handbook how students are evaluated by the Professional Fitness Review discussed previously. Students in Program A received the feedback from their evaluation and faculty discussed any concerns with the students and make efforts to provide assistance in areas where deficits or difficulty may be noted.

In regards to teaching burnout prevention the three representatives shared the importance of students learning how to engage in self-care strategies to prevent burnout. Representatives for Programs A and C shared that in the represented programs the students are educated about the importance of self-care in order to prevent burnout. Additionally, the representative from Program C shared that speakers from the local rape crisis center come to the class to speak about the importance of self-care for counselors. Furthermore, the representative from Program B discussed how the represented program emphasizes the importance of self-care in order to prevent unethical behavior, which can occur when counselors are impaired.
In addition to the two themes (ambiguity of self-care conceptualization and emphasis on prevention and early intervention) that emerged for the first research question, two common themes emerged between the three individual cases for the second research question. The two themes for research question two are discussed in the next section.

**Research Question Two**

In response to question two which explored how the programs are integrating self-care education into the curriculum, two common themes emerged between the three cases: specific course integration and infusion throughout the program, and faculty involvement and demonstration of importance.

**Specific course integration and infusion throughout the program.** When discussing integration, the representatives each identified one specific course in which the self-care education was integrated as well as explained how the self-care education is also infused throughout the program. Representative B explained that due to just receiving 2009 CACREP accreditation, his program will be starting the course in which the self-care education is integrated in the spring of 2013 and currently the self-care education is infused into courses throughout the program, including the practicum and internship courses. Representative B elaborated that self-care education will continue to be infused into the curriculum once the course is established in 2013. Although Program B will not have the course that incorporates self-care education until spring semester 2013, Programs A and C already have specific courses in which the self-care education is integrated. Representative A explained that self-care is integrated into their Introduction
course, skills course, and practicum and internship courses. Representative C explained that the self-care education is integrated into the Professional Orientation and Ethics Course, the human development course, and the practicum and internship courses.

When exploring how specifically self-care education was integrated into the courses, the identified faculty members from Programs A and C shared the following common mediums through which the self-care was integrated: lecture, activities, discussion, and anecdotal examples.

In addition to the similarity of having a specific course or courses in which the self-care education is integrated and infusing it into courses throughout the program, the representatives also similarly shared that the self-care education was integrated into practicum and internship course. Furthermore, the representatives shared that the practicum and internship course is when they felt that students best understood and grasped the concept and importance of self-care. As explained previously, Representatives A and B shared that practicum was the course in which the self-care concept resonated, whereas Representative C shared that internship is where the concept of self-care resonates with the students.

**Faculty involvement and demonstration of importance.** In addition to incorporating self-care education into the curriculum as previously discussed, all three representatives shared that faculty also spent time discussing or exploring their own personal self-care. The involvement of the faculty may convey the importance of self-care and the value placed on self-care in the program.
In addition to faculty creating their own plans for wellness or self-care, participants reported that faculty took active roles in facilitating the development of wellness plans with students beyond what was integrated into the curriculum. As previously mentioned, one way that this may occur is by faculty recommending personal counseling as explained by all three representatives or by helping students learn how to establish and maintain appropriate boundaries if they are struggling to do so. For Program A, it is suggested in all syllabi for students to contact the university counseling center if there are concerns that are impacting a student’s ability to be successful in the program and both the telephone number and web address for the counseling center are provided. One way of helping set appropriate boundaries was provided by Representative C. Representative C shared that in her program faculty will encourage students to take a class off if they are experiencing a significant life stressor to model the importance of taking care of oneself.

**Differences**

Although there were similarities between the three cases, differences between the cases also emerged. The differences between the three programs were more evident in the representatives’ responses to question two versus question one. Although each representative shared a different conceptualization of self-care (i.e., wellness is a component of self-care versus self-care is a component of wellness), the similarity was that the self-care conceptualizations were ambiguous and none of the representatives provided a clear conceptualization of self-care. Despite the lack of significant differences between the representatives’ responses to question one, there were more differences
between the representatives’ responses to question two asking how self-care education was integrated into the curriculum.

Differences between the cases in regards to question two regarding how the programs integrate the self-care education included where the self-care was integrated into the curriculum and how the self-care was integrated into the education. The first difference was the focus on overall wellness in the programs. In Program A and Program C, wellness was an integral component that was evident as soon as a student became engaged in the program (i.e., on the program website). This was not evident with Program B. However, John explained that self-care was not specifically integrated into the curriculum but instead discussed as the opportunities arose in courses. Program B’s website did not specifically discuss counselor self-care or wellness.

A second difference was that the representatives for Program A and Program B shared that self-care education was integrated into not only the curriculum but also co-curricular activities such as CSI events. In contrast, the representative for Program C explained that self-care education is not integrated into co-curricular activities but the academic curriculum only. However, as previously mentioned, Representative C shared that she believed that there could be value in incorporating the self-care education into co-curricular activities.

Despite the inconsistency of where the programs integrate self-care education, all three representatives for the programs shared that self-care education is integrated into the curriculum. However, each shared that the information was integrated in a different way. The curricular integration of self-care ranges from a very specific way to integrate
to no prepared plan but waiting for opportunities to arise. The representative for Program A shared that there is a specific curriculum for self-care education including the creation of a wellness plan that all faculty follow when teaching the courses in which self-care education is integrated. Additionally, there is a rubric to assess students’ wellness plans. Examples of the wellness plan students are expected to develop as well as the rubric used to assess the students’ wellness plans are provided in the practicum and internship handbook.

In contrast, the representative for Program B discussed how there is not a specific curriculum for self-care education. The representative for Program B elaborated that the program he represents does not have a specific medium or method for integrating self-care education but that faculty integrate the self-care education as opportunities arise. The representative for Program C shares that similar to Program A there is a wellness plan created by students which is graded based on a rubric provided to students. However, the wellness plan differs from the wellness plan created in Program A as the students in Program A revise the wellness plan over the course of the program whereas students in Program C create a wellness plan for 28 days as discussed in the previous section.

**Summary**

In this chapter, the analysis from the interviews with counselor educators who are representatives for each case, the counseling programs, as well as the questionnaires completed by faculty members identified by the counselor educators completing the interviews as teaching a course in which the self-care standard is integrated, and the
collected documents that contribute to the answers for the following two questions were reported.

1. How does your program conceptualize self-care?

2. How is your program integrating self-care education into the curriculum?

Additionally, the categories and themes that emerged from analysis of the interviews, member checks, peer reviews, and collected documents are discussed.

The themes that emerged in response to research question one was that self-care conceptualization was ambiguous and there was a focus on prevention and early intervention. The themes that emerged related to research question two were specific course integration and infusion throughout the program, and faculty involvement and demonstration of importance. These themes are described in more detail in the next chapter as well as connected with the current literature.
CHAPTER IV
DISCUSSION

The purpose of the current study was to explore how CACREP accredited Clinical Mental Health Counseling programs conceptualize self-care and integrate self-care education into the curriculum. The two questions that guided this research were:

1. How does your program conceptualize self-care?
2. How is your program integrating self-care education into the curriculum?

In this chapter the results and interpretations are explained, contributions to the current literature, implications, and limitations are discussed, and recommendations for future research are provided.

Interpretation of the Findings

In response to the first interview question (How does your program conceptualize self-care?), one of the initial consistencies between the cases was using the terms wellness and self-care interchangeably. This led to the researcher clarifying with the participants in the second interview how they would define self-care and how they would differentiate self-care and wellness, which is discussed later. The strong overlap in identity between self-care and wellness was evident by all three representatives’ references to Myers and Sweeney’s (2005, 2008) wellness model when discussing self-care. However, despite the reference to Myers and Sweeney’s model of wellness, the representatives’ description of self-care was more consistent with the model of wellness than the definition of self-care within the model.
Self-care is defined in the Indivisible Self model as “taking responsibility for one’s wellness through self-care and safety habits that are preventative in nature, minimizing the harmful effects of pollution in one’s environment” (Myers & Sweeney, 2008, p. 485). Three dimensions of self-care are described in the Indivisible Self Model including: behaviors that protect the individual from injury or death; having physical, medical, and dental checkups; and avoiding any harmful substances (Myers et al., 2000).

Although the participants’ conceptualizations of self-care were different than the self-care definition provided in the wellness model, a commonality between the Indivisible Self Model definition and the participants’ definitions was the focus on prevention. Consequently, the participants all shared that engaging in self-care is a preventative measure for counselors to avoid burnout or impairment which could potentially impact the counselor’s ability to work with clients effectively in contrast to the Indivisible Self Model’s focus on prevention from harmful effects in the environment (Myers & Sweeney, 2008).

In regards to the second question of how programs are integrating self-care education into the curriculum, there were also similarities and differences between the cases. However, for this question there were more differences between the cases than there were for the first question. The first similarity was that all representatives explained that in their programs there is an identified course in which self-care is integrated (One representative explained the program is in the process of developing the course for the Spring 2013 semester), and that self-care is infused throughout their programs in a variety of ways. The representatives listed similar courses in which self-
care is often discussed including practicum and internship, which are discussed later. 

Finally, for all cases it was reported that faculty had created their own wellness plans, which were shared with students in different modalities.

Despite these similarities, the programs then began to differentiate to some extent. The programs differed in that Representative A specified that there is a very specific dialogue used for the integration of self-care education, Representative B reported that the program did not have a specific way to address self-care into courses but looked for opportunities to arise to address self-care, while Representative C did not specify a specific dialogue but specific assignments related to self-care.

In addition to the differences in curricular integration, the programs also differed in regards to co-curricular integration. Two program representatives reported that self-care education is integrated not only into the curriculum but also into co-curricular activities. Although the third program representative did not share that self-care was integrated into co-curricular activities, the third program representative did express an interest in potentially integrating self-care education into co-curricular activities and specific ways it could be beneficial to integrate self-care into co-curricular activities for the represented program.

The themes that emerged between the cases as well as the differences noted between the cases are discussed in this section. First the common themes that emerged for each question are discussed.
**Self-Care Conceptualization Themes**

The following themes were evident in all three cases when answering the first question of how self-care is conceptualized in the program: ambiguity and prevention and early intervention. These themes are discussed in detail in this section.

**Ambiguity.** A common theme among program representatives in regards to conceptualizing self-care was that the conceptualizations were very ambiguous. Self-care was difficult to conceptualize for the program representatives and the program representatives provided concepts and terms that they associated with self-care rather than a concrete definition or conceptualization. A possible reason for this difficulty in clearly conceptualizing self-care could be due to the significant overlap between the terms self-care and wellness, as discussed by John, representative of Case B. A second reason for this difficulty in clearly conceptualizing self-care and delineating between the two could be due to the lack of an operational definition for self-care in the counseling profession (Richards et al., 2010). When asked to define self-care, there was a consistent reference back to the wellness model and the domains that encompass Myers and Sweeney’s wellness model.

As previously mentioned, all three program representatives referenced Myers and Sweeney’s wellness model as either a direct or indirect model to which the programs adhere when integrating self-care education. The program representatives referenced the five factor model as how the programs incorporated self-care education into the curriculum. Through the program representatives’ use of the terms self-care and wellness interchangeably, it was evident that there may not be a significant difference between the
two terms in the perspective of the program representatives. The program representatives were conceptualizing self-care differently from how self-care is defined within the wellness model as “taking responsibility for one’s wellness through self-care and safety habits that are preventative in nature, minimizing the harmful effects of pollution in one’s environment” (Myers & Sweeney, 2008, p. 485). However, a commonality between the definition of self-care used in Myers and Sweeney’s model and the program representative’s definition of self-care was the focus on prevention. Nevertheless, beyond this commonality the program representatives did not speak about the three dimensions of self-care described in the Indivisible Self Model including: behaviors that protect the individual from injury or death; having physical, medical, and dental checkups; and avoiding any harmful substances (Myers et al., 2000) when discussing self-care with the exception of John discussing how the students learn to engage in healthier ways socially without the use of alcohol. More frequently, the program representatives referenced the domains of wellness discussed in Myers and Sweeney’s wellness model rather than the actual term of self-care that is used in the wellness model, especially the social and physical components.

Social aspects included the incorporation of specific events such as program picnics, CSI events, and holiday parties to facilitate collaborative, supportive relationships between students to learn from each other as well as help accomplish personal growth goals. Physical aspects included maintaining physical well-being in order to be able to provide appropriate services. Furthermore, two participants shared that they believed that students who were already physically active may find it easier to
accept and integrate the self-care concepts. Myers and Sweeney (2005) supported the current research finding that if a person is engaged in one area of wellness that they are more likely to engage in another area of wellness.

One of the reasons for the common reference to Myers and Sweeney’s model of wellness when discussing self-care with counselor educators may be due to this model being the primary model of wellness discussed in the counseling profession.

Prevention and early intervention. The second common theme for the conceptualization of self-care was that all three representatives to the program discussed the importance of self-care being perceived as a preventative measure and more specifically burnout prevention, which corresponds with the ACA Code of Ethics in regards to impairment prevention as burnout can potentially lead to impairment (ACA, 2010). In regards to self-care, the ACA Code of Ethics (2005) stipulated that:

- Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients. (ACA, 2005, Standard 2.g)
In addition to professional counselors being aware of when their impairment may have a negative effect on clients, the ACA Code of Ethics (2005) also stipulates that counselors-in-training must also be cognizant of their personal well-being and its impact on clients.

Counselors-in-training refrain from offering or providing counseling services when their physical, mental, or emotional problems are likely to harm a client or others. They are alert to the signs of impairment, seek assistance for problems, and notify their program supervisors when they are aware that they are unable to effectively provide services. In addition, they seek appropriate professional services for themselves to remediate the problems that are interfering with their ability to provide services to others. (ACA, 2005, Standard F.8.b)

All three program representatives demonstrated the importance of this ethical code through the representatives’ creations of their own personal self-care plans and the facilitation of boundary setting for students who may need assistance with establishing healthy self-care plans. Ziomek-Daigle and Christensen (2010) supported boundary setting such as a leave of absence as a remediation plan for personal growth.

In addition to the importance for counselors to incorporate self-care strategies in order to promote wellness and prevent burnout and impairment (Venart et al., 2007), it is also important for counselor educators to provide education to counselors-in-training about the importance of self-care and examples of self-care strategies (Skovholt, 2001). Additionally, providing self-care education is a way for counselor educators to fulfill their role as gatekeepers to the profession (ACA, 2005; CACREP, 2009).
According to the ACA Code of Ethics (2005), counselor educators, throughout ongoing evaluation and appraisal, are aware of and address the inability of some students to achieve counseling competencies that might impede performance. Counselor educators (a) assist students in securing remedial assistance when needed (b) seek professional consultation and document their decision to dismiss or refer students for assistance, and (c) ensure that students have recourse in a timely manner to address decisions to require them to seek assistance or to dismiss them and provide students with due process according to institutional policies and procedures. (ACA, 2005, F.9.b)

In addition to adherence to the ethical codes, the focus on self-care in the counseling curriculum supports Myers’ (1991) focus on wellness as a cornerstone of the counseling profession. Furthermore, ACA (2011) reported that in 2010 ACA provided the following for a definition of counseling including an emphasis on wellness:

“Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals”
(Resources, para 5).

Myers (1991) also suggested that each counselor needs to live a lifestyle of wellness to model to clients. Cheryl supported this by explaining that students in her represented program are told “You should use this with your clients. Maybe not every client but some clients would certainly benefit from you talking to them about self-care and having a wellness plan” (Cheryl, I, 127).
Integration of Self-Care Education Themes

The following themes emerged between all three representatives when they answered the second research question of how their program was integrating self-care education: specific course integration and infusion throughout the program, and faculty involvement and demonstration of importance.

Specific course integration and infusion throughout the program. The program representatives discussed that self-care education was integrated into at minimum one specific course to meet CACREP’s requirement and self-care education was infused throughout other courses where either dialogue regarding self-care or the creation or review of a self-care plan was included. The integration of self-care education into one specific course and infusion throughout the program are two of the three methods of wellness education integration suggested by Witmer and Granello (2005) in addition to their third recommendation of integrating the wellness education into both courses and co-curricular activities.

Two specific courses into which all three program representatives reported self-care was integrated were practicum and internship, which are courses in which impairment can be recognized (Williams et al., 2012). Consequently, Williams et al. explained that if impairment is recognized in these courses, there needs to be a conversation to address the impairment with a focus on wellness to prevent any negative impact on client care. Program representatives in the current research also discussed engaging in conversations with students whom they had concerns as previously mentioned. Recognition of issues with lack of self-care or impairment during practicum
and internship are critical as they are the final courses before the students begin their professional careers.

For all three representatives, a way to encourage self-care in the program was for the representatives to make the recommendation that all students engage in personal counseling. The representatives further explained that personal counseling was also a recommendation for students in response to concerns regarding the students’ abilities to provide the services expected. In addition to the programs recommending personal counseling, CACREP requires that each accredited institution “provides information to students in the program about personal counseling services provided by professionals other than program faculty and students” (CACREP, 2009, p. 3), which all program representatives reported fulfilling. Each program representative shared that their respective program provided a campus counseling center as an on-campus resource for the students to use if interested in personal counseling.

Although personal counseling was not reported as a requirement for any of the programs in this study, it was a recommendation and became a requirement at times in the programs if necessary, which is consistent with the ACA Code of Ethics (2005). Some individuals have described requiring students to engage in personal counseling (i.e., Yager & Tovar-Blank, 2007). Yager and Tovar-Blank shared that oftentimes the personal counseling is not long term but that establishing a strong relationship with a counselor can be a way to enhance wellness. Furthermore, Ziomek-Daigle and Christensen (2010) found in their study exploring gatekeeping practices in counselor education that remediation plans were used when students were not performing at the
level they should be or if additional assistance was needed. The authors explained that remediation plans included intensified supervision and personal development, which could be personal counseling.

Moreover, counselor educators have an ethical responsibility to require professional counseling in some situations. “Counselor educators may require trainees to seek professional help to address any personal concerns that may be affecting their competency” (ACA, 2005, Standard F.7.B).

**Faculty involvement and demonstration of importance.** In addition to having an ethical and legal obligation to serve as gatekeepers to the profession (ACA, 2005; CACREP, 2009), counselor educators are in an opportune position to introduce counselors-in-training to the potential for impairment if the necessary preventative steps are not taken (Williams et al., 2012). In addition to counselor educators being in an optimal position to introduce the significance and reality of potential impairment, some researchers (see Williams et al., 2012) believe that it is imperative for educators to encourage wellness in the training programs. Yager and Tovar-Blank (2007) shared that professors are more effective in teaching wellness when they are able to model it to their students. Yager and Tovar-Blank further explained that if professors are not engaging wellness themselves, students may not see the importance of wellness. Representatives of the programs in this present study demonstrated taking advantage of their opportune positions.

All three representatives shared that faculty at each institution created a wellness plan of their own, which was shared with the students in the program through a variety of
modalities. Ellen discussed how important she believed it was to “walk the walk” (Ellen, II, 182) in order to be able to truly understand and communicate the importance of self-care to the students. Furthermore, Ellen shared that “I guess integrating it and talking about it is the first step [to communicate the importance of self-care to the students]” (Ellen, II, 186). This is supported by Witmer and Young’s (1996) belief that it was important that faculty provide a model of ways that students can engage in self-care strategies and prevent impairment. Thus, the environments in which the students are developing their professional identity are characterized by a focus on the importance of self-care. Likewise, Myers et al. (2003) attributed the wellness levels of the participants (counseling students) in their study to possibly the modeling of wellness behaviors by faculty or students.

Additionally, Williams et al. (2012) shared that it is beneficial for counseling students to hear how their counseling supervisors have dealt with the struggles of their wellness plan and the conversations also demonstrate the importance of engaging in a wellness plan. This is important for faculty to understand as oftentimes faculty will be in the role of supervisor in courses such as practicum and internship which were two classes that all three participants shared self-care is integrated.

**Differences**

In addition to the themes discussed in the section above, there were also differences between the cases. As explained in Chapter 3, there were not as many differences between the cases in regards to the conceptualization of self-care. However, there were differences in how self-care education was integrated into the curriculum
including the extent of integration, and the medium and the location for the integration of self-care education.

The first difference was the extent to which the self-care education was integrated. As stated in Chapter 3, the level of integration ranged from very specific and concrete integration of self-care education as discussed by Representative A to the approach that the self-care education was integrated only when the topic arises as discussed by Representative C.

The second difference was where self-care education was integrated and how self-care was integrated into the curriculum. Program representatives shared the integration of self-care education occurred into both curricular and co-curricular aspects of the program and did not demonstrate consistency. Additionally, the program representatives shared varying approaches and mediums for self-care integration into the curriculum.

The program representatives’ reference to curricular and co-curricular ways for self-care education to be integrated into the program is supported by Myers et al. (2003) who explained that incorporating experiences related to the wellness model into curricular and co-curricular activities by encouraging self-exploration, learning, and personal growth may enhance wellness. Additionally, Witmer and Granello (2005) also shared that the integration of wellness education into curricular and co-curricular aspects of the program as one method of wellness education integration.

A curricular experience is defined by CACREP as
A planned, structured, and formal teaching activities intended to enable students to learn and apply the specific information, principles, values, and skills that are the intended consequences of the formal education offered by an academic unit. In general, the term is used in these standards to mean either an academic course or a readily identifiable portion of an academic course. (CACREP, 2009, p. 60)

CACREP does not provide a definition for a co-curricular experience. However, despite a lack of a definition for co-curricular experiences from CACREP, Myers et al. (2005) explained that co-curricular events allow for “meaningful and relevant learning experiences” (pp. 91-92) that may not be able to be incorporated into typical courses. Additionally, the authors explained that co-curricular activities can “facilitate professionalism and advocacy, create community and collaboration, and promote professional involvement and leadership development” (Myers et al., 2005, p. 92).

In regards to how self-care education is integrated within the curriculum, the programs differed. John explained that in the program he represents, the faculty are sure to take opportunities when they rise in a course to discuss the importance of self-care rather than formally addressing it in a course,

What we like to do is to get into touch with the kinds of things they are feeling and the frustrations they are having. It is those critical times that the talk of self-care needs to be reinforced, opposed to just talking about it any given time. It’s when they are struggling with something, when they feel stressed those are the times they will say this is new to me this is something I need to pay attention to. So we try to integrate it when the situation arises. (John, I, 20)
Although John explained that the self-care education will be integrated into one specific course and then brought up as necessary throughout the course of the program he represents, Cheryl and Ellen explained the creation of specific wellness plans within the programs they represent to integrate self-care education which coincides with the suggestions of Williams et al. (2012). Additionally, Cheryl explained that in addition to creating a wellness plan, the students then revisit the plan at different points in the semester to revise and ensure they are implementing the strategies discussed in the plan which is done in the practicum and internship courses which is also supported by Williams et al. Although the program that Ellen represents incorporates a wellness plan, the plan is not revised and checked throughout the semester but instead completed for 28 consecutive days.

In addition to curricular implementation, differences were also present in the integration into co-curricular education as two of the program representatives expressed different ways that self-care education can be integrated beyond the classroom. Both Cheryl and John explained that activities with Chi Sigma Iota provided a medium to integrate self-care education as supported by Yager and Tovar-Blank’s (2007) suggestion of active involvement with Chi Sigma Iota Chapters to encourage a focus on self-care and wellness of counseling students as an innovative way to incorporate self-care education into the curriculum. In contrast to Cheryl and John, Ellen explained that her program was not integrating self-care education into co-curricular activities at this time. However, she stated that she believed that it would be beneficial to incorporate wellness into some co-curricular activities specifically Chi Sigma Iota also.
Implications

The findings of the current research not only contribute to the counseling literature but also have implications for professionals in counselor education and the counseling profession. In this section, the implications for counselor educators and supervisors are discussed.

Implications for Counselor Educators

Counselor educators are in an optimal position to enhance and place a focus on the importance of counselor self-care in the profession. Counselor educators have the advantage of working with future counselors who are just beginning to establish their professional identity. This is an opportune time to facilitate the incorporation of self-care into students’ professional identity, which is the foundation for future counselors. The current research supported the importance of self-care plans for counselor educators. Additionally, the findings supported counselor educators modeling self-care to students and facilitating students’ development of self-care when they may be struggling with the creation of a plan on their own. All three of the representatives shared that the faculty in their programs have their own self-care or wellness plans which are shared with the students to facilitate conversation and also the development of the students’ own plans. The conversations faculty engage in with the students regarding their own self-care plans demonstrates one way the faculty model self-care.

The findings of the current research also support self-care education integration into activities where students can explore how to create a personal self-care plan and not only into coursework. Representatives A and B shared that examples of self-care
education integration beyond the classroom could include CSI activities or social activities within the program that are not academic such as program picnics or social gatherings. These suggestions encourage counselor educators to be creative in incorporating self-care education into a variety of different methods.

Additionally, the findings supported the importance of counselor educator awareness of and response to opportunities to incorporate self-care education in order to prevent the necessity for a remediation plan. The three representatives explained that at faculty meetings students’ progress and performance are discussed to enable faculty to intervene before an issue develops. Additionally, the representatives explained that if an issue does arise the faculty discusses the concerns with the student to seek resolution.

**Implications for Supervisors**

In addition to counselor educators, supervisors find themselves in a unique role in that they are working with students when the program representatives in this study indicated students are most likely to grasp and integrate the self-care education they have been learning over the course of their program. Supervisors have an opportunity to monitor students’ abilities to integrate and maintain a self-care plan as well as to intervene when necessary if the lack of a self-care plan is negatively impacting the students’ abilities to provide appropriate client care. Furthermore, the practicum and internship classes are the final classes prior to students entering the professional world. Thus, supervisors are in the position to set a precedent regarding the importance of self-care to ensure appropriate client care and to prevent potential burnout and impairment of the counselor in the future.
**Limitations**

One of the limitations of this research was the limited number of participants due to the CACREP 2009 Standards not being integrated by all counseling programs at this point. Additionally, since the 2009 CACREP Standards are relatively new, some programs are just beginning to implement the standards and may not be able to reflect on the integration as much as if they had integrated them earlier. Although the researcher went through two full rounds of recruitment, the number of participants was still limited.

The initial round of recruitment included the following inclusionary criteria: the Clinical Mental Health program had to have eight year accreditation for the 2009 CACREP Standards, and the participant needed to fulfill the roles of CACREP liaison and academic unit leader. Once recruitment with these inclusionary criteria led to no participants, the researcher and faculty advisors revisited the criteria and removed the criteria of having eight year accreditation and included those with two year 2009 CACREP accreditation. Additionally, the inclusionary criteria of the participants being CACREP liaison and academic unit leader were also removed to increase the number of potential participants. IRB approval was received for these addendums.

The researcher acknowledges the number of participants is lower than may be included in a multiple case study but after multiple recruitment attempts, three participants were the most that could be recruited. Once more programs obtain 2009 CACREP accreditation, future attempts at recruitment of participants may be more successful.
A second limitation to this research is that the identified faculty member for Program B did not respond to contact attempts and John explained this individual is the person developing the course that would incorporate self-care education. Additionally, Programs B and C were not able to provide practicum and internship handbooks. John explained that his program does not have a practicum and internship handbook.

A third limitation of this research is that the researcher only examined the experiences of 2009 CACREP accredited institutions and did not explore programs under the 2001 CACREP standards or institutions that are not CACREP accredited. Despite not being required by CACREP to integrate the self-care standard, those under the 2001 standards and those not CACREP accredited may be conceptualizing self-care and integrating self-care education into the curriculum and be able to provide contributory information to the topic of self-care and wellness.

A fourth limitation of this research is a lack of cultural diversity as all three participants were Caucasian. Additionally, the three institutions represented only two regions of the United States: the Midwest and the Northeast. There was no representation from the Southern or Western regions of the United States.

**Future Research**

Although this research contributed to the literature by providing an understanding of how CACREP accredited Clinical Mental Health Counseling programs are conceptualizing self-care and integrating self-care education, it did not examine the effectiveness of the integration. It may be beneficial to explore both faculty and student perceptions of the effectiveness of the integration of self-care education into the
curriculum. Additionally, to gain an understanding of how students implement these strategies beyond the classroom and programs, it may be advantageous to explore with graduates of programs where self-care has been integrated if they continue to implement the self-care strategies beyond graduation and into their professional roles. And if so, how do they continue to integrate the self-care education.

In response to the ambiguity of the conceptualization of self-care, further exploration of the counseling profession’s understanding of self-care may be valuable. It may be beneficial to explore how professional counselors working directly with clients conceptualize and define self-care in addition to how counselor educators conceptualize and define self-care. Also, it may be helpful to examine how other helping professions conceptualize and define self-care.

Furthermore, it may be beneficial to physically observe the integration of the self-care education into the curriculum or the co-curricular activities discussed. Observing the integration compared to just hearing about the integration may provide a more in-depth understanding of the integration.

Finally, after more programs receive 2009 CACREP accreditation, it may be beneficial to conduct this research again to increase the number of participants and increase the number of perspectives.

**Summary**

The purpose of the current study was to explore how CACREP accredited Clinical Mental Health Counseling programs conceptualize self-care and integrate self-care education into the curriculum. Through the use of a multiple case study, the researcher
was able to explore the conceptualization of self-care and the integration of self-care education into the curriculum of three Clinical Mental Health Counseling programs through interviews, questionnaires, and review of pertinent documentation including syllabi, practicum and internship handbooks, and program recommended resources (personal counseling resources). The researcher hoped that the information gleaned from the current research would provide an understanding and framework for programs that will be integrating self-care education in their curriculum in response to the CACREP 2009 Standard as well as contribute to the counseling literature on self-care and facilitate future research on self-care and self-care education into the curriculum.

The findings of this research demonstrated that there is an overlap between the terms self-care and wellness in the profession. Counselor educators demonstrated difficulty in the conceptualization of self-care, and had a difficult time differentiating between self-care and wellness and providing a succinct definition for self-care and often used the terms interchangeably.

Additionally, the findings of this research demonstrated that 2009 CACREP accredited Clinical Mental Health Counseling programs are integrating self-care education into one specific course where it meets the CACREP standard and then infusing it into other aspects of the program including: other courses, dialogue with students to prevent the necessity for a remediation plan, and into co-curricular activities such as Chi Sigma Iota events.
APPENDICES
APPENDIX A

SELF-CARE STRATEGIES IN HELPING PROFESSIONS CHART
## Appendix A

### Self-Care Strategies in Helping Professions Chart

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<th>Psychology</th>
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<td><strong>Diet</strong></td>
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APPENDIX B

INSTITUTIONAL REVIEW BOARD APPLICATION
Appendix B

Institutional Review Board Application

KENT STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD
APPLICATION FOR APPROVAL TO USE HUMAN RESEARCH SUBJECTS

Move through this document using TAB or mouse. DO NOT USE THE ENTER KEY. Please type all information.
HANDWRITTEN FORMS WILL NOT BE ACCEPTED. To check a box, double-click in the box.
Submit completed form with signatures and all required attachments to the IRB REVIEWER associated with your
Department or College, or to: Office of Research Safety and Compliance, Research and Graduate Studies, 137 Cartwright
Hall. Phone: 330-672-2704.

Project Title:CACREP accredited, Clinical Mental Health Counseling Programs Conceptualization Of Self-Care and Integration of Self-Care
In The Curriculum: A Multiple Case Study

Principal Investigator
Name: Nicole Bradley  Department: CHDS
Address: 199 N. Bissell Rd. Aurora, Ohio  Email: nbradley@kent.edu
Phone: 330-398-2962
Status: ☐ Faculty  Project: ☐ Faculty Research
☐ Doctoral Student  ☐ Student Dissertation
☐ Graduate Student  ☐ Student Thesis
☐ Undergraduate Student  ☐ Course Requirement: (Course #:
☐ Other: (Specify: )  ☐ Other : (Specify: )

KSU Faculty Co-Investigator(s) (Use additional sheets if necessary)
Name:  Department:  
Address:  Email:  
Phone:  
Status: ☐ Faculty  
☐ Doctoral Student  
☐ Graduate Student  
☐ Undergraduate Student  
☐ Other: (Specify: : )

Faculty Advisor (If PI is a student)
Name: Dr. Jason McGlothlin/Dr. Lynne Guillot Miller  Department: Counseling and Human
Development Services
Phone: 330-672-0716/330-672-0697  Email: jmcgloth@kent.edu/lguillot@kent.edu

Protocol Funding: ☐ Not-applicable  ☐ Pending  ☐ Awarded  ☐ Federal: ☐ Yes ☐ No
Funding Agency: 
If funded or pending, attach detailed information regarding proposal (including title).

Estimated Project Duration: Starting Date: February 2012 (But not before approval is obtained) Ending Date: August 1, 2012

KSU IRB USE ONLY

IRB Reviewer Determination
☐ Level I – Exempt, Category_____
☐ Level II – Expedited, Category_____
☐ Level III – Full Board review
☐ Disapproved
Primary Reviewer  Date
Secondary Reviewer  Date

IRB Administration Action
☐ Approved Level I – Exempt, Category_____
☐ Approved Level II – Expedited, Category_____
Administrator, IRB  Date
Chair, IRB  Date

Full Board Review Action  Meeting Date:
☐ Approved  ☐ Contingent Approval  ☐ Tabled  ☐ Disapproved
☐ Contingencies Met Date:

AGENDA Date  
Correspondence  
E-mail approval  
Date  
E-mail notice of annual review  
Date  

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APPENDIX C

E-MAIL TO POTENTIAL REPRESENTATIVES
Appendix C

E-mail to Potential Representatives

Dear ____,

I am a Doctoral Candidate at Kent State University in the Counseling and Human Development Services program. I am beginning data collection for my dissertation on how CACREP accredited Clinical Mental Health Counseling programs conceptualize self-care and integrate self-care education into the curriculum. I was provided your name as a potential representative in my study by Dr. Robert Urofsky as one of the criteria for my study is the representative needs to be the CACREP liaison and Program Coordinator for the program. An additional inclusionary criteria for this study is that you have been in the Program Coordinator role for a minimum of two years. If you have been Program Coordinator for a minimum for two years, I was wondering if you would be interested in participating in my research?

If you choose to participate, participation would include two interviews via telephone or Skype—one ninety minute (approximately) interview and one twenty minute (approximately) interview—and a possible follow up e-mail. You would be able to choose to complete the interviews via telephone or Skype. The researcher would also request syllabi, internship and practicum handbooks, and program recommended campus resources for students. If these documents were not able to be sent electronically, the researcher would send a pre-addressed and stamped envelope to return these documents to the researcher. Information from the documents as well as all information gained from the interviews will be confidential. In addition to the interviews and document submission, portions of the transcript and submitted documents, and the interpretations of the interview portion and documents will be sent to you to check for accuracy and provide clarification if needed.

If you are interested in participating in the study, please contact me at nbradley@kent.edu.

I appreciate your consideration.

Thank you.

Sincerely,

Nicole L. Bradley M.S.Ed., PCC
APPENDIX D

E-MAIL SENT TO THOSE MEETING CRITERIA FOR PARTICIPATION
Appendix D

E-mail Sent To Those Meeting Criteria For Participation

Dear ____,

Thank you for expressing interest in participating in my dissertation research. If you are still interested in participating, the next step would be to schedule a time that is convenient for you to discuss the study and informed consent. Please send me a few days and times that would be convenient for you as well as a telephone number. (This will take approximately 15-20 minutes.) In addition, please provide me with a postal mailing address so that I can send you a copy of the informed consent and a pre-addressed and stamped envelope in which you can return the signed informed consent.

Thank you again for you willingness to participate in my dissertation research.

Sincerely,

Nicole L. Bradley M.S.Ed., PCC
Appendix E

Informed Consent

Informed Consent to Participate in a Research Study

**Study Title:** Council for Accreditation of Counseling and Related Educational Programs Accredited Clinical Mental Health Counseling Programs Conceptualization of Self-Care and Integration of Self-Care Education in the Curriculum: A Multiple Case Study

**Principal Investigator:** Nicole Bradley M.S.Ed., PCC

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will be provided with a copy of this document.

**Purpose:** The focus of the study is to explore how self-care is conceptualized and ways self-care education is integrated into Council for the Accreditation of Counseling and Counseling Related Programs (CACREP) accredited Clinical Mental Health Counseling programs. The purpose of this research is to explore how self-care is conceptualized in the CACREP accredited counseling programs and how self-care education has been integrated into the curriculum thus far.

**Procedures**

You will complete a brief demographic form and participate in a 90 minute (approximately) and 20 minute (approximately) interview with the principal investigator which will be audio recorded for the principal investigator to be transcribed by the principal investigator and the Kent State University Bureau Research and Training Services and to be reviewed by the principal investigator and peer reviewer. You will have the option of completing the interviews via Skype or telephone. The researcher will also request syllabi, practicum and internship handbooks, and program recommended campus resources provided to students. (You will be provided a self-addressed and stamped envelope to return any requested documentation.) All documents provided will be used solely for the present research and will not be shared or used for any other purpose. You will also be asked to provide the name of a faculty member who teaches a course in which the self-care standard is met. After each interview, you will then receive two pages of your individual transcribed, analyzed, and interpreted interview to review for accuracy and return to the principal investigator. Once the two pages of the transcripts are returned, the principal investigator will make necessary corrections to ensure
accuracy in response to your feedback. If the principal investigator needs more information, you will be sent a follow up email to obtain the necessary information.

Audio and Video Recording
The 90-minute and 20-minute interviews will be audio recorded and the recordings will be stored on the principal investigator’s password protected computer only and will not be shared. The audio recordings will be used for research purposes only.

Benefits
This research will not benefit you directly. However, your participation in this research will help to better understand ways that counselor educators can better provide and integrate self-care education into the counseling curriculum.

Risks and Discomforts
There are no anticipated risks beyond those encountered in everyday life.

Privacy and Confidentiality
Confidentiality will be maintained by the use of pseudonyms for the counselor educator as well as the universities in the transcripts. The peer reviewer and faculty advisors will also be reviewing the transcripts after the pseudonyms are used. The audio recordings will be kept on only the principal investigator’s password protected computer and will not be shared.
Your study related information will be kept confidential within the limits of the law. Any identifying information will be kept in a secure location and only the researchers will have access to the data. Research representatives will not be identified in any publication or presentation of research results; only aggregate data will be used. In addition, the program documents will be used solely for the purpose of this research.
The researcher is applying for a grant through CACREP. If the researcher receives the grant, the researcher will be submitting data and findings to them. However, no identifying information will be sent only aggregate information.
Your research information may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or others.

Voluntary Participation
Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.
**Contact Information**
If you have any questions or concerns about this research, you may contact Nicole Bradley at 330-672-2662 or Dr. Jason McGlothlin at (330) 672-0716 or Dr. Lynne Guillot Miller at 330-672-0697. This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research representative or complaints about the research, you may call the IRB at 330-672-2704.

**Consent Statement and Signature**
I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this research. I understand that a copy of this consent will be provided to me for future reference.

________________________________  _____________________
Representative Signature                        Date
APPENDIX F

AUDIOTAPE/VIDEO CONSENT FORM
Appendix F
Audiotape/Video Consent Form

Council for Accreditation of Counseling and Related Educational Programs Accredited Clinical Mental Health Counseling Programs Conceptualization of Self-Care and Integration of Self-Care Education in the Curriculum: A Multiple Case Study

Nicole L. Bradley M.S.Ed., PCC

I agree to participate in an audio-taped/videotaped interview about the integration of self-care education into the curriculum as part of this project and for the purposes of data analysis. I agree that Nicole Bradley may audio-tape this interview. The date, time, and place of the interview will be mutually agreed upon.

_________________________________________  __________________________
Signature                                      Date

I have been told that I have the right to listen to the recording of the interview before it is used. I have decided that I:
_____want to listen to the recording  _____do not want to listen to the recording

Sign now below if you do not want to listen to the recording. If you want to listen to the recording, you will be asked to sign after listening to them.

________________________ may / may not (circle one) use the audio-tapes/videotapes made of me. The original tapes or copies may be used for:

_____this research project  _____publication  _____presentation at professional meetings

_________________________________________  __________________________
Signature                                      Date

Address
APPENDIX G

DEMOGRAPHIC QUESTIONNAIRE
Appendix G

Demographic Questionnaire

The following is personal information about you related to the study. All information will be kept confidential.

Name: __________________________________________

Age: __________________________ Gender: __________________________

Race: __________________________ Ethnicity: __________________________

Number of years as a full time counselor educator: __________________________

Number of years as a full time counselor educator at current institution: __________

Please circle the graduate degree that you hold.

  Counselor Education
  Counseling Psychology
  Other __________________________

Are you a graduate of a CACREP accredited program? (Please circle yes or no)

  Yes       No

Professional Rank (Please circle the appropriate rank)

  Assistant Professor       Associate Professor
  Professor                  Part time faculty
  Instructor/ Adjunct Faculty

How many students are enrolled in your counseling program? ______

Please circle which of the following best describes your role in infusing the CACREP self-care standard into the curriculum?

  Very involved       Involved       Minimally involved       Not involved at all
APPENDIX H

E-MAIL FOLLOWING UP ON INTEREST IN PARTICIPATION
Appendix H

E-mail Following up on Interest in Participation

Dear ____,

I previously sent an e-mail regarding my dissertation research I wanted to check in to see if you were interested in participating in my research. I am a Doctoral Candidate at Kent State University in the Counseling and Human Development Services program. I am beginning data collection for my dissertation on how CACREP accredited Clinical Mental Health Counseling programs conceptualize self-care and integrate self-care education into the curriculum. I was provided your name as a potential representative in my study by Dr. Robert Urofsky as one of the criteria for my study is the representative needs to be the CACREP liaison and Program Coordinator for the program. An additional inclusionary criteria for this study is that you have been in the Program Coordinator role for a minimum of two years. If you have been Program Coordinator for a minimum for two years, I was wondering if you would be interested in participating in my research?

If you choose to participate, participation would include two interviews via telephone or Skype—one ninety minute (approximately) interview and one twenty minute (approximately) interview—and a possible follow up e-mail. You would be able to choose to complete the interviews via telephone or Skype. The researcher would also request syllabi, internship and practicum handbooks, and program recommended campus resources for students. If these documents were not able to be sent electronically, the researcher would send a pre-addressed and stamped envelope to return these documents to the researcher. Information from the documents as well as all information gained from the interviews will be confidential. In addition to the interviews and document submission, portions of the transcript and submitted documents, and the interpretations of the interview portion and documents will be sent to you to check for accuracy and provide clarification if needed.

If you are interested in participating in the study, please contact me at nbradley@kent.edu.

I appreciate your consideration.

Thank you.

Sincerely,

Nicole L. Bradley M.S.Ed., PCC
APPENDIX I

TRANSCRIPTION CONFIDENTIALITY AGREEMENT

KENT STATE UNIVERSITY BUREAU RESEARCH AND TRAINING SERVICES
Appendix I

Transcription Confidentiality Agreement

Kent State University Bureau Research and Training Services

I _________________________ agree to maintain the confidentiality of any information to which I become aware during the transcription process of Nicole Bradley’s interview data. I will not communicate any information in any format (including verbal, electronic, or written communications) related to the content or process of the interviews being transcribed to anyone other than Nicole Bradley. I understand that a breach of this confidentiality agreement will result in termination of my services and may result in further legal action.

Signed ________________________________ on ______________________
Name Date

Witnessed by ___________________________ on ______________________
Name Date
APPENDIX J

INFORMED CONSENT FOR FACULTY COMPLETING SURVEY
Appendix J

Informed Consent for Faculty Completing Survey

Informed Consent to Participate in a Research Study

Study Title: Council for Accreditation of Counseling and Related Educational Programs Accredited Clinical Mental Health Counseling Programs Conceptualization of Self-Care and Integration of Self-Care Education in the Curriculum: A Multiple Case Study

Principal Investigator: Nicole Bradley M.S.Ed., PCC

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose
The focus of the study is to explore how self-care is conceptualized and ways self-care education is integrated into Council for the Accreditation of Counseling and Counseling Related Programs (CACREP) accredited Clinical Mental Health Counseling programs. The purpose of this research is to explore how self-care is conceptualized in CACREP Accredited counseling programs and how self-care education has been integrated into the curriculum thus far.

Procedures
You have been identified as a faculty member teaching a course in which the CACREP Standard mandating the integration of self-care education is met. Once this informed consent form is returned to the researcher via postal mail in the provided pre-addressed and stamped envelope a questionnaire will be sent via email addressing how the self-care education was integrated into the course you teach. If you prefer a hard copy of the questionnaire the researcher will send the questionnaire via postal mail and a pre-addressed stamped envelope in which to return the questionnaire to the researcher.

Audio and Video Recording and Photography

There will not be any audio or video recording or photography.
Benefits
This research will not benefit you directly. However, your participation in this research will help to better understand ways that counselor educators can better provide and integrate self-care education into the counseling curriculum.

Risks and Discomforts
There are no anticipated risks beyond those encountered in everyday life.

Privacy and Confidentiality
Confidentiality will be maintained by the use of pseudonyms for the counselor educators as well as the universities in the findings. The peer reviewer and faculty advisors will also be reviewing the transcripts after the pseudonyms are used.
Your study related information will be kept confidential within the limits of the law. Any identifying information will be kept in a secure location and only the researchers will have access to the data. Research participants will not be identified in any publication or presentation of research results; only aggregate data will be used. In addition, the program documents will be used solely for the purpose of this research. The researcher is applying for a grant through CACREP. If the researcher receives the grant, the researcher will be submitting data and findings to them. However, no identifying information will be sent only aggregate information.
Your research information may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or others.

Voluntary Participation
Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

Contact Information
If you have any questions or concerns about this research, you may contact Nicole Bradley at 330-672-2662 or Dr. Jason McGlothlin at (330) 672-0716 or Dr. Lynne Guillot Miller at 330-672-0697. This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330-672-2704.
Consent Statement and Signature

I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this research. I understand that a copy of this consent will be provided to me for future reference.

________________________________ ___________________
Participant Signature Date
APPENDIX K

QUESTIONNAIRE FOR FACULTY TEACHING COURSES IN WHICH THE CACREP STANDARD FOR SELF-CARE IS INTEGRATED
Appendix K

Questionnaire for Faculty Teaching Courses

in Which the CACREP Standard for Self-Care is Integrated

For the following, please circle or highlight the best response and provide a written response if you select “other.”

1. When do you integrate self-care education into the course?
   a. Before midterm
   b. After midterm
   c. Throughout entire course
   d. I do not integrate self-care education into the course.
   e. Other________________________________________

2. Through which of the following do you integrate self-care education into the course?
   a. Lecture
   b. Media (youtube, video, etc.)
   c. Activity
   d. Discussion
   e. Personal reflection (i.e., journaling)
   f. Provide anecdotal examples
   g. All of the above
   h. Other________________________________________

3. Is the self-care content incorporated in a way in class that it figures into the students’ course grade?
   a. Yes
   b. No
   c. Other_________________________________________________________________________

4. Is the self-care content in the course presented in a similar way as the other course content?
   a. Yes
   b. No
   c. Other_________________________________________________________________________

Please feel free to share any further information about your personal experiences in this course teaching the self-care content in the space provided below.
Appendix L

Script for Faculty

I am a Doctoral Candidate at Kent State University in the Counseling and Human Development Services program. I am beginning data collection for my dissertation on how CACREP accredited Clinical Mental Health Counseling programs conceptualize self-care and integrate self-care education into the curriculum. My advisors are Dr. Lynne Guillot Miller and Dr. Jason McGlothlin. For my research I am contacting faculty members who teach in Clinical Mental Health Counseling programs that are accredited under the 2009 standards. ______(fill in advisor’s name) identified you as a faculty member teaching in a 2009 accredited Clinical Mental Health Counseling program. I was wondering if you would be interested in participating?

If you choose to participate, participation would include completion of a brief demographic questionnaire, two interviews via telephone or Skype—one ninety minute (approximately) interview and one twenty minute (approximately) interview—and a possible follow up e-mail. You would be able to choose to complete the interviews via telephone or Skype. Additionally, I would request the name of a faculty member who is teaching a course in which the self-care standard is integrated. I would also request syllabi, internship and practicum handbooks, and program recommended campus resources for students. If these documents were not able to be sent electronically, I would send a pre-addressed and stamped envelope to return these documents. Information from the documents as well as all information gained from the interviews will be confidential. In addition to the interviews and document submission and providing the name of a faculty member, you will be provided two pages of your individual transcribed, analyzed, and interpreted interview to review for accuracy and provide clarification if needed.

If you are interested in participating, I will send you an informed consent form to fill out and return. (I will send it via postal mail with a pre-addressed and stamped envelope unless you prefer I send it electronically for you to sign, scan and return to me via e-mail.) I would like to confirm the address that you prefer me to send it to.

Do you have any questions or concerns?
APPENDIX M

E-MAIL TO POTENTIAL PARTICIPANTS FOR SECOND RECRUITMENT ATTEMPT
Appendix M

E-mail to Potential Participants for Second Recruitment Attempt

I am a Doctoral Candidate at Kent State University in the Counseling and Human Development Services program. I am beginning data collection for my dissertation on how CACREP accredited Clinical Mental Health Counseling programs conceptualize self-care and integrate self-care education into the curriculum. My advisors are Dr. Lynne Guillot Miller and Dr. Jason McGlothlin. For my research, I am contacting faculty members who teach in Clinical Mental Health Counseling programs that are accredited under the 2009 standards. Dr. McGlothlin identified you as a faculty member teaching in a 2009 accredited Clinical Mental Health Counseling program. I was wondering if you would be interested in participating?

If you choose to participate, participation would include completion of a brief demographic questionnaire, two interviews via telephone or Skype—one ninety minute (approximately) interview and one twenty minute (approximately) interview—and a possible follow up e-mail. You would be able to choose to complete the interviews via telephone or Skype. Additionally, I would request the name of a faculty member who is teaching a course in which the self-care standard is integrated. I would also request syllabi, internship and practicum handbooks, and program recommended campus resources for students. If these documents were not able to be sent electronically, I would send a pre-addressed and stamped envelope to return these documents. Information from the documents as well as all information gained from the interviews will be confidential. In addition to the interviews and document submission and providing the name of a faculty member, you will be provided two pages of your individual transcribed, analyzed, and interpreted interview to review for accuracy and provide clarification if needed.

If you are interested in participating, please contact me at the e-mail address below and I will send you an informed consent form to fill out and return. (I will send it via postal mail with a pre-addressed and stamped envelope unless you prefer I send it electronically for you to sign, scan and return to me via e-mail.)

Thank you for your consideration.

Nicole Bradley
REFERENCES


