ABSTRACT

Crisis in the Family: Counselor Anxiety and Self-Efficacy in Responding to Family Crises

by

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Counselors are reporting their job duties include crisis response at a frequency of at least weekly. However, counselors have previously reported a lack of curriculum exposure to crisis response training. Unfortunately, there is a growing need for counselors to intervene with crises at the family level due to increases of children entering foster care and higher rates of mass causality events. This study will seek to assess counselor's anxiety and self-efficacy across licensure levels when responding to a family in crisis. Assessment of the counselor's anxiety and self-efficacy will be measured with the State-Anxiety Inventory (STAI) and the Counselor Self-Estimate Inventory (COSE).

This study used nonprobability sampling to recruit 30 participants. The research questions were answered with three repeated-measures MANOVAs, and six univariate analyses. No statistical significance was found with respect to the COSE. Additionally, no significance was noted with respect to curriculum exposure and changes on the COSE or STAI. Statistical significance was found on the STAI in a three-way interaction [$F (2, 26) = 7.31$, $p = .012$, $\eta_p^2 = .22$] between licensure, years of experience, and changes over-time on the STAI.

CRISIS IN THE FAMILY: COUNSELOR ANXIETY AND SELF-EFFICACY IN RESPONDING TO FAMILY CRISES

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CHAPTER ONE: INTRODUCTION

Introduction to the Study

The opioid crisis has created a host of issues in the Mental Health Professionals community; the impacts are far-reaching and steadily increasing within the last decade (Tucker, 2018). Some of the consequences of the opioid crisis have been individuals seeking long-term mental health and substance use services, an increase in the need for emergency responders, as well as a spike in children entering Foster Care services. Indeed, in 2011, there was an 11% increase in the number of children in need of Foster Care services due to the growing opioid crisis (Tucker, 2018). This is particularly alarming since, historically, the number of children in Foster Care has exceeded the available beds in foster homes. This crisis has impacted many families resulting in ongoing trauma for the children, resulting in feelings of abandonment, unresolved anger, and grief, as well as attachment issues. Consequently, counselors report growing case-loads of highly traumatized children and an increase in demands for crisis response in family settings (Freadling, & Foss-Kelly, 2014). Children often experience adjustment issues as a result of Foster Care placement. The children experience unpredictable expectations in a Foster Care home, based on cultural differences. As a result of these multiethnic placements, the counselors must be culturally sensitive and support children and families in the adjustment process (Chopra, 2013). The purpose of this project is to evaluate counselors' anxiety and self-efficacy, and training needs for responding to children, their biological parents or family of permanence, and foster parents during times of crisis.

By current accreditation and curriculum standards, counselors are unprepared to meet the above needs. (Larussi, Tucker, Crawford & Crawford, 2013). For example, current CACREP (2016) standards include only a cursory explanation of recommendations for crisis response

courses for counselor-education curriculums. Thus, for example, counselors in the field have reported responding to crises involving individuals at a frequency of at least once a week but feel unprepared to respond to crises (Watcher-Morris & Barrio-Minton, 2012). Moreover, research has not yet addressed concerns about counselors meeting the needs of families in crisis. These factors lead to the need for research regarding counselors' preparedness for crisis response, specifically, in family situations. For this research project, there will be an emphasis on crisis response in the family setting and will focus on the impacts on the community.

This chapter provides an overview of the presenting problem, intended measurement tool, purpose of the study, current gaps in research, states the research questions, and operational definitions. The topics discussed are followed by a summary of the chapter. Chapter two expands on these topics.

Background of the Study

To develop and define the purpose of this study, a review of the history of Foster Care is necessary. This section discusses the implications of the privatization of Foster Care, development of treatment levels of Foster Care, and the enhanced and complicated nature of crises in these services. To accurately discuss the need for the development of therapeutic Foster Care services, there must first be a detailed discussion of the privatization of Foster Care services. Following the discussion of the privatization of Foster Care services, is the discussion regarding the growing need for crisis response services for this population.

Privatization of Foster Care Services

As a result of the increase of children entering Foster Care services, particularly those children entering into care as a result of parental substance use, Foster Care advanced into a treatment service (RRFF, 2017). As the services changed, so did the providers. Recently, Foster

Care was privatized through the Department of Social Services (DSS). The privatization of Foster Care permitted private agencies to obtain licensure and offer placement to these children. The privatization of Foster Care services has been controversial. Stakeholders expressed concerns about privatizing the wellbeing of children (Humphrey, Turnbull, & Turnbull, 2006). Despite concerns from stakeholders, treatment providers (licensed counselors, licensed social workers, case managers, social workers, and psychiatric providers) established clear treatment guidelines and successfully met the needs of the families. The stakeholders and treatment providers collaborated to address meeting the needs of clients in Foster Care; as a result, several levels of Foster Care emerged. Unfortunately, despite the enhanced service provisions, children, foster families, and the family of permanence continue to have high rates of crises.

The privatization of Foster Care resulted in several levels of enhanced treatment services. Currently, there are three levels of Foster Care: Family Foster, Therapeutic Foster Care (TFC), and Intensive Alternative Family Treatment (IAFT; Rapid Resource for Families, 2017). Each level of Foster Care services offers an enhanced feature intended to meet the needs of each child in the least restrictive environment possible (NCDHHS, 2017). Serving as the entry-level of care, Family Foster Care is a service offered to children in need of emergency placement, safety, and underlying biological needs in a family setting (Pittcountync.gov, 2018). Family Foster Care is a service where children typically begin to share their traumatic experiences, access the necessary services (Pittcountync.gov, 2018). Family Foster Care is where most children are identified as needing a higher level of care, such as TFC or IAFT (RRFF, 2018); which are substantially more complicated levels of care.

Once a child receiving Family Foster Care has demonstrated challenging behaviors resulting in increased crisis response needs, they are typically referred to a more intensive level

of Foster Care (i.e., TFC or IAFT). Therapeutic Foster Care (TFC) is a level two, enhanced service, in which children can access several services. Children have access to 24/7 crisis response services, an individual therapist, and a foster family trained in supporting and housing a traumatized child (NCDHHS, 2017). These services include access to medical, psychiatric, therapeutic, and academic recommendations and treatment (NCDHHS, 2017). The services are person-centered for the individual child, and interventions are chosen based on the therapeutic need and feedback from the foster family's supervisor (NCDHHS, 2017). The supervisor of a foster family, a licensed counselor or case manager, provides weekly supervision and collaborates with other treatment professionals regarding the child's wellbeing and current behaviors (NCDHHS, 2017). The supervisor is also responsible for treatment planning and crisis preparation, intervention, and maintenance. The long-term goals with TFC, similar to family foster, is to reunify the child with their biological family (Pittcountync.gov, 2018). The long-term goals often require frequent collaboration and engagement with the child's biological family as well as the child and their foster family. In the event, a child continues to demonstrate increasingly more dangerous or maladaptive behaviors, or following hospitalization in an acute care setting, the child is then referred to Intensive Alternative Family Treatment (IAFT).

Intensive Alternative Family Treatment is a more intensive version of TFC. Children entering IAFT services can be referred from the other Foster Care services, hospitals, and group homes (RRFF, 2018). The children in IAFT services typically display dangerous and problematic behaviors in all settings, have expressed homicidal or suicidal ideation, and often engage in truant behaviors including leaving school or running away from their IAFT family (RRFF, 2018). Often the children entering IAFT services have multiple placement disruptions, meaning they have failed various foster families in the past (RRFF, 2018). The placement disruptions of

these children are often crisis-related, such as the child's behaviors are unsafe for a foster setting (NCDHHS, 2017). Unfortunately, due to the nature of services and child behaviors, some children in IAFT have experienced more than ten foster families since they entered the system. Many children have experienced hospitalization in a facility setting for at least 30 days. The foster families providing IAFT services for children are highly-trained and often have a wealth of experience in Foster Care. These families have regular oversight from counselors as part of a treatment team with a therapist and another team member to aid in crisis response as needed (RRFF, 2018).

In summary, there are several issues regarding client needs, service availability, treatment provider recommendations, stakeholder concerns, and ultimately, a lack of formalized training in family crises. Children in Foster Care have a history of complex trauma which requires trauma-focused interventions and treatment (Bartlett & Rushovich, 2018). Foster parents are offered little support and no formal training in crisis response. The majority of counselors are not exposed to family crisis response in academia, yet they are asked to respond to these crises as necessary for stabilizing the client and family. Research has not assessed the counselor's anxiety in responding to these crises, and any incongruency across academic programs, nor the influence of the counselor's experience on their anxiety and self-efficacy in responding to these events. The following section will detail concerns regarding counselor preparedness, self-efficacy, and anxiety in family crisis response.

Problem Statement

In each level of Foster Care, the family crisis response needs increase; consequently, the need for counselors to be competent in crisis response increases. Unfortunately, research is indicating that counselors do not hold much confidence in their ability to perform in a crisis

response situation (Watcher-Morris & Barrio-Minton, 2012). For example, the research conducted by Watcher-Morris and Barrio-Minton in 2012 noted that the majority of newly-graduated counselors (less than two years of experience) reported very little to no self-efficacy in crisis response. These same counselors also reported little to no preparation within the curriculum from their graduate program. Specifically, of the 193 participants, 24.35% reported no preparation in responding to individual or family trauma, while only 30% of counselors surveyed reported some crisis response training. These trainings come from sources such as a voluntary seminar, lecture, or dyadic experience. Despite the lack of training, these individuals reported their current job duties have them providing crisis response services at least weekly. This study may illustrate how current counselor-education programs miss the opportunity to prepare counselors to adequately respond to a variety of probable crises that they will encounter.

This lack of preparedness can have many consequences. For example, the lack of counselors-preparedness for crisis response when providing enhanced services, such as treatment Foster Care, can result in placement disruption. Once a placement disrupts, the child is then moved to another home, an acute care facility, or a group home. Regardless of where the child goes post-placement-disruption, there are several implications to their treatment prognosis (RRFF, 2017). Often, these children start their treatment process over, their trauma history will have grown, and they often experience more difficulty in making attachments (RRFF, 2017). The consequences of poor crisis-response services for these children and their families are profound. Unfortunately, very little research has focused on counselor crisis response for families. The research currently available on counselor crisis response has defined curriculum deficits as reported by counselors.

Statement of Purpose

Previous literature and research have indicated there are highly anxious and under-prepared counselors with low self-efficacy intervening and training others in crisis-response. As previously stated, the purpose of this project is to evaluate counselors' anxiety and self-efficacy, and training needs for responding to children, their biological parents or family of permanence, and foster parents during times of crisis. Specifically, counselor's anxiety, self-efficacy, and preparedness in response to family crises will be assessed. The study will utilize a quantitative analysis of the State Anxiety Inventory (STAI) and the Counselor Self-Estimate Inventory (COSE) in a repeated measures Multivariate Analysis of Variance (MANOVA). This study seeks to measure the influence of curriculum exposure as counselor preparedness, and licensure type as counselor experience (both independent variables) on the (dependent variables) measurements of the STAI and the COSE. Additionally, this study will capture how counselors currently meet their training and supervision needs in crisis response. If the implications of previous research hold, there are significant areas of concern regarding counselor education, clinical supervision, and agency supervisors.

Study Significance

The results of this study may reveal implications for counselor education, supervision, and practice. For counselor education, this study may indicate areas of deficits in curriculum standards. Previous research has shown little to no training for counselor-education students (Watcher-Morris & Barrio-Minton, 2012). Current CACREP standards regarding counselor-education programs offer vague operational definitions. For example, the outcome of the study may offer areas for improvement in counselors-education programs regarding family crisis training and education. Regardless of where counselors are accessing the necessary family crisis

response skills, the curriculum should reflect the inclusion of methods for learning about and responding to crises (Sawyer, Phillips, & Williams, 2013). This research study may support the need for curriculum-specific exposure to crises in families. If counselors are accessing family crisis response training, seeking clinical supervision, or learning through the experience, all these methods can be addressed in a curriculum or supervision setting.

For counselor supervision, this study may indicate areas supervisors compensate for deficits in curriculum exposure. For example, counselor supervision may provide novice counselors the opportunity to engage in training for crisis response. Additionally, this study may indicate strategies for addressing the curricular deficits during supervision. This study will also seek to propose, through Social Cognitive Theory (SCT; Bandura, 2002), methods of addressing families in crisis in clinical supervision. For example, there is the benefit of facilitating a counselor's acceptance and endorsement of current skills and abilities (Bernard & Goodyear, 2014). counselors self-endorsing of current skills and abilities may contribute to an overall increase in self-efficacy (Bandura, 2002). Higher self-efficacy rates often coincide with lower state-anxiety rates (Karaimak, 2018; Barbee, Sherer, & Combs, 2003).

As well, this study may detail opportunities to gain knowledge and prepare for crises. Strategies for counselors to prepare for high-intensity crisis-response situations for families can help counselors overcome gaps in their curriculum exposure. Strategies for accessing crisis-response training can include local training providers, clinical supervision, peer supervision, or experience. This study will indicate areas where counselors find the most success in preparing for crises with families.

Research Questions

For this study, there are six research questions. These research questions seek to assess the influence of experience and curriculum exposure independently, as well as curriculum exposure and experience interactions on counselor anxiety and counselor self-efficacy in crisis response. counselor experience (categorical, independent variable) will be categorized based on the counselor's licensure level, of which there are three: provisional, full license, and supervisor license (North Carolina Board of Licensed Mental Health Counselors; NCBLCMHC, 2019). The first continuous, dependent variable, counselor anxiety, will be measured using counselors' state anxiety scores from the State-Trait Inventory (STAI; Spielberger, 1983). The second continuous, dependent variable, counselor self-efficacy will be measured using the Counseling Self-Estimate Inventory (COSE; Larson et al., 1992). Previous research indicates the state-anxiety subscale is appropriate for use separate from the trait subscale questions of the STAI (Otori, Takahashi, Urashima, Kuwayami, & Quality of Life Committee, 2017). The brief version of the Counselor Self-Estimate Inventory (Karaimak, 2018) will measure counselor self-efficacy. This study will be guided by the over-arching question: Is counselor self-efficacy and anxiety influenced by curriculum-exposure and experience? The research questions for this study will be detailed later in chapter three.

Study Justification

This study will generate data regarding counselor anxiety and self-efficacy when responding to family crises. Similarly, this study will also assess the effects of curriculum, and counselor experience on counselor anxiety and self-efficacy when responding to family crises. As previously noted, counselors are consistently reporting a deficit in their programs regarding crisis-response (Larussi et al., 2013). Counselors report a deficit in academia regarding crisis

preparation. The lack of academic training may be due to the counselors-education governing body, which does not have any curriculum specifications for crisis response education (the Council of Accreditation of Counselor Education and Related Programs; CACREP, 2016).

The growing population in Foster Care services deserves appropriate and efficient services that facilitate their ability to meet long-term goals. The lack of current research, the implications of previous research, and the growing demand for Foster Care services are all calling for more information on counselors' anxiety, self-efficacy, and preparedness for crisis response. This study would assess crisis-response in family settings specific to education and experience levels. The findings of the study could offer some explanation as to the impact of experience and clinical supervision in the crisis state-anxiety and self-efficacy levels. In order to assess the variables and measure them appropriately, a definition of the terms used for this research are discussed.

Definition of Terms

This research study will require several definitions of terms to facilitate quantifying the information, and are as follows:

Family: For this research, any *family* with whom the child will be living post-services is the child's family of permanence. The intention of having a definition for this family is the result of many children not returning to their biological families. Children may be unable to return to their family of origin for various reasons, and instead, living with another family member, an adoptive family, or remaining in their foster family indefinitely.

Treatment Family: *Treatment family* will refer to any Foster Care family where there could be one or more adults present, regardless of the number of children in the home. Another definition of terms is the use of Foster Care services to encompass all three levels of Foster Care.

Experience: Please note that from the time the IRB approved this study and survey regarding licensure, the licensing board changed the name of the licensure from Licensed Professional Counselor (LPC) to Licensed Clinical Mental Health Counselor. Participants will be categorized as *new counselors* if they have graduated within the last two years and hold an Associate Licensed Mental Health Counselor licensure. Participants with experience past two years will be noted as *experienced* counselors and holding a full Licensed Clinical Mental Health Counselor licensure. Participants holding a supervisor's license, Licensed Clinical Mental Health Counselor Supervisor (LCMHCS) will be considered *experienced*.

Curriculum Exposure: Previous literature and research have referred to training and academic preparation of crisis response as "curriculum exposure" as defined by Watcher-Morris and Barrio-Minton in 2012 and this language will remain present throughout this dissertation.

State Anxiety: Spielberger (1983) noted that one of the two major components of anxiety is an individual's state anxiety. State anxiety is an individual's momentary anxiety in response to a particular state or situation.

Self-efficacy: Albert Bandura (2002) established the concept of self-efficacy as one's perception of their ability to perform a task. This self-perception or self-estimate of skill is often developed in relationship to peer performance. The COSE will measure counselor self-efficacy (Karaimak, 2018; Larson et al., 1992) in family crisis response events.

Chapter Summary

This research study is seeking to address the intersection of increased demands on crisis response services for families, the lack of crisis response training in the curriculum, and implications for counselor anxiety and self-efficacy. However, the counselor-education programs overall are not producing counselors prepared to respond to crises. Similarly, the changes in

Foster Care services and the growing need for Foster Care placements with access to crisis response services are not consistently resulting in the desired outcomes of reunification (RRFF, 2018). The use of defined terms of "family" and other variables for this study, as well as discussion of the gaps in research, inconsistencies in counselor preparedness and job duties, support this study's purpose. As the counseling field continues to develop in professional identity and scope of practice, the counselor-education programs will continue to modify curriculum standards. This research study will likely assist in defining considerations for training and teaching crisis-response to new counselors. Additionally, this study could identify where and how the learning is occurring post-graduation. The next chapter will provide an in-depth review of applicable literature in the field of counselor crisis-response and curriculum exposure.

CHAPTER TWO: LITERATURE REVIEW

Introduction

This chapter will review relevant theory and research pertaining to the development of crisis-response services, as well as counselors' crisis-response preparation and needs. First, a review of Social Cognitive Theory is presented as the basis for this study. Second, research on counselor anxiety is reviewed in a general context and in the context of crisis services. Third, research on counselor self-efficacy is reviewed in general and crisis services contexts. Fourth, crisis event research concerning family crises will be reviewed. Fifth, research on counselor training and supervision opportunities will be reviewed (Greene, Williams, Harris, Travis, & Kim, 2016; Sawyer, Peters, & Willis, 2013). Lastly, from these reviews, this chapter will conclude with hypotheses about counselor self-efficacy and anxiety in the context of crisis response. For this research, "counselor" will include Licensed Clinical Mental Health Counselor-associates (LCMHCAs), Licensed Clinical Mental Health Counselors (LCMHCs), and Licensed Clinical Mental Health Counselor Supervisors (LCMHCSs).

Social Cognitive Theory

For this research study, we will explore counselor anxiety and self-efficacy in response to family crises through the lens of Social Cognitive Theory (SCT; Bandura, 1977). Social Cognitive Theory was developed by Albert Bandura in 1977. Bandura (1977) presented several areas of consideration for how counselors in training acquire new knowledge and interpret their self-efficacy, and subsequent anxiety-response, in understanding new information and practicing new skills (Bandura, 1977). Social Cognitive Theory consists of six concepts regarding the motivation for counselors in training to learn and perform a new skill competently (Bandura, 2001). These six concepts include:

1. Social reinforcement
2. Reciprocal determinism
3. Behavioral capability
4. Observational learning
5. Reinforcements or expectation
6. Self-efficacy

In order to apply SCT to the current study, these major tenets will be discussed in the context of counselor self-efficacy when dealing with clients in crisis.

Social Cognitive Theory presents a strong focus on the importance of behaviors and social learning in human development (Bandura, 2002). Social Cognitive Theory is considered culturally sensitive in nature and appropriate for discussing self-efficacy in response to specific cultural contexts (Bandura, 2002; Larussi et al., 2016; Newman, 2013). Social Cognitive Theory is beneficial as a teaching, and potentially a supervision model, for counselors in training and development of counselors' crisis management strategies (Valle, Kacmar, Zivnuska, & Hartin, 2019). The interventions, such as role-plays, agenda-setting, and challenging cognitions, are all opportunities to reduce counselor anxiety (Tolleson, Grad, Zabek, Zeligman, 2017; Cummings, Ballantyne, & Scallion, 2015; Osborn, & Costas, 2013) and increase self-efficacy (Bernard & Goodyear, 2014).

Social Reinforcement refers to either internalized social constructs or current external cues that encourage or discourage the individual from continuing a skill. Reinforcements in counselor-education can be grades, peer or instructor praise, and in the work-place reinforcements may include pay, awards, or positive client-feedback. Supervisors can engage in social reinforcement in clinical supervision as well. For example, supervisors can decrease

anxiety and subsequently promote self-efficacy (Tolleson et al., 2017) by providing consistent and appropriate praise. Another example of social reinforcement in clinical supervision can be the use of dyadic supervision with structured agendas which allow one counselor to present on a case at a time and allow the other counselor to provide peer feedback.

The concept of ***reciprocal determinism*** is the idea of the dynamic interactions of the individual concerning their environment and skills. Reciprocal determinism is the interactions the individual has in their environments, including values, beliefs, stigmas, and self-perception. Following a family crisis, supervisors can support counselors through interventions based on reciprocal determinism. These interventions can include reviewing and praising skills in which the counselor demonstrated competency, as well as, praising the counselor's awareness of skills they can improve. Supervisors can also support counselors in preparing clients and families in managing their own crises. Supervisors can utilize the concepts of reciprocal determinism in promoting the counselors' ability to support clients and families in identifying community resources, assessing the family's protective factors and assisting them in identifying how to utilize those resources to prevent a crisis, intervene during a crisis, and post-crisis.

The ***behavioral capability*** of the individual is that an individual will demonstrate skills congruent with their knowledge (Bandura, 1986). The behavioral capability of the counselor can be addressed in academic work or supervision as well. New counselors may report low self-efficacy if they feel unprepared to intervene; providing new counselors with individualized training or educational opportunities to fill-in gaps in preparedness for crisis response can be helpful. Supervisors may also need to reinforce skills and knowledge the counselor has during the early stages of supervision (Stoltenberg, 1998). Providing social reinforcements of skills to

the counselor-in-training may reduce the counselor's anxiety and increase self-efficacy (Tolleson et al., 2017) which may ultimately increase their behavioral capability.

Observational learning occurs when the individual can observe a behavior demonstrated by another individual and then recreate the same behaviors (Bandura, 1986). Humans, as social creatures, engage in observational learning for many aspects of development. As a counselor-training technique, observational learning can include role-playing and shadowing in crisis events. Supervision, counselor-education programs, and job-training can all utilize observational learning opportunities. Dyadic supervision can allow the use of role-play with observational learning and ultimately decrease counselor anxiety while increasing counselor self-efficacy (Tolleson et al., 2017; Osborn, & Costas, 2013). The supervisor in dyadic supervision can encourage counselors to role-play clients while the supervisor provides crisis interventions (Tolleson et al., 2017). Counselors can also benefit from observing crisis-intervention from an experienced and competent colleague.

Expectations are the individual's anticipated outcomes for a skill (Bandura, 1986). The process of counselor-education and supervision can include case studies, anticipatory guidance, and guided imagery of a real or potential crisis the counselor may encounter. The use of anticipatory guidance and guided imagery of a potential crisis with a family can allow the counselor to develop realistic expectations of what could occur and their role in responding and de-escalating the crisis. Realistic expectations of crisis de-escalation interventions can protect the counselor from being overly critical of their skills and abilities. Ultimately, when the counselor's expectations and outcomes match, they develop lower anxiety and higher perceptions of self-efficacy.

Self-efficacy is an individual's perception of their ability to perform a task (Bandura, 2001). Self-efficacy develops as an individual perceives their competency of a new skill in comparison with peers, teachers, or experts in the field (Bandura & Watts, 1996). Concepts of efficacy and regulation in SCT develop through social and peer learning (Bandura & Watts, 1996). Additionally, SCT can be a framework for constructing educational programs and peer reinforcement (Bandura, 1977). Examples of reducing anxiety and building self-efficacy include challenging disruptive thoughts and facilitating the individual's replacement of negative thoughts with positive ones is a concept in SCT, which promotes healthy cognitions (Bandura, 2001). Another example of challenging cognitions in SCT could be, confronting the individual's unrealistic expectations of a task. Clinical supervisors, Professors, and agency supervisors can challenge the new counselor to develop healthy expectations, and access specific training needs, regarding new crisis response skills.

Social learning theories such as SCT provides methods of reducing anxiety and improving self-efficacy in new skill acquisition for counselors (Beeson, Whitney & Peterson, 2017). Moreover, the use of SCT for understanding the relationship between counselor anxiety and self-efficacy is warranted.

Counselor Anxiety

Counselor anxiety has a host of implications for the counselor, the profession, and the client (Pirtle, Wang, Brown, & Lainas, 2019). Research has revealed that counselors-in-training and newly licensed counselors indicate statistically significant anxiety scores regarding their general performance (Smith, Robinson, & Young, 2007). Additionally, counselor anxiety has been attributed to poor or inhibited counselor performance. For example, previous research has sought to explain the anxiety as a response to the ambiguity of helping duties compared to

counseling duties (Skovholt, & Ronnestad, 2003); however, more recent research has indicated anxiety stems from the lack of curriculum preparation (Watcher-Morris & Barrio-Minton, 2012). Research also highlights the negative impact of anxiety on overall wellbeing (physical and mental health), and consequently counselor burnout, or compassion fatigue (Pirtle et al., 2019; Young & Lambie, 2007). Essentially, research indicates that high rates of anxiety contribute to counselor burnout which can have dire implications for clients and their families (Pirtle et al., 2019), such as poor service delivery, disruption to the family function, and resulting conflict (Trepal, Wester, & MacDonald, 2006). Based on the research it is appropriate to conclude that counselor anxiety may permeate all areas of the counselor's professional efficacy, competency, and service delivery. Indeed, counselors continue reporting the same high rates of anxiety after the early stages of their professional development in regard to crisis response duties (Tuttle, Ricks, & Taylor, 2019).

Typically, counselor anxiety regarding the counseling practice appears to subside in the early stages of their professional career (Skovholt, & Ronnestad, 2003); however, counselor anxiety regarding crisis response persists over time. Crisis response duties are one of many vital tasks for which counselors are responsible during a client's treatment (Pirtle et al., 2019; McAdams, & Keener, 2008). Furthermore, counselors, as crisis responders, report feeling ill-equipped to use de-escalation strategies, are unfamiliar with crisis theory, and unsure how to debrief a client post-crisis (Greene et al., 2016; Watcher-Morris & Barrio-Minton, 2012). This is troubling since crisis response is an area of growing demand in the counseling field (Pirtle et al., 2019). Unfortunately, the nature of crises has changed over time to include mass casualty events resulting in larger populations of trauma survivors all requiring specialized services (McAdams & Keener, 2008).

Research conducted by Neimeyer and Neimeyer (1984) noted concerns regarding heightened anxiety of counselors in responding to suicidal clients. While this study did not indicate heightened anxiety for all counselors responding to suicide-specific crises as previous research had done, it did highlight the concern that some counselors may experience heightened anxiety regarding the crisis response event, and subsequent anxiety about responding in future crisis events. This heightened anxiety can impede the efficacy of the counselor and subsequent outcomes of interventions provided. Another, recent research study indicated treatment professionals (counselors, therapists) have an emotional response to clients experiencing suicidal ideations (Barzilay et al., 2018). These individuals may identify feelings similarly with the client, or experience transference issues. This research study presented unique concerns about the effects of long-term exposure of counselors to suicidal clients. This study also presents the first indications that counselors regularly responding to crises may experience anxiety from the client and crisis situation, in addition to previous concerns about the lack of curriculum exposure.

Previous literature suggests counselors may also encounter anxiety provoking situations around counseling groups. One article by Billow (2001) detailed how even experienced counselors may experience anxiety when adding a group member or suddenly losing a group member in counseling groups. Billow (2001) proposed the importance of anxiety management and noted that the feelings of anxiety may present in statements about their efficacy. Arguably, Shamoon, Lappan, Blow (2001) defined counselor anxiety as "the discomfort and innate reaction that occurs in response to a given stimulus" (p. 43); however, this can be a vague definition inclusive of the most subtle to the most detrimental of counselor reactions. This study will adhere to this definition of anxiety and include the idea that counselors will rate anxiety solely on the constructs presented in the State-Trait Anxiety Inventory (STAI) which will be discussed further

in chapter 3. The symptoms of counselor anxiety most often noted by researchers include negative introspection and subsequent reevaluation of self, possible reactivity and aggression in confrontation or transference and countertransference issues. All these symptoms can result in poor service delivery. While this article focused on group counselor anxiety, couples and families present more concerns regarding counselor anxiety.

One research study by Shamoon, Lappan, & Blow (2016) specifically noted concerns about counselor anxiety in couples and family counseling. These researchers expressed concerns about counselor anxiety in providing appropriate and effective couples and family counseling due to the high-tension relationships that present in these counseling settings. They noted increased concerns about counselor anxiety surrounding clients that are particularly hostile or closed-minded. Similar concerns are presented about a greater potential for the counselor to experience their own unresolved feelings regarding their family history when providing counseling services to hostile family members. Lastly, they present concerns about the number of family members as the propensity for hostile behaviors, conflict, and counselor reactivity may increase. These concerns were addressed by the researchers in proposing several strategies for counselor anxiety management including introspection, counseling, and supervision. These compounding factors are particularly concerning as this article presents on counselor anxiety only in the context of couples and family counseling, not specifically crisis-response.

The lack of curriculum exposure has even more implications for counselor anxiety as previous research indicates that self-efficacy (developed through counselor-education curriculum and assignments) can buffer the effects of anxiety (Skovholt & Ronnestad, 2003). Unfortunately, the few counselor-education programs which do address crises, may do so in an only one-time didactic presentation, and very few offer an entire elective course on the topic (Watcher-Morris

& Barrio-Minton, 2012). Programs for counselor-education also do not consistently provide similar content when addressing crisis response (Watcher-Morris & Barrio-Minton, 2012). Of the crisis response topics addressed, most often suicide prevention or natural disaster response are covered (Watcher-Morris & Barrio-Minton, 2012). The lack of curriculum exposure regarding crisis response has significant implications on counselor self-efficacy as well (Watcher-Morris & Barrio-Minton, 2012).

Counselor Self-Efficacy

It is common for new counselors to have low self-efficacy in the early stages of practice (Skovholt & Ronnestad, 2003). Indeed, some researchers explain self-efficacy is related to counselor development stages and indicate that once a counselor is past the early stages of development, they report higher levels of self-efficacy (Skovholt, & Ronnestad, 2003; Stoltenberg, 1998). Typically, counselor self-efficacy improves with practice of skills and clinical supervision interventions (Bernard & Goodyear, 2014). Similarly, counselors report the knowledge and experiences they gain in their coursework helps to build their confidence while they develop self-efficacy in practice (Skovholt, & Ronnestad, 2003). These assumptions, supported by research, are indicative of the social learning concepts in SCT (Bandura, 1996), as anticipated a counselor's self-efficacy increases with knowledge and practice (Bernard & Goodyear, 2014). However, for many counselors, low self-efficacy rates persist regarding perception of his or her crisis response skills.

An article by Neimeyer, Fortner, and Melby (2001) noted the importance of experience and exposure in developing counselor self-efficacy regarding counseling. Their research noted that counselors with experience counseling suicidal clients, were more successful in intervening when a client expressed suicidal ideation. They also indicated the importance of counselor's

attitudes towards suicidal ideations as a symptom or suicide as an impulsive act, as those that indicated openness on these topics had more experience and indicated they would be more likely to respond optimally. Lastly, they noted the counselor's attitude around suicide, and a person's right to die can interfere with their ability to provide effective intervention and ultimately contribute to the counselor's low self-efficacy. These findings indicate that counselors are both ill-prepared and unaware of how their attitudes towards these topics can adversely affect their clients when responding to crises.

Another research study indicated low self-efficacy among counselors responding to clients with suicidal ideations. Elliot et al., (2018) noted concerns regarding the development of self-efficacy in counseling students and the lack of curriculum exposure in responding to suicidal clients. This research study indicated clinical supervision may be the most critical intervention in increasing self-efficacy regarding counseling suicidal clients, especially as a result of a lack of curriculum exposure. This study noted that clinical supervision provided counselors-in-training the opportunity to confront counselor's self-blaming statements and reinforce skills and abilities. Additionally, this study noted the importance of additional trainings in developing self-efficacy in working with suicidal clients. Much of this study translates well to crisis response as individuals and family members may experience suicidal ideations resulting in crises and impacting counselor self-efficacy.

Several studies have detailed the limited nature of crisis-response training in curriculums (Watcher-Morris & Barrio-Minton, 2012; Allen et al., 2002), and as a result, licensed clinicians (and even more so, newly licensed clinicians) have consistently reported low self-efficacy with regards to crisis response duties (Sawyer, Peters, & Willis, 2013). Concerns regarding changes in the nature of crisis response from solely natural disasters to include domestic violence and mass

casualty events, such as shootings and bombings, have forever changed the landscape of crisis response services (Donahue & Tuohy, 2006). Curriculums have yet to meet the needs of counselors-in-training in preparing to prevent, intervene, or respond post-crisis to these mass-casualty events (Sawyer, Peters, & Willis, 2013). Domestic violence crises, as well as family crises, include multitudes of dynamics, emotional connections, and attachments. These situations can be highly volatile in the most benign circumstances and pose greater risk of compassion fatigue or counselor burnout for many reasons (Lee, Veach, MacFarlane, & LeRoy, 2015).

Domestic violence and/or family crises, are often high-tension situations, for which, counselors with high anxiety and low self-efficacy, can be chaotic and potentially dangerous situations. Unfortunately, family members can provoke or exacerbate these crises, contributing to poor outcomes for crisis response interventions for the identified patient (Gladding, 2015). While there is very limited research explaining counselors' low self-efficacy in family crisis response interventions, there are several factors to consider as possible explanations. Counselors responding to family crises are tasked with intervening at the individual and family system level (Gladding, 2015), prompting input from family members, and healthy communication across all involved parties. Additionally, counselors are responsible for ensuring the safety of all members which can result in hospitalization for the identified patient, or contacting the police on behalf of the family, in the event of child abuse or other mandated responder criteria (Tuttle et al., 2019). The profundity of several factors including counselor liability, safety, family dynamics requires a skilled counselor with low anxiety and high self-efficacy, to intervene.

Counselor Crisis Response in Families

Counselors serve several functions in administering counseling services to clients. One of the counselor duties includes responding to clients during times of crisis. Many service

definitions and Community Mental Health Providers are required by third-party payors to provide a protocol for crisis response (North Carolina Department of Health and Human Services; NCDHHS, 2019b). The counselor is responsible for delivering these interventions. During a crisis event, the counselor's responsibilities can increase with respect to the service level (NCDHHS, 2019; 2017a). There appears to be a positive correlation between levels of care, such as inpatient services, rates, and intensity of crisis events (NCDHHS, 2017b). This is due to the increase in frequency and/or intensity of crises as a higher level of care is required for safety and stabilization purposes. Often the populations in enhanced levels of care are also heavily traumatized (Zelechoski et al., 2013). The specific crisis-intervention provided by the counselor can have a profound influence on the client's progress in treatment and overall wellbeing (Bode, George, Weist, Stephan, Lever & Youngstrom, 2016). As the chosen intervention can significantly impact the outcome of the crisis, regulations on crisis response services have changed over time drastically. In discussing counselor duties and preparedness, the current research indicates an area of deficit regarding crisis response: the family.

Consideration of the family dynamics during a crisis is critical to the counselors' management of crises. Clients' family members can have a significant influence on client outcomes and greatly influence the efficacy of de-escalation techniques during a crisis (Cardona, Breseke, Nelson, Johns, & Mack, 2013). Some family members can exacerbate the conflict, provoke reactive behaviors or threats, and contribute to continued problematic communication (Myer et al., 2014). These family members can create a toxic environment for crisis de-escalation. Family systems are also affected by the outcome of the crisis intervention. As a result of crisis intervention, the family system will change, their engagement in the treatment process may also change, and communication with the identified patient is affected (Tuttle et al., 2019).

Crisis interventions can have profound consequences for children, whether the child or parent is the identified patient (Tuttle et al., 2019). The presence of police or other emergency responders can have weighty consequences for the child's emotional and mental wellbeing (Tuttle et al., 2019).

More concerning still, is that the incidence of mass casualty violence has been steadily increasing (Gramlich, 2019; DiLeo et al., 2018). Unfortunately, school shootings, for instance have been increasing both in frequency and fatalities with the most deadly occurring in Sandy Hook Elementary school in Connecticut in 2012 (DiLeo et al., 2018). The ramifications of the violence in Connecticut had significant impacts on all families with children attending Sandy Hook Elementary, families that lost loved ones, and may be a source of vicarious or secondary trauma for families nationwide. These types of mass causality events have led some states such as Connecticut to develop specialized taskforces comprised of individuals such as law enforcement and mental health professionals to intervene at the community, family, and individual level (DiLeo et al., 2018). These taskforces introduce specialized crisis intervention services which include mental health counselors as service providers (DiLeo et al., 2018). All of these factors, and job duties, can have serious consequences for the client and family if crisis response services are inadequate further emphasizing the need for appropriate training and education.

Counselors working in family services and settings need to be able to support the families when caring for clients in crisis. Since counselors often need to respond to both the client and the family during the crisis event, they should be well trained in interventions such as compromise, problem-solving, stabilization of client behaviors, and confrontation. (Lancaster, Ovrebo, & Zuckerman, 2017). These skills can be challenging for new counselors, especially in crises where

several counselors-in-training are contributing to, and responsible for resolving the crisis event (McAdams & Keener, 2008). Moreover, counselors report high anxiety and low confidence in their ability to implement these interventions (Al-Darmaki, 2004; Barbee, Sherer, & Combs, 2003). Formal crisis response training, curriculum exposure, and clinical supervision may be the first opportunities to develop counselor crisis response skills.

Crisis-Response Training and Supervision

A commonality across the above research is poor curriculum exposure and lack of training in counselor-education programs. Research has consistently demonstrated less than 30% of counselors had any formal course work or training during their academic programs regarding crisis response. Moreover, in a research study conducted by Watcher Morris and Barrio Minton (2012) produced alarming results. This study found approximately 44% of counselors had minimal to no preparation regarding crisis definitions, and over 60% reported minimal to no preparation regarding crisis theory. While 50% of counselors have reported minimal to no preparation regarding crisis intervention skills, almost 60% indicated minimal to no preparation was provided regarding crisis case management skills. Consistently, counselors indicated at a rate of 50% or greater, minimal to no preparation regarding intimate partner violence, sexual assault, physical assault, violence intervention, and community disaster. Of particular concern, 57% of counselors indicate little to no preparation regarding crisis at the individual or family level. These researchers also noted that of the few counselors obtaining training regarding crisis response, are doing so outside of the curriculum. One of the concerns contributing to the lack of formal training and curriculum exposure could be the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards.

The CACREP (2016) standards do not isolate specific expectations for crisis response; these standards defer crisis training to the ethical codes such as the duty to warn (American Counseling Association; ACA, 2014). The lack of continuity in crisis response training provided to counselors-in-training is noted consistently as problematic in research (Wachter Morris, & Barrio Minton, 2012). Most counselors (and counseling students) are reporting a lack of training in school regarding crisis events, including infrequent chances to volunteer or role-play crisis response (Binkley & Leibert, 2015; Barrio Minton & Pease-Carter, 2011; Hansel et al., 2011). Hence, most counselors-in-training and new professionals indicate low self-efficacy, thusly supporting their recommendations for curriculums to address crisis intervention, prevention, and planning (Binkley & Leibert, 2015). Counselors are reporting low self-efficacy regarding crisis response including feeling ill-equipped and unprepared for managing crises (Brinkley & Leibert, 2015). The increased responsibility of counselors to respond to various crises indicates the need for counselor educators and supervisors to address crisis response in the curriculum (Binkley & Leibert, 2015). Counselors will likely begin to explore their fears or deficits regarding crisis response for the first time in clinical supervision.

Supervision

Newly licensed counselors have consistently reported low self-efficacy (Sawyer et al., 2013) and high anxiety (Skovholt, & Ronnestad, 2003). Recent research studies have indicated several factors of clinical supervision contribute to higher levels of self-efficacy and lower levels of anxiety in new counselors regarding general counseling skills (Dupre, Echterling, Meixner, Anderson, & Kielty, 2014). Some of the factors influencing self-efficacy include: the supervisory alliance, genuineness of the supervisor, supervisors' willingness to problem solve with the supervisee, the supervisor's provision of resources, and homework assignments (Alfonsson,

Spannargard, Parling, Andersson, & Lundgren, 2017; Haarhoff, & Kazantzis, 2007; Dupre et al., 2014). Another factor is multicultural awareness.

Multicultural interventions are necessary for Community Mental Health Provider supervisors, inpatient supervisors, and crisis responders in all settings and services. The supervisor's willingness to address multicultural issues contributes to a stronger working alliance with the counseling student or newly licensed counselor (Crockett, & Hays, 2015; Chopra, 2013). Additionally, multicultural awareness in supervision is essential for crisis response with families as families can be blended, coexist in larger multigenerational systems, and/or serve as foster or adoptive families, and the counselor is responsible for attempting to stabilize the entire family unit during a crisis. The changes in society have been noted as contributing to intergenerational conflict (Raiz, Malik, Yasmin, & Malik, 2017). These societal changes and increase in intergenerational conflicts have consequences for family crises. Family crises will likely continue to increase in frequency, subsequently increasing the need for crisis-competent clinical supervisors (Raiz et al., 2017).

Research Questions

Based on the above, in application of the theoretical lens of SCT to counselor self-efficacy and anxiety in responding to families in crisis, there are several research questions worth answering.

RQ1: What is the influence of counselors' experience levels on their change in anxiety when responding to a family crisis?

RQ2: What is the influence of counselors' experience levels on their change in self-efficacy when responding to a family crisis?

RQ3: What is the influence of counselor curriculum-exposure on counselor anxiety when responding to crises in a family setting?

RQ4: What is the influence of counselor curriculum-exposure on counselor self-efficacy when responding to crises in a family setting?

RQ5: When responding to a family crisis, does the effect of curriculum-exposure on counselor anxiety depend on the counselor's experience?

RQ6: When responding to a family crisis, does the effect of curriculum-exposure on counselor self-efficacy depend on the counselor's experience?

These research questions will be explored further in chapter 3.

Chapter Summary

This chapter reviewed the basic premise and tenets of SCT, application to counselor anxiety and self-efficacy as well as counselor education. Several concerns regarding deficits in academic settings concerning crisis training were presented as well. Research implications for how to address deficits, consequences of unprepared counselors, and subsequent research questions were proposed. The concerns surrounding crisis response in the curriculum of counselor-education programs are consistent, such as a lack of training and lack of continuity across programs (Watcher Morris & Barrio Minton, 2012). The lack of crisis response training can contribute to a host of issues for the individual, the individual's family, and the community (Schiele, Weist, Youngstrom, Stephan, & Lever, 2014). Inadequate crisis response can cause compassion fatigue in caregivers and result in counselor burnout (Bellamy, Wang, McGee, Liu, & Robinson, 2018). Compassion fatigue for caregivers of the identified client can present as depressive symptoms, anxiety, and ultimately require additional mental health services for a family (Birkeland, Weimand, Ruud, Høie, & Vederhus, 2017; Lee et al., 2015). Inappropriate

hospitalizations can result in the client's exposure to multiple stressors, including distrust of the mental health system, re-traumatization, victimization, and medical bills for services rendered against their will (as is the case with involuntary hospitalization). Hospitalization and potential escalation in support services (such as inpatient, enhanced, case management, as well as any specialized therapy services) could all contribute to recidivism among higher levels-of-care for the client as well as exorbitant costs to the client and family (Schiele et al., 2014).

Inappropriate crisis response, and subsequent hospitalization result in higher-level services and ultimately longer lengths of stay in services. The influence of an unprepared counselor in crisis response has far-reaching consequences such as years of mental health services for the clients (Schiele et al., 2014). The need to train counselors in crisis response for both the clients and the families only increases over time. As a result of these concerns, this study will seek to identify the areas of deficit, identify methods of improvement, and assess the influence of curriculum-exposure on the counselor's anxiety and self-efficacy. The next chapter will review the study protocol and data collection procedures.

CHAPTER THREE: METHODS

Introduction

This chapter presents the methods and study design for measuring counselor anxiety and self-efficacy in crisis response for families. This chapter also discusses the purpose of the study and clearly defines the variables, population, and sample. Statistical analyses regarding counselor anxiety and self-efficacy in providing crisis response in families is also discussed. Lastly, ethical considerations, limitations and delimitations is assessed.

Research Questions

The purpose of this study is to assess for differences across licensure types for Licensed Clinical Mental Health Counselors (LCMHCs) regarding counselor anxiety and self-efficacy in family crisis response.

The research questions for this study were:

RQ1: What is the influence of counselors' experience levels on their change in anxiety when responding to a family crisis?

RQ2: What is the influence of counselors' experience levels on their change in self-efficacy when responding to a family crisis?

RQ3: What is the influence of counselor curriculum-exposure on counselor anxiety when responding to crises in a family setting?

RQ4: What is the influence of counselor curriculum-exposure on counselor self-efficacy when responding to crises in a family setting?

RQ5: When responding to a family crisis, does the effect of curriculum-exposure on counselor anxiety depend on the counselor's experience?

RQ6: When responding to a family crisis, does the effect of curriculum-exposure on counselor self-efficacy depend on the counselor's experience?

This study used three levels of licensure as the independent variable of experience. curriculum exposure was based on self-report on the demographic question and served as an independent variable. The use of the State-Trait Anxiety Inventory (STAI) was used to address the dependent variable of counselor anxiety and Counselor Self-Estimate Inventory (COSE) measured the other independent variable of counselor self-efficacy in responding to family crises. The responses of participants from different licensure levels on the demographic survey assisted in measuring the effects of experience as well as education requirements on counselor anxiety and self-efficacy.

These research questions sought to describe the influence of curriculum exposure and experience on counselor anxiety and self-efficacy in family crisis events. These questions also sought to assess the influence of experience on counselor anxiety and crisis response in family crisis events. Lastly, these questions sought to assess the interaction of experience and curriculum exposure on counselor anxiety as well as counselor self-efficacy.

Population and Sample

The identified target population was newly licensed, fully licensed, and licensed supervisors from the Licensed Clinical Mental Health Counselor (LCMHC) field in North Carolina. Demographic information collected on the participants, such as licensure-type, determined which group the participants were placed in for data analysis. The surveys were provided to individuals licensed through the LCMHC licensing board. There are currently over 3,000 LCMHCs practicing in North Carolina of various licensure levels, of which approximately

75-80% are female and predominately Caucasian (Burns & Cruikshanks, 2018; Lent & Schwartz, 2012).

Sample Size

The sample size for this study was determined based on several factors including the actual population of Licensed Clinical Mental Health Counselors in North Carolina, G*power estimates, and the statistical analyses utilized. G*power is a software used to facilitate an accurate prediction of the sample size necessary to accurately measure the effects and interactions based on the statistical analysis utilized (Laerd, 2018). Use of G*power requires the researcher to set, a priori, an effect size, an alpha level, a beta level, and the planned statistical analysis. For the current study, a Cohen's *f* was used with a value of .25 for the power analysis (Moore, McCabe, & Craig, 2009). This *f* value of .25 is a moderate effect of significance. The chosen significance level is .05 based on similar research in the counseling field, and the applied beta level of .8 produced a sample size of 27. For the purpose of meeting all assumptions of the MANOVA the desired sample size was 30, with ten participants in each licensure group. The repeated measures MANOVA design offers unique advantages of group comparison and is more reliable even with smaller sample sizes (Moore, McCabe, & Craig, 2009); Manly, 2004). Additional statistical analyses assessed for effect size, as well as Cronbach's alpha for power analysis (Moore, McCabe, & Craig, 2009).

Participant Inclusion

The inclusion criteria for participants was that they must hold licensure through the North Carolina Board of Licensed Clinical Mental Health Counselors (NCBLCMHC). There are three licensure types for Licensed Mental Health Counselors; Licensed Mental Health Counselor Associates (LCMHCAs), Licensed Mental Health Counselors (LCMHCs), and Licensed Mental

Health Counselor Supervisors (LCMHCS; NCBLCMHC, 2019). These licensure types are further defined in the variables section of this chapter.

Participant Sampling and Recruitment

Non-probabilistic sampling was used to build a stratified sample of participants. Specifically, the use of social media and emails provided a link to the measurement tools to recruit participants meeting the inclusion criteria. Non-probability sampling is a form of non-random sampling (Dudovskiy, 2019). This sample was recruited through emails sent to alumni from counseling programs in North Carolina and to local agencies, as well as posts to social media, specifically Facebook and Linkedin.

Participants were recruited with a three-phase process. The first phase of the recruitment was sending emails and posting on social media regarding the upcoming research surveys and incentives. The second phase was when the emails and links on social media provided a link to the actual surveys. The sample was recruited through social media and email listservs. Emails provided to licensed professionals in the Department of Addictions and Rehabilitation Studies, previous graduates of the program, and posts on social media platforms such as Facebook. These emails and posts outlined the research, principal investigator, and consent to participate in research. The link to the online survey provided the same information and required the participant to agree to volunteer and indicate their understanding of confidentiality in the research. The last phase provided participants with the same links and included a final reminder of the upcoming study completion date.

Procedure

The use of a non-probabilistic sample of participants was selected for sampling this population based on the time available to conduct data collection. individuals were stratified

based on licensure from the non-probabilistic sample of participants. Demographic information regarding age, ethnicity, experience in years, and the types of services provided by the individual was collected for anecdotal purposes. This study utilized three measurement tools, the STAI, COSE, and a demographic survey. Participants were asked to respond to the questions on the measurement tools in consideration of family crisis events. For example, participants were asked to respond to questions on the STAI with consideration to their anxiety in responding to family crises. The order of the measurement tools was an essential consideration (Heppner et al., 2016). The STAI was the first measurement tool administered to avoid the effects of a counselor's self-efficacy on their state anxiety. The choice of using the State-Anxiety Inventory only is well-rooted in previous research and literature regarding counselors. Previous research has indicated that the state-anxiety inventory alone appropriately measures an individual's anxiety in response to a specific event (Daniels & Larson, 2001). This study is interested in the counselor's change in anxiety in response to the specific event of the family crisis vignette. Even more appropriate is the use of the anxiety inventory alone when in a repeated measures analysis as participant's pre-scores are compared to their post-scores, which is indicative of each participant serving as their own control. Specifically, the COSE may ask questions that make counselors aware of skill deficits, which could have an effect on the STAI if the STAI were to follow the COSE in the pre-test. For this research study, only the State-scale of the STAI will be used. Previous research has indicated the state-anxiety subscale is a valid and reliable measure of state-anxiety in an individual (Williams, Schute, Holkup, Evers, & Muilenberg, 2000).

The use of surveys facilitated the coding of participant responses and interpretation of scores to answer the research questions via repeated measures MANOVA. Specifically, data collection occurred across a three-phase process. The first phase of the data collection was sending out the

pre-measurement tools (STAI-state only, COSE, and demographic survey) and vignette with post-measurement tools (STAI-state only and COSE) via email and on social media. The email and social media posts contained a link to the consent to participate in this research study. This consent detailed the volunteer nature of the surveys, the sensitive nature of the crisis vignette, and a summary of the contact information in the event the vignette causes any distress. Once participants consented to participation in the study, they were able to access the pre-measurement tools, vignette, and post-measurement tools in that order. The data collection occurred over a period of one month. Once the participants completed the measurement tools participant responses were stratified into one of the three licensure groups during the second phase. If participants express needing therapeutic support post-family crisis, participants were provided with several resources to debrief.

These resources included statewide resources such as the Real Crisis contact information, and the Managed Care Organizations (MCOs) for North Carolina including: Trillium, Alliance, Vaya Health, Cardinal Innovations, Partners Behavioral Health Management, Sandhills, and Eastpointe (North Carolina Department of Health and Human Services; NCDHHS, 2019a). The MCOs provide mobile crisis services, and coordinate entry for new clients and access to care (NCDHHS, 2019a). Once the surveys were completed, and sent via the electronic format, statistical analysis of data began in third phase. The third phase included assigning participants identification numbers, and coding scores, and storing the data in Excel and SPSS.

Vignette Development

The vignette is a brief description of a fictional crisis event developed based on real crisis events for families served by the researcher. Other professionals in the field were contacted to review and provide feedback on the reality of the vignette, or “pretested” as defined by

Shoenberg and Ravdal (2000). The use of expert review in pretesting the vignette assured face validity of the vignette for measuring counselor anxiety and self-efficacy in family crisis response (Heppner et al., 2016; Shoenberg & Ravdal, 2000). Three reviewers were selected based on years of experience in the field (ten years or more) and work completed with families. These reviewers were asked to rate the vignette based on clarity and realism on a scale from 1 "not clear and unrealistic to 10 "very clear and very realistic." The three raters indicated different responses. One rater indicated a 7 for realism due indicated limitations with the biological parent not being a mother, and instead a father, as well as the father dropping the child off at the foster parent's home. Another rater indicated an 8, for the same reasons. The third rater indicated a 10, stating from their experience it is a very realistic scenario and one they had similarly encountered. The average rating by experts in the field was 8.5. Previous research indicated the use of vignette as appropriate for sensitive topics (Shoenberg & Ravdal, 2000), the use of a vignette instead of an actual crisis is appropriate for the safety of the family and counselor in this study. Previous research in the field of counseling has established precedence in using vignettes to measure counselor's attitudes and beliefs (Schoenberg & Ravdal, 2000; Ingamells & Goodwin, 1996; Aubry et al., 1995). The use of vignettes in measuring counselor's reactions to their own attitudes and beliefs regarding their self-efficacy and their self-reports of state-anxiety are then appropriate as established by previous research. Additional research has indicated vignettes are appropriate for measuring counselor self-efficacy with high-risk clients (Lee et al., 2018). This study will seek to assess counselor self-efficacy and anxiety in response to an emotionally charged incident regarding high-risk clients, all factors established with precedence in literature for the use of vignettes.

Operational Definitions of Variables

This section reviews operational definitions of the variables presented for measurement in this study.

Licensed Clinical Mental Health Counselor-Associates (LCMHCAs) are provisionally licensed counselors who have completed the basic educational and internship requirements per licensing standards. The minimum standards to obtain this licensure include successful completion of an accredited graduate program and the licensure exam. The counselors holding this licensure are required to have regular clinical supervision at a rate of one hour of supervision per 40 hours of clinical work weekly.

Licensed Clinical Mental Health Counselors (LCMHCs) are fully licensed counselors who no longer require regular clinical supervision as they have completed the required clinical supervision and subsequently their clinical supervisor has recommended them for full licensure.

Licensed Clinical Mental Health Supervisors (LCMHCSs) are clinical supervisors who have completed the same requirements of LCMHCs in addition to supervision training requirement.

Family: For this research, any *family* with whom the child will be living post-services is the child's family of permanence. The intention of having a definition for this family is the result of many children not returning to their biological families. Children may be unable to return to their family of origin for various reasons, and instead, living with another family member, an adoptive family, or remaining in their foster family indefinitely.

Treatment Family: *Treatment family* will refer to any Foster Care family where there could be one or more adults present, regardless of the number of children in the home. Another definition of terms is the use of Foster Care services to encompass all three levels of Foster Care.

Experience: Participants will be categorized as *new* counselors if they have graduated within the last two years and hold a LCMHCA licensure. Participants with experience past two years will be noted as *experienced* counselors and holding a full LCMHC licensure. Participants holding a supervisor's license, LCMHCS will be considered *experienced*. The choice of licensure level over actual years is based on licensure requirements. An applicant for an LCMHCA license must complete basic coursework from a Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2019), an internship with a minimum of 180 direct counseling hours, and a total of 300 hours field experience (NBCC, 2019). A fully licensed, LCMHC, must have completed the same educational requirements, and 3,000 hours of counseling field experience. The LCMHC applicant may complete those hours in a full-time or part-time position, which indicates the number of years of practice may vary; however, the number of hours of experience is the same. To obtain a supervisor licensure (LCMHCS), the applicant would need to have completed the same educational and hour experiences, as well as an additional 45 contact hours or 3 semester hours of clinical supervision specific training, and at least five years of full-time or eight years part-time experience and/or 2,500 direct counseling hours. Again, the number of years is not as significant as the direct counseling hours.

Curriculum Exposure: As defined in chapter 1, previous literature and research have referred to training and academic preparation of crisis response as "curriculum exposure" as defined by Watcher-Morris and Barrio-Minton in 2012.

State Anxiety: Spielberger (1983) noted that one of the two major components of anxiety are an individual's state anxiety. State anxiety is an individual's momentary anxiety in response to a particular state or situation.

Self-efficacy: Albert Bandura (2002) established the concept of self-efficacy as one's perception of their ability to perform a task. This self-perception or self-estimate of skill is often developed in relationship to peer performance. The COSE will measure counselor self-efficacy (Karaimak, 2018; Larson et al., 1992) in family crisis response events.

Instrumentation

The three instruments utilized in this study included the STAI, the COSE, and demographic questions. The State-Trait Anxiety Inventory measures of participant anxiety in providing crisis response services in family settings. The Counselor Self-Estimate Inventory measures participants' perceptions of their ability to effectively provide crisis response services in family settings. The demographic survey gathered supplemental evidence regarding years of experience, curriculum exposure to crisis response, and gathered participant feedback on recommendations for improving counselor-education programs. This section of chapter three discusses the psychometric properties of each instrument.

State-Trait Anxiety Inventory

This research study used one of the two subscales of the STAI, the state anxiety inventory, to measure counselor's anxiety in responding to family crises. The STAI consists of two subscales, state which measures the current level of anxiety, and a trait which measures the baseline anxiety for the participant (Julian, 2011). The STAI was administered with the participants responding through self-reflection concerning their current anxiety when responding to crisis events. For this study, the researcher utilized the STAI to assess for differences across licensures and experience.

Scoring. The State Anxiety Inventory (STAI) was used for this research study; which is a subset of the State-Trait Anxiety Inventory developed by Spielberger in 1983 utilizes a 4-point

Likert scale to rate responses to anxiety-present and anxiety-absent items (Grös, Antony, Simms, & McCabe, 2007). The 4-point scale ranges from 1 “not at all” to 4 “very much” (Grös et al., 2007). Scores for the STAI range from 20 to 80. Scores above 39-40 indicate clinically significant symptoms for the state-anxiety subscale. For this study, using only the state-anxiety subscale consisting of 20 questions, scores over 39 will indicate significant anxiety scores, scores below 20 will be used to indicate no to little anxiety and scores pre and post will be compared.

Background. The STAI, a 40-item questionnaire, was created in 1983 by Charles D. Spielberger (Julian, 2011; Grös et al., 2007). Over the last several decades, researchers have published validity and reliability for the anxiety measurement tool. The STAI was translated for 48 different languages, and applicable to both adults and children. The STAI has also demonstrated effectiveness in measuring anxiety with specialized populations such as the Military (Julian, 2011). Several studies have indicated this measurement tool is appropriate for use with counselors. One study conducted by Daniels and Larson (2001) utilized the STAI with counselors-in-training. They noted the scores can range from 20 to 80, where higher scores on the inventory were indicative of counselors with higher anxiety. In this study, Daniels and Larson (2001) indicated a statistically significant score of 26.43 for the state-anxiety subscale in their repeated measures analysis.

Reliability. The STAI consists of 40 self-report items, 20 items for the state and 20 items for the trait subscales (Julian, 2011). Several studies have published the inventory throughout the early 1990s and 2000s. Similarly, these assessments consistently indicated (r=.88) a high test-retest reliability when measured multiple times over several months (Grös et al., 2007). Reliability and validity were further published by Grös, Antony, Simms, & McCabe through the

use of 1124 psychiatric outpatients comparatively to 877 healthy subjects in their 2007 study. The published reliability for the STAI was a range of .86 to .95 (Grös et al., 2007).

Validity. The STAI maintains appropriate convergent validity, in essence, expected relatable dimensions are related (Grös et al., 2007). The STAI also has divergent validity as expected, the dimensions that should not correlate, do not as indicated by differences in patient and control samples (Grös et al., 2007). The use of the STAI with the participants demonstrated a range of .73 to .85 validity was demonstrated across all critical domains of anxiety when a confirmatory factor analysis model for clinical and nonclinical samples (Grös et al., 2007).

Counselor Self-Estimate Inventory

The COSE is a questionnaire regarding five domains of beliefs of self-efficacy in counseling. A 6-point Likert scale used by participants to self-report their agreement or disagreement with the statements in the inventory. The Likert scale ranges from 1- strongly disagree to 6 strongly agree. This inventory measures the following five domains: micro-skills, counseling process, dealing with difficult client behaviors, cultural competence, and values. The questions pertain to skills such as attending and reflection, role-plays and homework, as well as cultural issues and focus during sessions.

Scoring. The COSE uses a continuum of confidence scores ranging from no confidence to some confidence to complete confidence. These scores are provided based on the counselor's self-rating of their self-efficacy on several facets of the counselor's duties in the field.

The first portion of the questionnaire focuses on the counselor's self-efficacy in performing specific counselor duties such as; attending, listening, role play and behavior rehearsal. The subsequent section utilizes the same scoring and confidence indications with respect to a client’s clinical needs. This section reviews the counselor's confidence in serving

clients with specific needs such as; clinically depressed, sexually abused, and suicidal for example. The last set of questions focuses on the tasks of the counselor. These questions are specific to the counselor's ability to appropriately follow through with tasks such as staying on task in session and knowing what to do or say after the client talks.

The COSE measures counseling self-efficacy of counseling skills through 37 items. Scores can range from 37 to 222 with higher scores indicating higher counseling performance competency. All responses are self-report of participants' perspectives of their confidence in the five domains of counseling. Certain items on the inventory require inverse scoring to decrease the impact of dishonest self-report. Previous literature has indicated a pre median score of 141 with a post-median score of 144 across 213 participants and indicated a pre-post comparison is appropriate to indicate a change or difference in self-efficacy across and between groups (Larson et al., 1992).

Background. Dr. Larson created the Counselor Self-Estimate Inventory in 1988 and conducted follow-up measurements through 5 studies to validate the inventory. The COSE was created based on Albert Bandura's (1977) theory on self-efficacy, the Social Cognitive Theory. The Counselor Self-Estimate Inventory was initially devised with only 14 items, however after measuring the reliability and validity with participant responses, additional questions were added and ultimately the reliability and validity improved (Larson et al., 1992).

Reliability. Reliability has been relatively high with the inventory. The five studies of 213 participants demonstrated an internal consistency of .93 while the test-retest reliability was .87 (Larson et al., 1992). Reliability for the five dimensions is indicated at a .93 Cronbach alpha level for micro-skills, .88 Cronbach alpha for the process, .87 Cronbach alpha for difficult client behaviors, and .80 Cronbach alpha for cultural competence (Larson et al., 1992). Lower

reliability Cronbach alpha levels indicated for cultural competence at .78, and awareness of values at a .62 Cronbach alpha level (Larson et al., 1992). Reliability will be conducted through Cronbach's alpha with this study.

Validity. The psychometric properties of the Counselor self-estimate inventory were initially conducted in 2003 by Lent, Hilly, and Hoffman and based on Hill and O'Brien's work with the Career Counseling Self-Efficacy Scale (CCSE) from 1999. Reliability and validity were assessed for the Counselor Self-Estimate Inventory (COSE) through several comparisons and analyses of counselor responses on the Counselor Activity Scales (CASES) the CCES, and the Guided Group discussion Self-Estimate Inventory (GGSE-I). There was a high rate of internal validity across those assessments as evidenced by high correlations with the other self-estimate scales, indicating the scale measures what it intends to measure and does so consistently.

Convergent validity was assessed through the 213 participants concerning the five dimensions, as those participants that reported higher confidence also indicated higher self-concepts when compared to the participant rating on the Tennessee Self Concept Scale (TSCS; Larson et al., 1992). Discriminate validity was also assessed in the study. The study of 213 participants demonstrated the participants' scores on the COSE minimally correlated with their measurements of defensiveness and faking on the TSCS (Larson et al., 1992). While minimal correlation was present, as expected with on defensiveness and faking, significant correlations were found in the micro-skills; and weak correlations were noted on the dimension of awareness of values (Larson et al., 1992).

Demographic Survey

This research study utilized a demographic survey created by the researcher. This survey consisted of several items; age, gender, ethnicity, licensure type (LCMHCA, LCMHC, LCAS),

years of experience in the field, as well as blank space to provide feedback on ways to improve the counselor-education curriculum. Experience in the field was gathered by participant response to an open-ended question requesting a specific value in years. Once the STAI and COSE were completed, participants were provided the demographic survey. This study will adhere to the expectations of external validity as the sample is reflective of the population. However, unfortunately, the self-report nature of the instruments presents some limitations. Additionally, validity will be measured through further assessment of alpha levels.

Statistical Analysis

This section will discuss the use of repeated measures MANOVAs and Split-Plot Analysis of Variance (SPANOVA) to assess for effects and interactions for the variables in this study. The researcher focused on the effects of education and experience, as licensure type, on counselor anxiety and self-efficacy in providing crisis response services to families in a pre-post MANOVA statistical analysis. The use of a repeated measures MANOVA means each group was be measured twice, both before and after the vignette. The groups were separated by two licensure types (LCMHCs with less than Seven Years of Experience and LCMHCAs were combined, and LCMHCs with Eight Years or more of experience and LCMHCSs due to unequal group sizes) which facilitated the assessment of the effects of education and experience on counselor anxiety and self-efficacy in crisis response. Specific considerations had to be made regarding which significance values to choose due to unequal group sizes as well as additional statistical analyses to ensure the assumptions of the MANOVA were met.

Due to the unequal group sizes for crisis exposure and licensure type, Pillai's trace values were considered for assessing effects and interaction of crisis exposure on anxiety and self-efficacy. In order to meet one of the assumptions of a MANOVA, the dependent variables were

assessed for multicollinearity and singularity using a Pearson coefficient. Based on literature in the field, a Pearson correlation with a value of 0.46 is acceptable and does not indicate issues with redundancy between the independent variables, nor does it indicate they are unrelated (Dancey & Reidy, 2016). The independent variables for this study were licensure type and exposure to crisis response in the academic curriculum. The dependent variables for this study were the self-report of anxiety and self-efficacy in providing crisis response services in a family setting. The anticipated significance values for the pre-test and post-test, as well as interaction, were $p < .05$, indicating there was only a 5% chance the outcome was due to chance. Demographic and qualitative information provided by participants provided anecdotal evidence of the supplemental training or the effects of experience on the dependent measures.

Multivariate Analyses of Variance have several assumptions, and subsequently, several limitations. The assumptions of the MANOVA that had to be met prior to running the analysis were: 1) linearity among all dependent variables, 2) there are no outliers, 3) multivariate normality, 4) multicollinearity and singularity, 5) homogeneity of variance. Essentially, the data was assessed for outliers, and the outliers were either be removed or assessed for the degree to which the data point is outlying. The data was also be assessed for multicollinearity and singularity with a Pearson's coefficient, which indicated the relatedness, and if the dependent variables violated assumptions by being overly related (a value of .8 or higher) or completely unrelated (a value of .5 or lower). This leads to concerns regarding the limitations of the statistical analysis. Overly related, or completely unrelated, variables contribute to issues with redundancy and invalidates a MANOVA approach to analysis (Heppner et al., 2016).

The limitations of a MANOVA include the multiple assumptions which are difficult to meet. Additionally, MANOVAs are very sensitive to outliers, and as such, this study needed to

assess for outliers as described above, as well as using measurements of skewness and kurtosis for each group (Dancey & Reidy, 2016). Another limitation of MANOVAs is that variation across groups results in additional statistical analyses such as Box's M test of normality (Dancey & Reidy, 2016). Lastly, the concerns regarding the relatedness of variables can invalidate the entire research study. If the dependent variables are too closely related, they are considered redundant measures of the same variables. Conversely, if the variables have no relatedness, the study cannot measure an interaction as there is not an interaction (Dancey & Reidy, 2016; Heppner et al., 2016). The next section discusses the psychometric properties and relatedness of the measurements for the dependent variables of counselor anxiety and self-efficacy.

Threats to Validity

There are several threats to validity due to the nature of this study. This study does not provide a specific intervention to participants, which limits the continuity of training across participants. Nonprobability sampling is also referred to as non-random sampling, as each member of the population does not have an equal chance of being selected, which does pose a threat to the internal validity of the study. Similarly, participants were informed regarding the study and purpose based on IRB requirements (ECU, 2017), which provides participants with the opportunity to engage in a crisis-specific training, on-the-job experience, and other maturation and compensatory equalization of treatment threats (Heppner, Wampold, Owen, Wang, & Thompson, 2016). A similar threat is participant bias with the use of incentives; participants may feel the need to respond in a specific manner due to the offer of an incentive (Heppner et al., 2016). Due to the length of the survey and questionnaire, some participants did not complete both items, and those scores were not included in the data analysis as participants were not listed if they did not complete the survey. Part of controlling for the threat of attrition, was asking

participants to complete all survey questions at one time and not permitting participants to return to the survey once they leave. Another threat could have been the order in which the surveys are presented. The choice to present the state-anxiety survey first was to avoid any influence of participants identifying deficits in skills when completing the COSE.

Research design threats can include content, construct, and internal validity. Content validity refers to the threat of poorly worded research questions and results in poorly measured concepts. Construct validity can be a threat when creating a new tool for measurement, which has no published validity or reliability with the established dependent variables. Internal validity threats result from poor participant selection, compensatory equalization of treatment, and setting. However, for this study, participants did not have enough time to seek out additional training prior to completing the surveys, and the setting would be somewhere of their choosing to avoid a negative influence of setting. Similarly, due to this study utilizing a one-time survey, external threats to validity have been addressed, such as maturation threats have been eliminated, and attrition decreased. Lastly, any concerns about construct and content validity have been addressed by precedent in counseling literature and published research. Just as there are threats to validity in any research study, there are ethical concerns to be addressed as well.

Ethical Considerations

Ethical considerations for this research included several aspects of cultural sensitivity, the nature of rural populations, data management, managing participants' expectations, and reporting data accurately. Most instruments have an ethical consideration concerning cultural sensitivity and bias. The STAI and COSE have been assessed for any bias and noted as applicable to a variety of cultural backgrounds, delimitating the cultural sensitivity concern (Julian, 2011; Larson et al., 1992).

Self-report concerns can occur as a result of poorly worded questions or response bias. As this study did use previously established inventory measurements with published reliability and validity, the concerns of poorly worded questions are limited. The researcher did attempt to address the ethical concerns of self-report by encouraging participants to respond to their own experiences as opposed to asking comparison or judgment questions. Confidentiality was maintained as the researcher adhered to the ethical practices presented by the American Counseling Association (ACA, 2014) by not accessing the IP address information stored by the online service. The intervention was provided to all groups, the participants will not require any debriefing post-survey, however the content may be considered upsetting due to the nature of the vignette and participants will be provided with contact information should they need counseling support. All information and data gathered were reported as obtained, no manipulation of data or responses occurred, regardless of the outcome.

Limitations

This research study had several limitations, including confidentiality, access to participants, and the emergency nature of counseling services provided in North Carolina. Confidentiality limitations were due to the method in which the participants are able to complete the survey and inventory online. The tool for gathering responses was Qualtrics, which does retain participant IP addresses, which is accessible by the researcher. To minimize the effects of limited confidentiality, the researcher indicated that no one would be accessing the IP address information. This researcher used online surveys and inventories to increase the sample number as the participants could respond at their convenience. The limitation of the nature of the research design, a stratified random sample, is that one group had more participants who require

additional statistical analysis to ensure equal group sizes and no violations of the assumption of homogeneity for MANOVAs (Heppner et al., 2016).

The nature of the instruments chosen for measuring counselor anxiety and self-efficacy presented several limitations. The STAI does not discriminate between depression and anxiety for elderly populations, which could create issues in discussing crises as crisis events are varied, and depending on participant age, their responses may skew the overall data (Grös et al., 2007). This inventory also requires approximately 10 minutes to complete, which could be a limitation if participants have a hectic work schedule or other time constraints (Grös et al., 2007). Both the STAI and the COSE are self-report instruments and, as such, are subject to response bias (Grös et al., 2007; Larson, 1988). Lastly, as both instruments were used to compare scores across professions, there is a concern about compensatory rivalry (Grös et al., 2007; Larson, 1988).

As previously discussed, self-report instruments are limited regarding accuracy. It is possible participants responded in a more socially desirable manner. Additionally, the nature of the family crisis event as a vignette rather than an actual crisis event is limiting. Participants may not feel anxious about responding to the scenario, however, in real-life situations, participants may experience anxiety. Participants may have also under-anticipated the amount of time required to complete the surveys pre and post, as well as read the vignette resulting in drop-out. As with any research study relying on technology, this study was subject to potential technical issues such as emails sent to spam or junk mail, technical glitches in the surveys, and other issues. The researcher worked with the support staff for the online survey program to ensure appropriate functioning with the survey and monitor use as appropriate and respectful of confidentiality.

Chapter Summary

This research study focused on the implications of curriculum exposure, licensure types, and experience on counselor anxiety and self-efficacy in responding to a crisis in families. The use of the STAI and COSE measured participant's perceptions of their anxiety and self-efficacy levels during different licensure stages and experience with respect to crises in families. The demographic survey gathered information on the amount of experience each participant has concerning crises, as well as the type of crisis exposure they may have had in their curriculums. This study consisted of only the inventories and survey, and participants were asked to complete the STAI based on their anxiety in responding to crisis vignette. Data was collected via Qualtrics and utilized a repeated measures MANOVA for analysis. Varying ethical concerns were addressed and included cultural bias, response bias, and confidentiality.

CHAPTER FOUR: DATA ANALYSIS

Introduction

The purpose of this study was to measure counselor anxiety and self-efficacy in responding to family crises. Specifically, this study sought to assess the effects of counselor experience and curriculum-exposure on their state anxiety and ability to intervene with a family in crisis effectively. This study utilized the following measurement tools: State-Trait Anxiety Inventory (STAI; state anxiety scale only), Counselor Self-Estimate Inventory (COSE), and a demographic survey. Participants were provided a list of contacts in the event the participants needed to debrief post-family crisis or had strong emotional responses to the vignette. This chapter discusses the data analysis, design threats, and a summary of results.

Sampling Procedures

This study used a non-probabilistic sampling to build a stratified sample of participants. Participants were recruited through social media such as Facebook and LinkedIn as well as email recruitment starting January 23rd, 2020, through February 28th, 2020. The initial incentive opportunity included a chance to win a $50 gift card; however, after participants were not responding at the rates needed for data analysis, after approval from the IRB, the researcher increased the incentive opportunity for a chance for one participant to win a $95 gift card and more participants responded. All participants were provided both the pre-test measurements (STAI, COSE), vignette, and the subsequent post-test measurements (STAI, COSE, demographic survey) at one time. The survey was provided in entirety via a weblink to Qualtrics. All data was downloaded, stored, and analyzed in SPSS 26. A total of 30 participants completed the Qualtrics survey, with a few questions not answered; for these unanswered questions mean values across

participants for the question were used. Statistical analysis of participants' demographics and responses were completed.

Descriptive Data Results

The sample consisted of 30 participants, all Licensed Clinical Mental Health Counselors (LCMHC) in the state of North Carolina. There were 11 LCMHCAs (Associate), 15 LCMHCs, and five LCMHCSs (Supervisor), of which two participants reported licensures of both LCMHC and LCMHCS. Ninety percent of participants were Caucasian (*n*=27), 10% were African American (*n*=3). The participants ranged in age from 24 years old to 54 years old, with an average of 31.9 years. The participants reported a rangeof experience from 2 years to 30 years, with an average number of 8.5 years of experience in the field. For gender, 83.33% of participants were females (*n*=25), and 13.3% of participants were males (*n*=4), and one participant reported "other." The percentage of counselors that reported receiving some form of curriculum exposure was 83%, of which the exposure type in the curriculum included volunteer experience, a one-time lecture, a presentation, or a specific course. The participants with curriculum exposure to crisis response included: 12 participants reported more than one of the crisis exposure types during their graduate program, eight participants reported only a one-time lecture or presentation as their exposure type, one individual reported other and indicated their exposure to crises did not occur until their practicum and internship experiences. While five participants reported no exposure to crisis training during their graduate programs, three reported attending a specific course on a family crisis. Participant attrition occurred during this study.

Attrition

The study utilized three instruments, two completed at baseline and two repeated post-test and the demographic survey. Once data collection ended, there were 31 completed surveys,

one of which had to be removed as they were not an LCMHC (associate, unrestricted, or supervisor), and another 37 with responses in progress remaining. The length of the entire survey was reported as "prohibitively long" by some potential participants. While the sample size of 30 was obtained, the in-progress responses remaining could have been that either the participant opened the survey and had to stop or did not complete the survey. The assumption is that attrition was an issue as a result of the number of surveys in-progress and the report of some individuals that they were unable to complete the survey and ultimately dropped out. Participants were not initially responding at high rates, and an increase in the amount for the lottery incentive was requested and approved by the IRB to attempt to recruit additional participants.

Descriptive Statistics

Prior to data analysis and baseline measurements for pre-test groups, certain questions on the STAI and demographic questionnaire had to be recoded. For example, the STAI required recoding on questions framed in the positive such as, "I feel steady" or "I feel pleasant." Once the responses were recoded, data analysis could occur. Recoding also occurred with specific questions on the COSE for the following item numbers: 2, 6, 7, 9, 16, 18, 19, 21, 22, 23, 24, 26, 27, 28, 31, 33, 35, 36, and 37. The reliability for both the STAI and COSE pre and post, were over 0.94, which demonstrates high reliability with the measurement. Baseline measurements were subsequently computed for the pre-test groups and then compared to the means for post-test groups.

Due to a violation of the MANOVA assumption of equal group sizes when separating participants by licensure, the licensure groups were separated into two groups instead of three groups and based on years of experience. Please note the licensure group was separated into two categorical groups by LCHMCA, and some LCMHCs were one group based on Seven Years or

less of experience, while the LCMHCs and LCMHCSs was a group with Eight Years of Experience or more. Pre-test scores for the STAI (counselor anxiety) for the participants was 41 and calculated by running the descriptive statistics for the total score for each participant. The post-test scores on the STAI for participants was 42.83 (please note scores above 39-40 indicate clinically significant symptoms for the state-anxiety subscale) the same mathematical steps were taken to calculate the post-scores. The group with Eight Years of Experience or more had an average change over time of 2.5 with a standard deviation of 0.56; while the Seven Years of Experience or less group had an average change over time of 1.69 with a standard deviation of 0.6. Overall, the means for the pre-test STAI for all participants was 41, indicating the presence of anxiety for participants. The post-test mean for the STAI was 42.83, indicating the presence of anxiety and an increase in participants' anxiety. The LCMHCs and LCMHCS with Eight Years of Experience or more group had change over time of an average 1.69 with a standard deviation of 0.6. Post-test scores for the STAI (counselor anxiety) for the LCMHCA and the LCMHCs with Seven Years of Experience or less group averaged 2.47 with a standard deviation of 0.23, and the LCMHCs with Eight Years of Experience or more and LCMHCS group averaged 1.69 with a standard deviation of 0.46.

The pre-test scores for the COSE (counselor self-efficacy) for the LCMHCAs and the LCMHCs with Seven Years of Experience or less group had a mean 3.69 (0.19), and the LCMHCs with Eight Years of Experience or more and LCMHCS group had a mean of 3.6 (0.18) calculated by running the descriptive statistics analysis in SPSS. The post-test scores for the COSE (Counselor self-efficacy) for the LCMHCAs and the LCMHCs with Seven Years of Experience or less group averaged 3.6 with a standard deviation of 0.12, and the LCMHCs with

Eight Years of Experience or more and LCMHCS group averaged 3.6 with a standard deviation of 0.2.

MANOVA Assumptions

This section will review the assumptions of MANOVAs and the statistical procedures conducted to ensure assumptions of the MANOVA were met. Due to the pre-post design of this study, the pre-test measures served as a baseline comparison to post-scores. This study utilized a repeated measure MANOVA to analyze the data and interactions of the variables. Both the STAI and COSE were included in each analysis due to the negative correlation between the pre-test STAI and pre-test COSE (r= -.71) and the post-STAI and post-COSE (r = -0.66). Box's M Test of equality of variance (see Table 1.1 below) was not significant, indicating there was no violation of the assumption of variance as evidenced by a critical F value of (20, 6060,54) =.88, p=0.89. In addition to Box's M test, Levene's test of variance was conducted. Levene's test of homogeneity of variance was not significant based on the mean values. Levene's test for the pre-STAI was .900 and p = 0.46, indicating no violation of the assumption of group variance. The same was true for post-STAI values with a mean statistic of .16 and p=0.92. The pre-COSE mean was not significant with a value of 1.12 and p=0.36, as well the post-COSE mean of 1.11 with p=0.36. Non-significant finding was noted for Levene's test indicated no issues with the group variance and subsequent violation of the MANOVA assumption of homogeneity of variance.

However, there were unequal sizes per group based on licensure type. To avoid a violation of assumptions of equal group sizes, the experience and licensure group were recoded into two categorical groups, instead of three separate groups. The licensure group consisted of unequal group sizes, and some participants selected more than one licensure type during the

survey. To avoid violation of assumptions of the MANOVA, and in seeking to create more equal group sizes, the participants appeared to have equal groups when separated by Seven Years of Experience or less, and Eight Years of Experience or more; this led to the recoding of experience by years and two licensure groups. Licensure requirements for Clinical Supervisors include five years full-time work, post-graduation, and 2,500 direct hours (NCBLCMHC, 2019). The licensure requirement may contribute to this divide in years of experience as counselors may need more than five years to complete these requirements. Social Cognitive Theory has an emphasis on experience (Bandura, 1986), which guided the process of dividing the groups into two instead of three groups as there appeared to be a natural break in the data with almost equal group sizes based on Seven Years or less of experience and Eight Years or more of experience.

As a result of the unequal group sizes, experience was divided into two levels instead of three; licensure was changed from LCHMCA, LCMHC, and LCMHCS, to LCMHCA and LCMHC with Seven Years of Experience or less, and LCMHC and LCMHCS with Eight Years of Experience or more. The years of experience for the groups had 14 participants had Eight Years of Experience or more and were mostly LCMHCSs with a few LCMHCs, while 16 participants were in the LCMHCA and LCMHC group with Seven Years of Experience or less. For the respective analysis, Pillai's trace will be discussed when interpreting significance due to the unequal sample sizes (Dancey & Reidy, 2016). In addition to interpreting significance due to the unequal sample sizes, the assumption of sphericity had to be assessed.

The MANOVA assumption of sphericity is that the data does not vary significantly from one group to another. The unequal group sizes were also assessed for variance and sphericity issues. Mauchly's test of sphericity did not indicate significance with a Huynh-Feldt value of 1.00. The lack of significance allows the researcher to assume there was no violation of the assumption

of sphericity (Dancey & Reidy, 2016). Another assumption of the MANOVA is linearity and co-linearity, which is assessed with the Pearson correlation value.

The Pearson correlation demonstrated appropriate singularity and multicollinearity between pre-STAI and pre-COSE (r= -.71) and between post-STAI and post-COSE (r = -0.66). The Pearson correlations were not overly correlated at a value of 0.66 for the STAI and the COSE, which indicated the dependent variables were appropriate measurements for different variables and not redundant. The STAI and COSE measurements had a Cronbach's alpha level over 0.94, indicating high reliability in repeatedly measuring counselor anxiety in response to family crisis events. The repeated measure MANOVA was conducted using two groups based on change over-time on the STAI and COSE (the within-subjects variables) by subtracting pre-scores from post scores for each participant and comparing the scores based on two groups licensure and experience (between-subjects variables).

Data Analysis

This section will cover three major components of the analysis: repeated measures MANOVA, SPANOVA, and the application of the analyses for the research questions. This section will answer the six research questions based on the analysis of the repeated measures MANOVA and SPANOVA. Specifically, research questions one and two will be addressed using the experience and family crisis repeated measures MANOVA. Research questions three and four will be addressed using the graduate curriculum exposure, and family interaction repeated measures MANOVA. While questions five and six will also be answered with the repeated measures MANOVA of experience, graduate curriculum exposure, regarding counselor self-efficacy, and anxiety with respect to family crisis interaction.

Research Questions

This section reviews the outcome of the data analysis in response to the six research questions. These research questions assessed the effect of experience and curriculum exposure on counselor anxiety and self-efficacy. In order to answer these questions, this study provided participants with a vignette of a family crisis scenario and asked participants to respond to the STAI and COSE twice in a pre-post format. The following research questions are grouped based on independent variables, for example, research questions one and two are grouped based on counselor experience. The Split-Plot Analysis of Variance (SPANOVA) will be discussed separately based on the measurement tool, i.e., the STAI or COSE.

Research Question One: *What is the influence of counselors' experience levels on their change in anxiety when responding to a family crisis?*

Research Question Two: *What is the influence of counselors' experience levels on their change in self-efficacy when responding to a family crisis?*

In order to answer the first two questions, there were two statistical analyses. The first statistical analysis was a repeated measures MANOVA, followed by a SPANOVA (Table 1 below).

Table 1

*Family Crisis * Experience*

	PRE-STAI	POST-STAI	PRE-COSE	POST-COSE
Total 0-7 Years	2.38 (0.36	2.48 (0.56)	4.42 (0.62)	4.45 (0.68)
8- 40 Years	1.77 (0.47)	1.80 (0.50)	5.23 (0.47)	5.21 (0.44)
Total	2.08 (0.52)	2.14 (0.62)	4.82 (0.68)	4.83 (0.69)

RM MANOVA

Independent variable	Pillai's Trace	Df1	Df2	*F*	*p*	η_p^2

Family Crisis * Years Experience	.174	2	25	2.64	.091	.17

SPANOVA

Independent variable	Mean Square	Df1	Df2	*F*	*p*	η_p^2
Family Crisis *Years Experience (STAI)	3.78	1	26	3.57	.063	.13
Family Crisis * Years Experience (COSE)	.10	1	26	.10	.121	.01

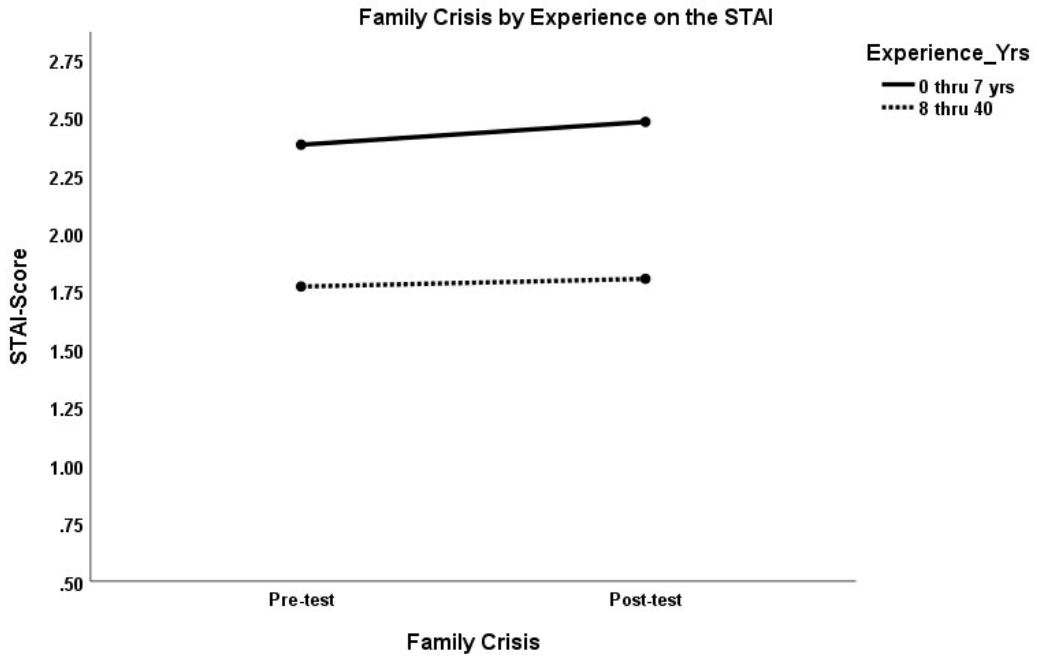
Repeated measures MANOVA. The Repeated Measures (RM) MANOVA revealed a statistically non-significant interaction effect of counselor experience and family crises on their ratings of anxiety and counseling self-efficacy. Although the groups were not significantly different from one another, the values were approaching significance [F (2, 25) = 2.64, p = .09, η_p^2 = .17]. This multivariate test of the counselors' experience level (i.e., 0 to 7 years, 8-40 years), had a noticeable, albeit non-significant multivariate effect on counselor state anxiety and self-efficacy. Although the multivariate test of the Family Crisis * Years of Experience interaction indicated a non-significant difference between the levels of experience, to answer Research Questions 1 and 2, two SPANOVAs were conducted. With the SPANOVA procedure, a univariate F test for each dependent variable was examined to interpret its respective effect and identify the contribution of state anxiety and counselor self-efficacy to the overall effect. The next two paragraphs describe these findings.

Research question one: SPANOVA. The RM multivariate test was not statistically significant; the follow-up SPANOVA (see Table 1.1 above) was conducted to examine the changes in the effect of the level of counselor experience on counselor state anxiety. Because little research has been conducted about the influence of counselor experience and family crisis counseling, an exploratory alpha-level of .10 was used. Using this alpha-level, there was a

statistical significance between the two levels of counselor experience as measured by counselor state-anxiety [F (1, 26) = 3.57, p = .06, η_p^2 = .13]. Thus, after reading the vignette, there was a noticeable difference observed on the STAI between counselors with Seven Years of Experience or less, and those with Eight Years of Experience or more.

Figure 1

Family Crisis by Experience on STAI

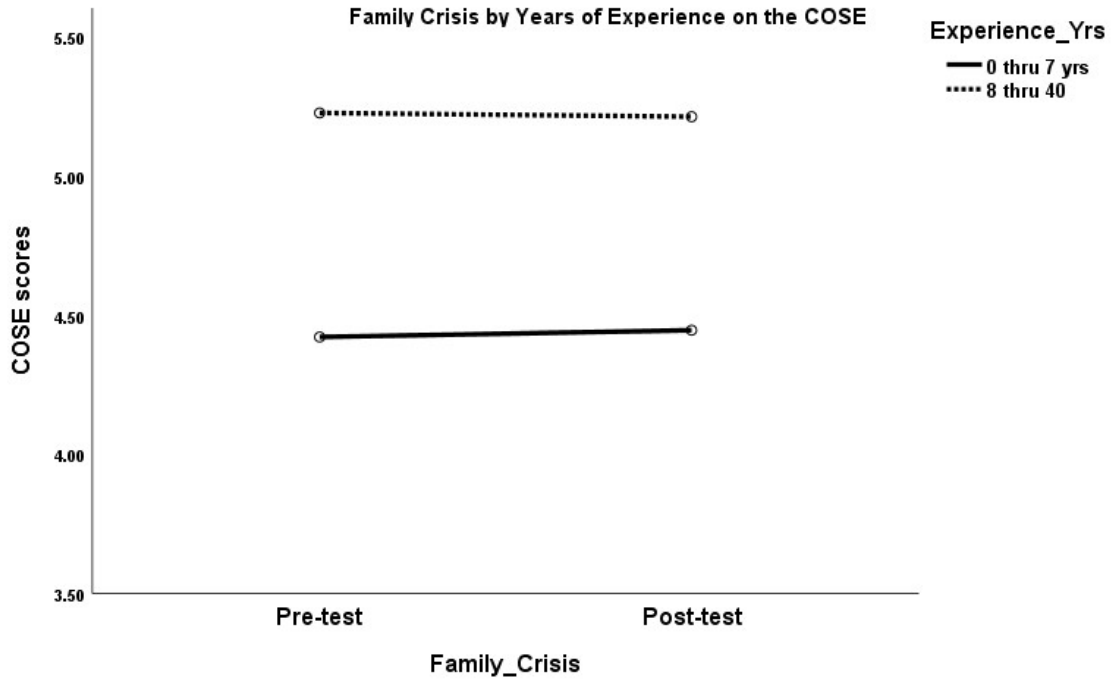


Research question two: SPANOVA. The follow-up SPANOVA (see Table 1.1 above) was conducted to examine changes in the effects of the level of counselor experience on counselor self-efficacy. The SPANOVA examining the influence of the level of counselor experience on counselor self-efficacy indicated a statistically non-significant difference between the two levels of experience after reading the vignette [F (1, 26) = .10, p = .12, η_p^2 = .01]. The statistical non-significance finding indicates that counselors' level of experience did not influence the counselors' self-efficacy after reading the vignette.

Figure 2 (below) is the pre-test and post-test means for groups by experience on the COSE. The group with Seven Years of Experience or less has a pre-test mean value of 3.91, while the group with Eight Years of Experience or more has a pre-test mean value of 3.65. The post-test group with Seven Years of Experience or less had a score of 3.73, while the post-test group, Eight Years of Experience or more, has a score slightly higher than the other group of 3.74.

Figure 2

Means of COSE by Years of Experience



Research Question Three: *What is the influence of counselor curriculum-exposure on counselor anxiety when responding to crises in a family setting?*

Research Question Four: *What is the influence of counselor curriculum-exposure on counselor self-efficacy when responding to crises in a family setting?*

Eight participants indicated they had no curriculum exposure or training on family crises, while another 4 participants neither agreed or disagreed regarding curriculum exposure. All but five participants reported curriculum exposure on some form of crisis during their graduate program, including a one-time presentation, lecture, volunteer experience, or specific course. In order to answer this research question, a RM MANOVA and a SPANOVA were conducted.

Table 2

*Family Crisis * Curriculum*

	PRE-STAI	POST-STAI	COSE-PRE	COSE-POST
None	1.76 (0.45)	1.96 (0.59)	4.97 (0.70)	5.01 (0.71)
Yes	2.14 (0.51)	2.18 (0.63)	4.80 (0.68)	4.80 (0.69)
Total	2.08 (0.52)	2.14 (0.62)	4.83 (0.68)	4.83 (0.69)

RM MANOVA

Independent variable	Pillai's Trace	Df1	Df2	*F*	*p*	η_p^2
Family Crisis *Curriculum Exposure	.019	2	25	.71	.77	.019

SPANOVA

Independent variable	Mean Square	Df1	Df2	*F*	*p*	η_p^2
Family Crisis *Curriculum Exposure (STAI)	.07	1	26	.97	.33	.04
Family Crisis *Curriculum Exposure (COSE)	.03	1	26	.05	.825	.002

Repeated measures MANOVA. Using the RM MANOVA procedure, the interaction effect of family crisis and curriculum exposure was examined. After reading the family crisis vignette, the difference for those participants with curriculum exposure compared to those without curriculum exposure did not yield a significant multivariate effect on the dependent

measures of state-anxiety and counselor self-efficacy [F (2, 25) = .71, p = .77, η_p^2 = .02]. This finding suggests that the level of curriculum exposure did not appear to affect the counselor's anxiety and self-efficacy about family crisis intervention. Although the multivariate test of the Family Crisis * Curriculum Experience interaction indicated a nonsignificant statistical difference between curriculum exposure and no curriculum exposure groups, to answer Research Questions 3 and 4, two SPANOVAs were conducted. With the SPANOVA procedure, a univariate F test for each dependent variable was examined to interpret its respective effect. So, in order that the contribution of counselor state anxiety and counselor self-efficacy to the overall effect could be identified. The next two paragraphs highlight these findings.

Research question three: SPANOVA. Although the multivariate test was not statistically significant, the SPANOVA was conducted further to examine the effects of curriculum exposure on counselor anxiety. A SPANOVA examining the influence of the level of curriculum exposure on the changes in the STAI after reading the family crisis vignette was statistically non-significant [F (1, 26) = .10, p = .33, η_p^2 = .04]. The statistical non-significance indicates that the level of curriculum exposure did not influence on the changes in the STAI after reading the vignette.

Research question four: SPANOVA. The RM multivariate test did not yield a statistically significant effect of curriculum exposure on counselor self-efficacy. However, to answer research question four, a SPANOVA was conducted to examine the effects of curriculum exposure on counselor self-. The SPANOVA did not result in statistically significant effects of curriculum exposure on counselor self-efficacy [F (1, 26) = .03, p = .83, η_p^2 < .01]. Following the analysis of effects for Research Questions 1 through 4, an analysis of the Research Questions 5 and 6 regarding interactions of the research variables was conducted.

Research Question Five: *When responding to a family crisis, does the effect of curriculum-exposure on counselor anxiety depend on the counselor's experience?*

Research Question Six: *When responding to a family crisis, does the effect of curriculum-exposure on counselor self-efficacy depend on the counselor's experience?*

Repeated measures MANOVA. In order to answer these questions, a two-step statistical process was conducted. Beginning with a RM MANOVA, a three-way interaction (Family Crisis * Years of Experience * Curriculum Exposure) was conducted to examine its effect on the participants' state anxiety and counseling self-efficacy. With the RM MANOVA, a non-significant three-way interaction was found [F (2, 25), $p = .25$, $\eta_p^2 = .11$]. That is, when responding to a family crisis vignette, the effect on curriculum exposure on the dependent measures was not significantly influenced by the counselors' level of experience. Next, although the multivariate test of the Family Crisis * Curriculum Exposure * Experience interaction was not statistically significant two three-way SPANOVAs were conducted to answer Research Questions 5 and 6. With the SPANOVA procedure, a univariate F test for each dependent variable was examined to interpret its respective effect and identify the contribution of state anxiety and counselor self-efficacy to the overall effect. The next two paragraphs describe these findings.

Table 3

*Family * Curriculum Exposure * Years of Experience*

		PRE-STAI	POST-STAI	COSE-PRE	COSE-POST
No Curriculum Exposure	0-7 years	2.20 (0.14)	2.13 (0.67)	4.31 (0.44)	4.36 (0.36)
	8-40 years	1.47 (0.28)	1.85 (0.66)	5.41 (0.39)	5.43 (0.51)
	Total	1.76 (0.45)	1.96 (0.59)	4.97 (0.70)	5.01 (0.71)
Curriculum Exposure	0-7 years	2.41 (0.38)	2.53 (0.55)	4.44 (0.65)	4.46 (0.73)
	8-40 years	1.85 (0.49)	1.79 (0.49)	5.18 (0.49)	5.16 (0.43)
	Total	2.14 (0.51	2.18 (0.63)	4.80 (0.68)	4.80 (0.69)
Total	0-7 years	2.38 (0.36)	2.48 (0.56)	4.42 (0.62)	4.45 (0.68)
	8-40 years	1.77 (0.47)	1.80 (0.50)	5.23 (0.47)	5.21 (0.44)
	Total	2.08 (0.52)	2.14 (0.62)	4.83 (0.68)	4.83 (0.69)

RM MANOVA Independent variable	Pillai's Trace	Df1	Df2	*F*	*p*	η_p^2
Family Crisis * Years Experience * Curriculum	.11	2	25	1.48	.246	.02
SPANOVA Independent variable	Mean Square	Df1	Df2	*F*	*p*	η_p^2
Family Crisis * Years Experience * Curriculum Exposure (STAI)	.07	1	26	.97	.334	.04
Family Crisis * Years Experience * Curriculum Exposure (COSE)	< .00005	1	26	.0000	.987	<.0001

Research question five: SPANOVA. Although the RM multivariate test was statistically non-significant, a follow-up SPANOVA was conducted to examine if the effect of curriculum exposure on the counselors' state anxiety depends on the counselors' experience level. The SPANOVA produced statistically non-significant results [F (1, 26) = .97, p = .33, η_p^2 = .04].

That is, the effect of curriculum exposure on state anxiety is not significantly influence by the counselors' level of experience.

The following two paragraphs report the mean cell scores of the Curriculum Exposure * Years of Experience interaction on the STAI pre-test and post-test. For counselors who had not had exposure to a crisis curriculum, both experience levels did not have a statistically significant change to their STAI after reading the vignette. That is, the group with 0 to 7 years of experience had non-significant decrease of their STAI from pre-test (M = 2.20) to post-test (M = 2.13). Likewise, the counselors with more experience had a non-significant increase in STAI from pre-test (M = 1.47) to post-test (M = 1.85).

The finding for the counselors who had had exposure to a crisis curriculum, also did not have a significant change in STAI after reading the family crisis vignette. Specifically, the counselors with less experience had a statistically non-significant increase in STAI from the pre-test (M = 2.41) to the post-test (2.53). Interestingly, the more experience counselors had a statistically non-significant decrease in STAI from the pre-test (M = 1.85) to the post-test (1.79).

Research question six: SPANOVA. Although the RM multivariate test was statistically non-significant; the follow-up SPANOVA was conducted to further examine the effects of counselor experience and curriculum exposure on counselor self-efficacy. Statistical non-significance was found regarding counselor self-efficacy depending upon the counselor's experience after reading the family crisis vignette (F (1, 26) = .00, p = .99, η_p^2 < .00). The non-significance indicates that curriculum exposure does not have an effect on counselor self-efficacy depending on counselor experience.

The following two paragraphs note the mean scores of the Curriculum Exposure * Years of Experience interaction on the COSE pre-test and post-test. For counselors who had not had

exposure to a crisis curriculum, both experience levels did not have a statistically change to their COSE after reading the vignette. That is, the group with 0 to 7 years of experience had a non-significant increase in their COSE scores from the pre-test (M = 4.31) to the post-test (M = 4.36). Likewise, the counselor with more experience had a smaller non-significant increase in COSE from pre-test (M = 5.41) to post-test (M = 5.43).

The finding for the counselors who had had exposure to a crisis curriculum also did not have a significant change in COSE after reading the family crisis vignette. Specifically, the counselors with less experience had a statistically non-significant increase in COSE from the pre-test (M = 4.44) to the post-test (M = 4.46). Interestingly, the more experienced counselors had a statistically non-significant decrease in COSE from the pre-test (M = 5.23) to the post-test (M = 5.21).

Chapter Summary

This chapter discussed the statistical analysis of the data collected. Additionally, this chapter reviewed the results of the data analysis and how the data collected answered the six research questions. The RM MANOVA was utilized to assess changes in counselor anxiety and self-efficacy when responding to families in crises. Although statistical significance was not found for measurements on the COSE and STAI, some values were approaching significance on the STAI, which led to a post-hoc analysis, which will be discussed in Chapter 5. A statistically significant three-way interaction was found for the licensure type and years of experience groups on the STAI. The implications of the results will be discussed in Chapter 5.

CHAPTER 5: DISCUSSION

Introduction

This chapter includes a discussion of the summary of results, interpretation of the results, limitations, and implications, as well as recommendations for future research. This chapter will discuss limitations such as instrumentation and design threats. Additionally, there will be a review of the implication for counselors and counselor supervisors and educators. The results of this study will be discussed as it pertains to the significance found with the STAI and COSE. The discussion in this chapter will detail the implications of this research study and discuss the limitations, as explained by previous research. Lastly, discussions will focus on the recommendations for future research, such as a larger sample size. The first section will discuss the summary of results compared to changes in the field and previous research outcomes.

Interpretation of Results

This section discusses the results specific to the research questions. Interpretations of results are made so with caution as there could potentially be many interpretations. These results are also discussed in the context of the theoretical orientation of the measurement tools.

Research question one: *What is the influence of counselors' experience levels on their change in anxiety when responding to a family crisis?*

The statistical significance of this exploratory study with an alpha level of $p < .10$ indicated there is an influence of counselor experience levels on their change in anxiety when responding to a family crisis on the RM MANOVA. The output of the RM MANOVA regarding the STAI indicated values were approaching significance and prompted further statistical analysis to include the SPANOVA.

Repeated measures MANOVA. The RM MANOVA statistical analysis indicated that the years of experience, including licensure type, did result in a statistically significant influence on participants' level of anxiety with respect to family crises. The statistical analysis for this research question did result in statistically significant effects of counselor experience on counselor state anxiety on the RM MANOVA. Overall, significance for these two analyses did indicate a statistically significant influence of counselor's experience levels on their anxiety levels with the alpha level of $p<.10$ due to the exploratory nature of this research study. Although there was an observed trend of the data towards significance with respect to counselor anxiety changes from pre-test to post-test based on counselor experience. This trend in the data indicates that with a larger sample size, there could be a potential effect for counselor experience on counselor anxiety. Social Cognitive Theory explains that experienced counselors would likely have lower anxiety rates as a result of their experience in the field. The newly licensed LCMHCs (less than Seven Years of Experience in the field), appeared to have higher anxiety rates post-family crisis, than LCMHCs with Eight Years of Experience or more when combined with LCMHCSs.

Another explanation for the decrease in anxiety for the Eight Years of Experience or more group is their professional developmental stages (Stoltenberg, 1998). Developmental theories regarding counselor development include developmental stages with new skills compared to years of experience. Many of the developmental theories regarding counselor development reinforce concepts presented in SCT, including increased self-efficacy with field experience (Bernard & Goodyear, 2015). Another concept is the idea of decreased anxiety with more experience in the field (Barbee et al., 2003). One possible trend presented by data, was both groups started with very similar anxiety rates, although the Seven Years or less experience group

indicated a slight increase in anxiety, while the Eight Years or more group indicated a decrease in anxiety. These trends between the groups could be indicative of participants that were already anxious, or the thought of family crises was anxiety-provoking; however, upon reading the vignette the Eight Years or more group may have had higher self-efficacy, and as a result, their anxiety decreased as they recognized they had the skills to intervene effectively.

SPANOVA. The SPANOVA did indicate statistical significance, at the exploratory alpha level of $p < .10$, with respect to experience based on licensure and years, on changes over time with counselor anxiety. Statistical significance was found regarding the effect of experience in years and licensure on counselor anxiety; however, the trend of the data did indicate potentially more experienced counselors will have lower anxiety in response to family crises. The idea of more experienced counselors having lower anxiety in response to crises (Pirtle et al., 2019; McAdams, & Keener, 2008) and family counseling (Shamoon et al., 2016) is supported by previous research.

Research question two: *What is the influence of counselors' experience levels on their change in self-efficacy when responding to a family crisis?*

This research question was assessed based on the outcome of the RM MANOVA and SPANOVA. The statistical analyses indicated there was no influence of the counselors' experience levels on their self-efficacy in responding to crises.

Repeated measures MANOVA. The RM MANOVA did not indicate significance with respect to the changes in counselor self-efficacy with an influence of their experience. Overall, the group means were similar when separated by years of experience and licensure type both pre-test and post-test after reading the family crisis vignette, significance was found on the RM MANOVA. The non-significance regarding changes in self-efficacy indicates the counselor's

experience level did not have a significant influence to change counselor self-efficacy after reading the family crisis vignette. Another explanation can be that the concept of self-efficacy may be less variable than anxiety as it is developed over a lifetime of experiences and less variable for a one-time family crisis vignette (Neimeyer et al., 2001). The difficulty in measuring or finding changes with the COSE scores can be attributed to the number of participants without curriculum exposure. Most participants reported some form of curriculum exposure, which previous research has indicated mitigates the effects of anxiety, resulting in higher perceptions of self-efficacy (Skovholt & Ronnestad, 2003). Previous research has also indicated that less experienced individuals tend to have higher anxiety and lower self-efficacy (Sawyer et al., 2013) and high anxiety (Skovholt, & Ronnestad, 2003)**. H**owever, these studies were conducted prior to the CACREP (2016) changes. The data from this research study indicates that most groups started with similar means on both the STAI and COSE.

SPANOVA. The group means appeared to be similar at pre-test and post-test family crisis, no statistical significance was found. The similar pre-test intervention means can be indicative of the efficacy of the participants' curriculum exposure. Although no statistical significance was found on with respect to counselor experience and self-efficacy in this research study, another research study indicated more significant changes in self-efficacy occur over time (Osteen, 2018). As this research study did not offer training to enhance self-efficacy, the lack of informational presentation or training provided may explain why participants did not report a change in self-efficacy from pre-test and post-test. Participants may continue to reflect on the incident and their skills and abilities post-completion of the survey, which could have an effect on their self-efficacy.

Research question three: *What is the influence of counselor curriculum-exposure on counselor anxiety when responding to crises in a family setting?*

Research question three was answered using a RM MANOVA and SPANOVA. This section will discuss the interpretation of the outcomes found from each statistical analysis. The two analyses indicated there was no influence of counselor curriculum-exposure on counselor anxiety when responding to families in crisis. The data analyses indicated that when a family crisis occurs, the counselors with Eight Years of Experience or more did not have statistically different levels of anxiety when compared to counselors with Seven Years of Experience or less.

Repeated measures MANOVA. Overall, statistical significance was not found with respect to individuals' anxiety when they received some form of curriculum exposure during their graduate program as opposed to no exposure. Despite the vague operational terms in the CACREP standards regarding crisis exposure in the curriculum, the type of training or information received by participants had still potentially met the needs of the students. The participants were noted as having a change in anxiety, increasing over time, and while some had more significant changes in their anxiety, neither were statistically significant. The non-significance is contrary to previous research, which indicates counselors experience high anxiety when preparing when serving families (Shamoon et al., 2016), as well as the importance of curriculum exposure in preparing to respond to crises (Watcher-Morris & Barrio-Minton, 2012).

SPANOVA. No statistical significance was found on the SPANOVA either; however, the SPANOVA was conducted further to evaluate the effects of curriculum exposure on counselor anxiety. The lack of statistical significance is consistent across all statistical analyses completed for this research. Ultimately, counselor curriculum exposure did not influence counselor anxiety.

Research question four: *What is the influence of counselor curriculum-exposure on counselor self-efficacy when responding to crises in a family setting?*

There were no statistically significant outcomes for counselor self-efficacy based on curriculum exposure when responding to crises in a family setting. The study did produce very similar pre- and post-family crisis outcomes across groups, within groups, and with respect to curriculum exposure. The lack of significance indicates there was no influence of counselor curriculum-exposure on counselor self-efficacy in responding to families in crisis.

Repeated measures MANOVA. No statistical significance was found on the RM MANOVA, indicating there were no significant influences of curriculum exposure on counselor self-efficacy when responding to crises in a family setting. This finding is contrary to previous research, which indicates that counselors had low rates of self-efficacy likely due to a lack of curriculum exposure to crises (Watcher-Morris & Barrio-Minton, 2012). Non-significance may be due to the limited number of participants who had no exposure (only two), compared to the 28 participants who had exposure, as well as the variation of exposure types. Overall, this lack of significance is consistent with the previous statistical analysis, and it indicates there is not influence of curriculum-exposure on counselor's self-efficacy.

SPANOVA. The SPANOVA also did not demonstrate statistical significance with respect to the counselors' self-efficacy and curriculum exposure. This means there was no influence of curriculum-exposure and counselor experience on counselor self-efficacy when responding to crises in a family setting.

Research question five: *When responding to a family crisis, does the effect of curriculum-exposure on counselor Anxiety depend on the counselor's experience?*

Overall, the RM multivariate test and SPANOVA did not demonstrate statistical significance when including curriculum-exposure influence on counselor anxiety.

Repeated measures MANOVA. Participants who reported no curriculum exposure also reported higher anxiety, although it was not statistically significant on the repeated measures MANOVA. There can be several explanations regarding the outcome of this research study for this research question. Some explanations may include the curriculum exposure, small sample size, and societal changes regarding crises. Additionally, the small sample size may contribute to a limited interpretation of the influence of the curriculum exposure; had there been more participants, the data would have been more robust, as well as the qualitative feedback at the end of the survey may have provided more information on their curriculum exposure. While the difference in anxiety rates between more experienced and less experienced groups is supported by previous research (Watcher-Morris & Barrio-Minton, 2012), the lack of influence of curriculum experience is not. This sample was acquired through convenience sampling, and as such many of the participants could have attended the same University with the same graduate program exposure.

SPANOVA. The SPANOVA did not indicate statistical significance with respect to counselor experience and curriculum-exposure with changes in counselor anxiety. This lack of significance could be due to the changing nature of crises in the United States. Prior to the events of September 11, 2001, the threat of terrorism, mass shootings, and wide-spread natural disasters or pandemics were scarce (Donahue & Tuohy, 2006). These more recent crisis events have inundated counselors and individuals living in the United States through media outlets with information regarding these crises. One could speculate that crisis exposure could be happening at high rates outside of the curriculum, although no curriculum context for the exposure as

counselors and counselors-in-training may hear, see, or read about how their profession is responding to these events. When reading the word "crisis" or considering the implications of the word "crisis" for novice counselors today, they may have more anxiety about family crises, including events such as those listed above, which may include violence.

Research question six: *When responding to a family crisis, does the effect of curriculum-exposure on counselor self-efficacy depend on the counselor's experience?*

While the research study did not produce statistically significant results for counselor self-efficacy, SCT has been used to detail how exposure to situations or techniques can increase one's self-efficacy and performance for those situations or techniques (Bandura, 1986). There was no effect of curriculum exposure on counselor self-efficacy, depending upon the counselor's experience.

Repeated measures MANOVA. The RM MANOVA indicates a statistical non-significance of counselor experience regarding counselor self-efficacy and curriculum exposure. Some research studies have noted that self-efficacy scores may increase or decrease depending on the individual's developmental stages as a counselor or supervisee, and their self-awareness (Stoltenberg, 1998). Previous research studies noted that counselors reported little to no curriculum exposure for crisis response or intervention and lower self-efficacy (Watcher-Morris & Barrio-Minton, 2012). Most often, counselor anxiety regarding counselor work-duties and interventions tend to subside over time and with experience (Smith et al., 2007); however, counselor anxiety regarding crisis response and families persists. While these anxieties appear to persist, the negative effects of counselor anxiety on counselor self-efficacy can be mitigated by the counselor's curriculum exposure and academic preparation (Pirtle et al., 2019). Without curriculum exposure and the resulting increase in confidence gained from curriculum exposure

(Watcher-Morris & Barrio-Minton, 2012), counselor anxiety regarding crises can have profound impacts on the efficacy of interventions provided and the counselor's overall well-being (Pirtle et al., 2019).

Overtime, counselors report higher self-efficacy with experience and supervision with many of their duties as counselors (Smith et al., 2007). Previous research such as that by Skovholt & Ronnestad (2003) indicates that the curriculum exposure, although not having significance, may need further analysis as to the type of curriculum exposure, frequency of curriculum exposure, and the topic of the curriculum exposure (i.e., natural disaster, suicidal ideations, or family crises).

SPANOVA. The SPANOVA indicated no statistical significance for the interaction of counselor self-efficacy, experience, and curriculum experience, meaning there were no significant interactions between these three variables. While the SPANOVA indicated no significance, there could be several explanations for this outcome. Self-efficacy is a concept presented in Social Cognitive Theory by Albert Bandura. This concept and theory offers explanations for the results of this study. While there was a small change in means over-time, all the LCMHCAs and the LCMHCs, and LCMHCSs indicated a similar starting point regarding anxiety and performance. There was a statistically significant three-way interaction with regards to licensure level (LCMHCA and LCMHCs with less than Seven Years of Experience over time) regarding counselor anxiety. The family crisis intervention, a vignette, may have been problematic in eliciting the anxiety response in some participants. Also, possible, is that since the 2016 CACREP recommendations regarding infusing crisis discussion in the curriculum, counselor education programs have consistently prepared newly licensed individuals to address and de-escalate crises. While no statistical significance was found with respect the a priori

research questions, further analysis was conducted post-hoc to examine the values approaching significance on the STAI with respect to counselor experience.

Post-Hoc Analysis

As a result of value approaching significance on the STAI with respect to counselor experience, a post-hoc RM MANOVA and SPANOVA were conducted with respect two additional research questions.

Research question seven: *When responding to a family crisis, does the effect of licensure on counselor anxiety depend on the years of experience?*

Research question eight: *When responding to a family crisis, does the effect of licensure on counselor self-efficacy depend on the years of experience?*

Table 4

Family Crisis Licensure * Experience*

		Pre-STAI	Post-STAI	Pre-COSE	Post-COSE_
LCMHC-A	0 thru 7 yrs	2.32 (.22)	2.47 (.49)	4.40 (.49)	4.43 (.58)
	8 thru 40 yrs	2.28 (.18)	1.65 (.35)	5.05 (.46)	4.93 (.36)
	Total	2.31 (.21)	2.33 (.56)	4.51 (.53)	4.52 (.57)
LCMHC, LCMHC-S	0 thru 7 yrs	2.50 (.56)	2.51 (.73)	4.46 (.89)	4.47 (.93)
	8 thru 40 yrs	1.69 (.46)	1.83 (.53)	5.25 (.48)	5.26 (.45)
	Total	1.92 (.60)	2.02 (.65)	5.04 (.69)	5.04 (.69)
Total	0 thru 7 yrs	2.38 (.36)	2.48 (.56)	4.42 (.62)	4.45 (.68)
	8 thru 40 yrs	1.77 (.47)	1.80 (.50)	5.23 (.47)	5.21 (.44)
	Total	2.08 (.52)	2.14 (.62)	4.83 (.68)	4.83 (.69)

Independent variable	Pillai's Trace	Df1	Df2	*F*	*p*	*ηπ2*
Family Crisis * Years Experience * Lic	.11	2	25	*4.71*	*.018*	*.27*

Independent variable	Mean Square	Df1	Df2	*F*	*p*	η_p^2
Family Crisis * Years Experience * Licensure (STAI)	.456	2	25	7.31	.012	.22
Family Crisis * Years Experience * Licensure (COSE)	.013	2	25	.263	.612	.01

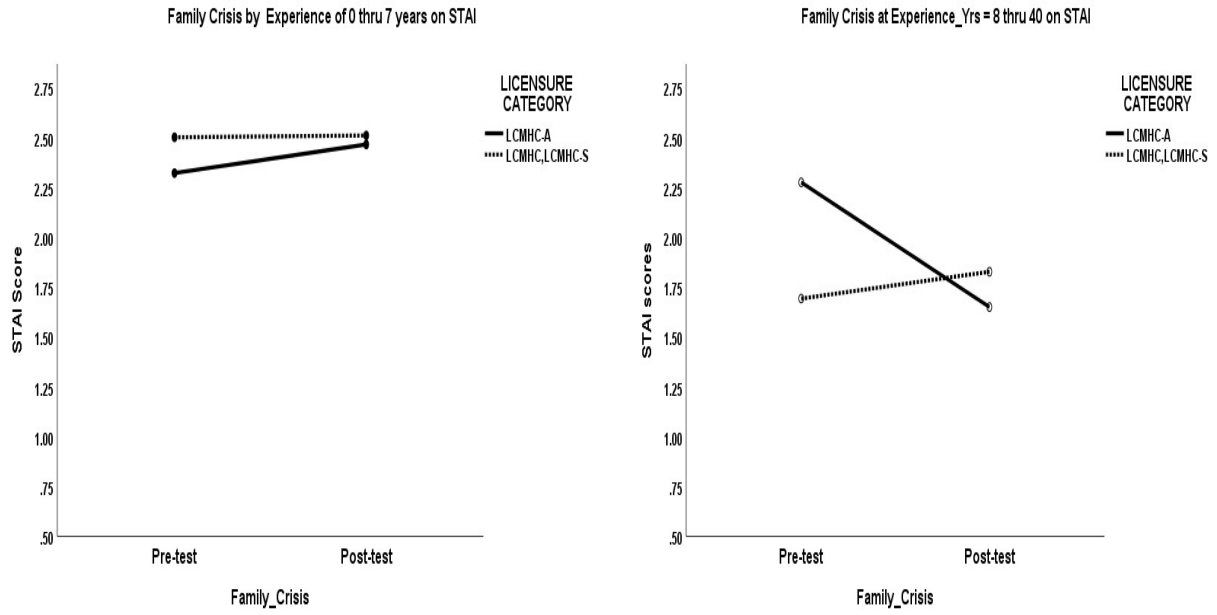
Repeated measures MANOVA. The RM MANOVA resulted in a statistically significant (F (2, 25) = 4.71, p = .018, η_p^2 = .27) interaction for two levels of experience: years (i.e., 0-7 and 8-40 years) and licensure type (LCMHCA and LCMHC, or LCMHC and LCMHCS) on the STAI with respect to the effect of the family crisis vignette. This multivariate test of counselors' experience based on licensure and years indicated a significant multivariate effect of the interaction of counselor Experience in Years*Counselors Experience with Licensure* Counselors State Anxiety and Self-Efficacy with respect to the family crisis vignette, to answer Research Questions 1 and 2, two SPANOVAs were conducted. With the SPANOVA procedure, a univariate F test for each dependent variable was examined to interpret its respective effect. So, in order that the contribution of state anxiety and counselor self-efficacy to the overall effect could be identified. The next two paragraphs highlight these findings.

Research question seven SPANOVA. The RM multivariate test was statistically significant, the follow-up SPANOVA (see Table 1.4 above) was conducted to examine the effects of the level of counselor experience based on years of experience and licensure type on counselor state anxiety. The SPANOVA indicated a statistically significant three-way interaction for years of experience by licensure on counselor anxiety [F (2, 25) = 7.31, p = .012, η_p^2 = .22]. The three-way interaction was statistically significant, indicating that the two levels of counselor experience (licensure and years of experience) had a significant effect on counselor state anxiety when exposed to the family crisis vignette. The interaction was noted where the group with Eight

Years of Experience or more with licensure types LCMHC and LCMHCS had less reactivity or anxiety after reading the family crisis vignette than the group with Seven Years or less of experience and licensure type LCMHC and LCMHCA based on their pre-test and post-test STAI scores (see Figure 3 below). Essentially, the family crisis vignette had a significant effect on the group with Seven Years or Less of Experience and licensure type LCMHC and LCMHCA.

Figure 3

Licensure and Years of Experience on STAI



The trend of the data indicated individuals with a LCMHC licensure and Seven Years of Experience or less, had an increase in their anxiety post-family crisis. The LCMHCA licensure with Seven Years of Experience or less, had a decrease in their anxiety post-family crisis (see Figure 4 below). While the licensure group with Seven Years of Experience or less had an interaction, the group with Eight Years of Experience or more indicated a trend of decreasing anxiety post-family crisis (see Figure 3 above).

The trends of the data on the SPANOVA for counselor's experience levels on their change in anxiety are illustrated in the graphs in Figure 3 (above). Figure 3 illustrates the difference

between the first licensure group for those individuals who hold a LCMHC comparatively to those who hold a LCMHCA and no more than Seven Years of Experience (see side-by-side graphs above in Figure 3). Figure 3 (above), the graph on the left illustrates that those individuals who hold a LCMHCA indicated a small increase in their anxiety post-family crisis, while those who held a LCMHC licensure indicated a small drop in their anxiety post-family crisis. Those participants with Seven Years of Experience or less had a higher starting anxiety and an increase in anxiety. Those with eight years or more of experience started with a lower level of anxiety and indicated a decrease from pre to post-STAI.

The following two paragraphs note the mean scores of the Licensure * Years of Experience interaction on the STAI pre-test and post-test. The effect of Counselor Licensure status on STAI after reading the family crisis vignette depended on the Counselors' level of Experience, the LCMHC-A counselor group with 0 to 7 years of experience had a non-significant increase in their STAI scores from the pre-test ($M = 2.32$) to the post-test ($M = 2.47$). However, the LCMHC-A counselors with more experience had a significant decrease ($p = .019$) in STAI from pre-test (M = 2.28) to post-test (M = 1.65).

By contrast, the LCMHC or LCMHC-S counselor group, regardless of experience level, had a significant change in STAI after reading the family crisis vignette. Specifically, counselors with less experience had a statistically non-significant increase in STAI from the pre-test ($M = 2.50$) to the post-test ($M = 2.51$). Likewise, although the more experienced counselors STAI scores increased from the pre-test ($M = 1.69$) to the post-test ($M = 1.83$), this change was not statistically significant. In conclusion, for counselors with and the LCMHC-A, the effect of the family crisis vignette depended on the level of experience. Only LCMHC-A counselors with 8 to

40 years of experience showed a significant change (decrease) in STAI after reading the family crisis vignette.

The following two paragraphs note the mean scores of the Licensure * Years of Experience interaction on the COSE pre-test and post-test. For LCMHC-A counselors, both experience levels did not have a statistically change to their COSE after reading the vignette. That is, the group with 0 to 7 years of experience had a non-significant increase in their COSE scores from the pre-test (M = 4.40) to the post-test (M = 4.43). Likewise, although the counselor with more experience had a smaller non-significant increase in COSE from pre-test (M = 5.05) to post-test (M = 4.93).

Likewise, the LCMHC and LCMHC-S counselor group, regardless of experience level, also did not have a significant change in COSE after reading the family crisis vignette. Specifically, the counselors with less experience had a statistically non-significant increase in COSE from the pre-test (*M* = 4.46) to the post-test (*M* = 4.47). Interestingly, the more experienced counselors had a statistically non-significant decrease in COSE from the pre-test (*M* = 5.25) to the post-test (*M* = 5.26).

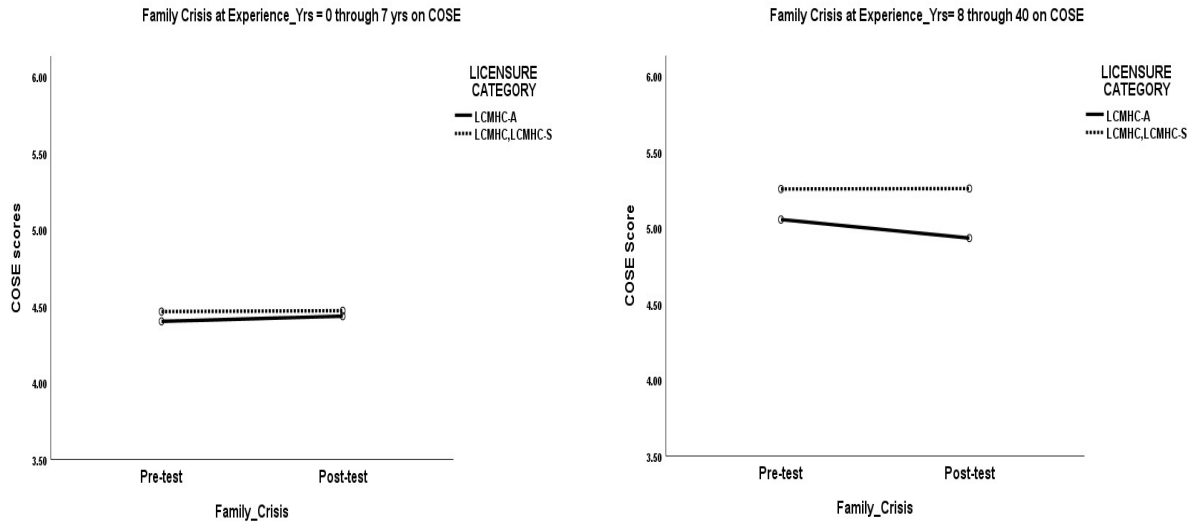
The group with Seven Years of Experience or less had a pre-test mean of 2.41 in the pre-STAI, and the group with Eight Years of Experience or more had a pre-test mean value of 1.98. However, those participants with Seven Years of Experience or more reported little change in anxiety to an increased post-test mean value of 2.49 change over time with a decrease in anxiety; the group with eight years or more of experience or more group had a statistically significant decrease from pre to post-STAI with the post mean value of 1.74.

Research question eight SPANOVA. The RM multivariate test was not statistically significant; the follow-up SPANOVA was conducted to examine the changes in the effect of

counselor experience in years and licensure type on counselor self-efficacy. The SPANOVA indicated no statistical significance for the effect of counselor experience in years and licensure type on counselor self-efficacy [F (2, 25) = .26, p = .61, η_p^2 = .01]. Thus, after reading the vignette, there was no observable difference between the two levels of counselor experience (see Figure 4 below) on counselor self-efficacy. The non-significance is not consistent with previous research, where researchers noted more counselor experience was correlated with higher counselor self-efficacy. The non-significance can be indicative of new counselors having appropriate experiences in graduate school, which prepare them for crisis situations. Additionally, the non-significance may also indicate that counselors are aware of their anxiety as new counselors and have possibly learned coping mechanisms to prevent their anxiety from affecting their self-efficacy.

Figure 4

Licensure and Years of Experience on the COSE



Limitations

The study had limitations, such as instrumentation and design threats, which will be discussed in this section. The limitations include issues regarding the incentive, recruitment,

length of the survey, and sample size. Initially, the incentive was a chance to win $50; however, when participants were slow to complete the survey, the research obtained approval to increase the incentive to $95 when recognizing most counselors in North Carolina are paid more than $50 an hour, and the survey may have taken some participants close to an hour to complete. Once the incentive was increased, individuals appeared more willing to invest the time in completing the survey. Congruent to the incentive issue is the length of time participants may have needed to complete the survey in its entirety. The time investment may have been difficult depending on the participants' schedule, as well as the redundancy of the instruments.

Instrumentation

All instruments (STAI, COSE, and demographic survey) included in this study are self-report. The limitation of social desirability of responses are present in a self-report instrument. While the construct validity was published for the STAI, this research study noted the anxiety change over time was statistically significant with a small effect size for the three-way interaction for two levels of experience (years and licensure). In addition to instrumentation limitations, are design threats.

Design Threats

This research study presented several design threats including the use of a vignette, self-report survey, sample size, and non-probability sampling. Although the most ethical option, the use of a vignette rather than a real crisis situation, was a threat as participants may not have felt as anxious about responding to the vignette situation as they might have been in a real crisis situation. Similarly, the use of the vignette may have resulted in a time issue, as the individuals were allowed more time to assess the family crisis situation, and participants may have felt more competent responding than they would in a real-life situation.

The self-report survey is subject to participants' response-biases. Participant response biases could include socially-desirable responses instead of responding honestly. Participants may have reported less anxiety for fear of judgment, or as a result of talking to other participants before taking the survey. This study did not take steps to prevent participants from talking to one another prior to or after taking the survey. While self-report is a limitation of this study, the small sample size is also a limitation.

A larger sample size may have improved the statistical significance for this study as it pertains to questions about self-efficacy. Additionally, the non-probability sampling method prevented all members of the population from having equal chances of being selected. The limitation of the non-probability sampling could have resulted in many participants from the same graduate program. The participants from the same graduate programs may have experienced the same crisis-exposure methods in the curriculum. Similarly, this study had no participants outside of Caucasians and African Americans, which limits the diversity of responses or cultural differences for specific ethnicities. Despite these threats, the study did yield statistically significant results in the three-way interaction on the STAI. In addition to design threats, was the presence of attrition and compensatory equalization of treatment threats.

Attrition and Compensatory Equalization of Treatment

Attrition and compensatory equalization of treatment could have had significant effects on this study. Participants could have dropped out due to the length of time necessary to complete the survey. At the time of data analysis, there were over 30 surveys in-progress, and some potential participants reported the study as “prohibitively long." Similarly, participants may have begun the survey questions and identified professional deficits in crisis-response skills, resulting in them seeking additional information before returning to re-take the survey. To limit

the effects of compensatory equalization of treatment, participants were only able to access the survey one time in its entirety. However, the one-time access may still have resulted in participants talking about the survey to each other, including how on participant responded affecting another participant's responses, further lending to the social threats of the study.

Social Threats

Despite the use of a one-time access, online survey, social threats remained. Participants may have responded to the measurement tools in socially desirable ways, such as reporting higher confidence or lower anxiety than is accurate. Similarly, participants may have sought out additional information prior to returning and taking the survey that subsequently influenced their responses. Additional information could have been found in participants that already completed the survey and experiences between their initial access to the survey and when they returned to take the survey. The non-probability sampling may have also contributed to social threats, and individuals may have shared the study with others resulting in a feeling of obligation to take the survey rather than genuine interest, possibly resulting in more neutral responses. As a result of these threats, there are several implications for future research regarding family crises.

Implications

The purpose of the study was to assess counselor anxiety and self-efficacy regarding family crisis response for curriculum exposure and experience. The study utilized two measurement tools, in a pre-post design, with an additional demographic survey. Thirty participants who were licensed clinical mental health counselors (either provisionally, fully, or supervisor status) responded to all portions of the study. The purpose was to assess the effects of curriculum exposure and separately experience on counselor anxiety and self-efficacy, respectively. Additionally, the purpose of the study was to assess for the interaction of exposure

and experience on counselor anxiety and self-efficacy, respectively. This study did identify a three-way interaction between licensure type, experience, and anxiety. Despite the limitations of this study, there are several implications for counselors, counselor supervisors, and counselor educators.

Counselors

There were several implications for counselors, including the anxiety reports, implications for their overall wellbeing and performance, where to seek information regarding family crises, and current events. Research has indicated that newly licensed counselors experience high rates of performance anxiety, which often contributes to poor performance (Pirtle et al., 2019; Smith et al., 2007). The high rates of anxiety regarding performance can result in negative effects on their self-efficacy and, ultimately, their performance in counseling (Skovholt, & Ronnestad, 2003). High rates of anxiety can also have terminal effects on their wellbeing and ability to serve clients unimpaired or resulting in compassion fatigue and burn out (Pirtle et al., 2019; Young & Lambie, 2007). Curriculum exposure to crisis intervention strategies, regardless of the topic or type of exposure, appear to have a significant effect on the counselor's anxiety and awareness (Elliot et al., 2018). Various resources can be helpful to counselors with high anxiety about crisis intervention.

Counselors and counseling students can benefit from seeking out opportunities to learn more about crisis situations to continue to decrease their anxiety and increase self-efficacy prior to actual clients. Counselors are required by the NCBLCMHCs (2019) to engage in annual continuing education, which can be composed of various topics or techniques. Counselors unfamiliar with topics regarding client crises can benefit from seeking out continuing education specific to this content. Counselors working in agencies, or in partnership with other counselors

can benefit from peer supervision and collaboration as well. Counselors, newly licensed or experienced, appear to feel their clinical supervisors are knowledgeable about family crises and how to intervene.

Counselors seeking more information about family crises can also seek out agency supervisors, clinical supervisors, previous research, as well as further continuing education regarding family crises if they do not feel prepared or they do feel overly anxious about responding to family crises. This study utilized a demographic survey that asked participants to rate their agency and clinical supervisors' knowledge regarding family crises. Only four participants reported feeling as though their agency supervisor was not knowledgeable regarding family crises, and only six participants reported feeling as though their clinical supervisor was not knowledgeable about family crises. The demographic survey indicated it is safe to assume that counselors should be encouraged and empowered to seek clinical supervision regarding family crises.

The nature of family crises has changed over time. The changes in the family crises arose with societal changes. The definition of "family" has changed to include the acceptance of unwed mothers having children, the increase in divorce rates and increased need for foster parents have all contributed to a change in the traditional idea of family. Additionally, the increase in the number of individuals living with multiple generations in one home contributes to different types of family crises. These changes in the definition of "family" require culturally sensitive approaches to crisis intervention and counseling. Similarly, the definition of family for this research study includes multi-ethnic placements, where parents, children (foster, adopted, or biological) and other familial generations are present emphasizes the importance of working with each family in an individualized therapeutic approach. Lastly, while considering the importance

of culture for these families, counselors can support these families in defining the significance of crisis events either occurring in their community or country, as well as immediate family crisis needs.

In the last decade, society has witnessed an increase in mass casualty events, military personnel returning from serving in active war zones, and the opioid epidemic. The nature of all the events results in crisis response needs. Mass casualty events have resulted in individuals traumatized both directly and vicariously. Some individuals may experience Post-Traumatic Stress (PTS) as a result of surviving a mass casualty event (Lowe & Galea, 2017). Other individuals may experience vicarious trauma and display symptoms of heightened anxiety or depression as a result of feeling unsafe due to these events (Day, Lawson, & Burge, 2017). Similar to the symptoms resulting in mass casualty events are the symptoms of military persons returning home.

Similarly, military individuals returning from active war zones may have experienced significant trauma, sexual assault, and injury. These individuals returning from war have specialized needs and may experience high rates of crises, resulting in family crises, as they transition back home (Cole, 2016). Military individuals will likely have difficulty transitioning to civilian life, as well as the family demands, or work demands (Cole, 2016). They will also likely experience family conflict and have higher rates of intimate partner violence (Sparrow et al., 2017). The familial conflict and intimate partner violence require therapeutic intervention and support to de-escalate. Another concern is the high rates of PTS for individuals serving in the military (Brickell, Russell, & Smith, 2015). Additionally, many military personnel have struggled with the opioid epidemic as well (Bennett, Golub, & Elliott, 2017).

As previously discussed, the opioid epidemic has resulted in dramatic increases in children entering foster care services (Tucker, 2018). As a result, these children have often experienced significant trauma from abandonment, neglect, to various forms of abuse (Freadling, & Foss-Kelly, 2014). Due to the increasing needs of these populations, the novice counselor is more likely to respond to family crises, personal crises, and mass crises, than previously thought (Freadling, & Foss-Kelly, 2014). Additionally, counselors can benefit from training in specialized trauma services such as Eye-Movement Desensitization and Reprocessing (EMDR; Brickell et al., 2015). This study noted the importance of clinical supervisors in facilitating newly licensed or provisionally licensed counselors accessing pertinent information to prepare them for family crises, such as specialized training.

Counselor Supervisors

There were several implications for counselor supervisors as a result of this study including accessing resources for crisis intervention and specialized therapy training, supporting supervisees in practicing anxiety management strategies, and engaging in self-care which is a content implication rather than a specific research implication from this study; however, this study did find that newer counselors experience anxiety at higher rates when faced with crisis situations and previous research has found anxiety can have negative implications for self-efficacy. Only a few participants reported feeling as though their clinical and agency supervisors were not knowledgeable about family crises. Counselor supervisors can benefit from knowing where to access information to prepare supervisees for family crises. Counselor supervisors, including agency and clinical supervisors, can support newly licensed and provisionally licensed counselors in managing their anxiety when responding to family crises. Conducting a brief inventory of the supervisee's curriculum exposure to crises and their anxiety about responding to

crises can provide insight to the supervisor regarding the supervisee's needs in preparing for crisis intervention.

Clinical supervisors and agency supervisors can spend a portion of supervision emphasizing the importance of self-care and anxiety management strategies. Supervisors can encourage a schedule of self-care routines and follow up during supervision on the efficacy of the routines for anxiety management. Additionally, supervisors can recommend various anxiety management strategies for supervisees. As well as recommending anxiety management strategies, supervisors can engage supervisees in techniques during supervision to decrease anxiety such as role-plays (Tolleson et al., 2017; Cummings et al., 2015; Osborn, & Costas, 2013).

Several continuing education providers, universities, and training programs offer support and guidance for supervisees who need more information. Counselor supervisors can expect supervisees to benefit from additional training and seek to include these strategies in their supervision.

Lastly, counselor supervisors can support novice counselors in accessing specialized therapeutic approaches. When counselor supervisors note a trend with the type of therapeutic needs of individuals or the population served, following up to ensure, the counselor providing the most efficacious service is necessary. Counselor supervisors can ensure that the most appropriate service is being rendered when talking with the supervisee about their clients' perceived therapeutic needs, such as trauma-focused services for individuals in foster care. Counselor supervisors can also benefit by noting their own limitations or familiarity with a specific population and encourage the counselor to reach out to experts in the field in addition to trainings

and research articles. In addition to counselor supervisors, there are implications for counselor educators as a result of this study.

Counselor Educators

While this study noted many participants as feeling prepared for family crises, the counselor's anxiety persisted for provisionally and newly licensed counselors. Counselor educators may find their students benefit from both the curriculum exposure, as well as anxiety management strategies. One change that has occurred since previous research studies such as Watcher-Morris and Barrio-Minton's (2012) article was the CACREP (2016) changes requiring crisis exposure in the curriculum. Many participants reported the curriculum exposure; however, ten participants reported their graduate program did not prepare them for family crises based on their responses to the demographic survey, while only four reported no exposure to crises in their graduate program. Counselor educators might consider seeking program participant feedback on how to best address this need and include more family-crisis specific content in the curriculum.

One recommendation may be for each of the CACREP (2016) content areas such as spirituality, family, substance use, a program could benefit from a one-time lecture on crises based on the specific content topic. Encouraging counseling students to seek out opportunities to volunteer and learn crisis intervention strategies prior to graduation can also benefit students in reducing their anxiety. Collaborating with community stakeholders, advocating for student involvement, and assisting with supervision for the volunteer sites can support the students in having positive experiences and opportunities for growth at the volunteer sites specific to crises prior to practicum, internship, and graduation. The additional lecture or volunteer opportunity assists in producing more well-trained graduates with lower anxiety and potentially higher self-efficacy in responding to crises, especially with families. Lastly, providing curriculum-specific

context for current crisis events, including domestic violence, mass violence, terrorism, natural disasters, and pandemics, can benefit counselors in training.

Recognizing the implications of this research was that new counselors have higher anxiety about family crisis response. Participants also reported not feeling prepared for family crises. Generalizations to other crisis response maybe that new counselors also feel anxious and under-prepared to respond. Counselor educators can support counseling students and counselors in training in learning how the field of counseling responds during different crisis events. These crisis events could be specific family crises or domestic violence situations that occur in their community or news headlines that they are exposed to when watching the evening news. Additionally, the more catastrophic events could have impacts on students and counselors in training, allowing time for these individuals to process their needs in an educational setting, and how to support others during the crisis can prepare them for success in responding to crises in their community. Lastly, providing a curriculum-specific context for current events can support counseling students and counselors in training with real-life scenarios and how to intervene in high-intensity situations appropriately.

Recommendations for Future Research

Future research can benefit from several recommendations, including larger sample sizes, national surveys, a live intervention strategy, a controlled environment, and counseling students. The first recommendation is a larger sample size. The larger sample size may provide more details regarding training, curriculum exposure, and counselor anxiety and self-efficacy measurements. Probability sampling may also provide more insight across various programs, as well as more diversity across cultures, clinical supervisors, and agency supervisors. Additionally, further exploration regarding other states could provide more feedback regarding regional

differences, program variations, and types of crisis exposure in the curriculum. This study only included professional counselors in North Carolina; however, other studies indicate this is potentially a national issue (Watcher-Morris & Barrio-Minton, 2012). Future studies can benefit from a national survey of all counselors, especially as regional differences may provide more insight into crisis response and training across many programs. Future studies may be able to assess for systemic deficits in training and find statistically significant outcomes for the COSE. One method of assessing for deficits in training could be using a live intervention scenario.

Future studies may also benefit from a live role-play crisis scenario in a controlled environment with live actors. A live role-play may have a more profound effect on participants' responses on the STAI and result in more significance across various licensures and experience levels. Similarly, participant responses on the COSE may demonstrate more significance with a live role-play. Additionally, a controlled environment may prevent participants from sharing their knowledge of the survey with other participants prior to completion. A live role-play with counselors engaging in de-escalation, or crisis-intervention techniques may provide more awareness and insight. In addition to the completion of the live role-play and survey, a more accurate measurement of the counselors' performance could be obtained by having experienced counselors rate the individual's performance when engaged in the role-play as this has been done in similar studies with clinical supervisors and supervisees regarding aptitude (Larson et al., 1992). Comparison of observer and participant responses on the COSE has been used to rate performance in previous studies yielded high reliability and validity scores (Larson et al., 1992) Lastly, future research may also ask questions regarding what participants felt was adequate preparation for responding to family crises as 10 participants indicated they were not adequately prepared for family crises in their graduate program.

Counseling students could offer information regarding the efficacy of anxiety management strategies and contextual knowledge in mitigating the negative effects of anxiety on self-efficacy. Including some students who have already had curriculum-exposure to crises compared to students who have not already had curriculum-exposure could better capture the effects of contextual knowledge. Similarly, their perspective of curriculum-exposure comparatively may provide better insight into the differences across experience levels as this study included all individuals post-graduation, meaning all participants had field experience per CACREP (2016) standards during practicum and internship. The use of students may better facilitate a clear delineation between experienced and non-experienced counselors. Lastly, incorporating students into a research study such as this could promote more awareness of self-efficacy as their overall lifetime experiences regarding feedback on their counseling skills is limited to the graduate program, rather than clinical supervisor, agency supervisor, and client feedback if they have not yet completed practicum and internship.

Conclusions

This chapter reviewed the interpretations of the results, limitations, and implications. This chapter also discussed the recommendations for future research. Despite limitations with the non-probability sampling, the study did result in statistically significant outcomes and implications for the counseling field. Counselor educators have been appropriate and effective in addressing crises in the curriculum, and according to the outcomes of this study, the curriculum exposure has not had a statistically significant effect on counselor anxiety scores when responding to family crises in North Carolina. Unfortunately, the COSE did not provide much insight into the effects of curriculum exposure or experience in self-efficacy when responding to family crises; however, this may have been a result of a limitation with the sample size. Ongoing

assessment of counseling students may provide insights into areas of deficits regarding preparation to respond to family crises, as a third of the participants reported not feeling as thought their program prepared them for this type of crisis response.

Lastly, this study noted several implications for counselors, counselor supervisors, and counselor educators. Ethically, counselors are work in their scope of practice, seek additional training or information when they find areas of deficit (ACA, 2014), and counselor supervisors may be the first intervention to accessing that information. Counselor supervisors, including clinical supervisors and agency supervisors, can support provisionally and newly licensed counselors in seeking resources to address the areas of deficit regarding family crises. Counselor educators can seek feedback from program participants and graduates in how to address areas of deficits, including family crises.

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APPENDIX A: Participant Informed Consent

You are being invited to participate in a **research** study titled "*Crisis in the Family: Counselor Anxiety and Self-Efficacy in Responding to Family Crises"* being conducted by J. Hillary DodgeEvans, a Doctoral Student in the Department of Addictions and Rehabilitation Studies at East Carolina University. The goal is to survey approximately 30 individuals licensed to practice counseling in North Carolina. The survey will take approximately 60 minutes to complete. It is hoped that this information will assist us to better understand Counselor anxiety and self-efficacy when responding to families in crisis. Your responses will be kept confidential and no data will be released or used with your identification attached. Your participation in the research is **voluntary**. You may choose not to answer any or all questions, and you may stop at any time. There is **no penalty for not taking part** in this research study. Please call J. Hillary DodgeEvans at 252-744-6300 for any research related questions or the University & Medical Center Institutional Review Board (UMCIRB) at 252-744-2914 for questions about your rights as a research participant.

APPENDIX B: Permission to Use the STAI

Approval for Remote Online Use of a Mind Garden Instrument

Effective date is November 14, 2019 for:

Hillary DodgeEvans

You submitted your Application for Remote Online Use at 6:22 am EST on November 14, 2019.

mind garden

APPENDIX C: STAI Preview

Self-Evaluation Questionnaire
STAIAD Short Form Y-1

Please provide the following information:

Name_____ Date_____ S____

Age_____ Gender (*Circle*) **M** **F** T____

Directions: A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel ***right*** now, that is, ***at this moment***. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best. Use the following scale:

NOT AT ALL – SOMEWHAT – MODERATELY SO – VERY MUCH SO

	NOT AT ALL	SOMEWHAT	MODERATELY SO	VERY MUCH SO
1. I feel calm	1	2	3	4
2. I am tense	1	2	3	4
3. I feel at ease	1	2	3	4
4. I am presently worrying over possible misfortunes	1	2	3	4
5. I feel frightened	1	2	3	4
6. I feel nervous	1	2	3	4
7. I am jittery	1	2	3	4
8. I am relaxed	1	2	3	4
9. I am worried	1	2	3	4
10. I feel steady	1	2	3	4

APPENDIX D: Survey Questionnaire

I. **First please tell us a little about yourself:**

1. Please indicate which license(s) you currently hold in North Carolina:
    a. Licensed Mental Health Counselor (LCMHC)
    b. Licensed Mental Health Counselor-Associate
    c. Licensed Mental Health Counselor-Supervisor
2. Years of experience as in mental health services: ____ years
3. Number of years post-graduation: ____years _____ months
4. What is the frequency to which you respond to crises:
    a. Never
    b. Once a week
    c. Once a month
    d. Multiple times a week
    e. A few times a year
5. What gender do you identify as? 1.Male___ 2. Female____ 3. Other_____
6. What crisis exposure did you have while in your graduate program (circle all that applies):
    a. None
    b. Volunteer experience
    c. One-time lecture/presentation
    d. A specific course
    e. Other: please provide details in blank space at the bottom of this survey
7. What is your age: _____years
8. What is your ethnicity:
    a. African American
    b. Caucasian
    c. Hispanic
    d. Native American
    e. Asian
    f. Other: _____

II. Rate and circle the number that fits you best on the following statements when 5= Strongly Agree, 4= Agree, 3= Neither, 2= Disagree, 1= Strongly Disagree

Please circle the number that best reflects your opinion for each question or prompt.		Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
1.	I feel that my graduate program adequately prepared me for crisis-response in the field.	**5**	**4**	**3**	**2**	**1**

2.	I feel that my graduate program adequately prepared me to work with families.	**5**	**4**	**3**	**2**	**1**
3.	I feel that my graduate program adequately prepared me to work with families in crisis.	**5**	**4**	**3**	**2**	**1**
4.	I was provided no training, lectures/presentations, or volunteer opportunities to prepare me for family crisis-response during my graduate program.	**5**	**4**	**3**	**2**	**1**
5.	I obtained information on family crisis response during clinical supervision.	**5**	**4**	**3**	**2**	**1**
6.	My clinical supervisor did not demonstrate knowledge of crisis response.	**5**	**4**	**3**	**2**	**1**
7.	My direct supervisor (agency or otherwise) was knowledgeable about family crisis response.	**5**	**4**	**3**	**2**	**1**
8.	My direct supervisor (agency or otherwise) provided adequate training to me regarding family crisis-response.	**5**	**4**	**3**	**2**	**1**

III. Thank you for your time and contribution!

Please provide any comments in the space provided:

APPENDIX E: Counselor Self-Estimate Inventory

COUNSELING SELF-ESTIMATE INVENTORY

This is not a test. There are no right or wrong answers. Rather—it is an inventory that attempts to measure how you feel you will behave as a counselor in a counseling situation. Please respond to the items as honestly as you can so as to most accurately portray how you think you will behave as a counselor. Do not respond with how you wish you could perform each item—rather answer in a way that reflects your actual estimate of how you will perform as a counselor at the present time.

Below is a list of 37 statements. Read each statement, and then indicate the extent to which you agree or disagree with that statement, using the following alternatives:

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

PLEASE — Put your responses on this inventory by marking your answer to the left of each statement.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

1. When using responses like reflection of feeling, active listening, clarification, probing, I am confident I will be concise and to the point.

2. I am likely to impose my values on the client during the interview.

3. When I initiate the end of a session I am positive it will be in a manner that is not abrupt or brusque and that I will end the session on time.

4. I am confident that I will respond appropriately to the client in view of what the client will express (e.g., my questions will be meaningful and not concerned with trivia and minutia).

5. I am certain that my interpretation and confrontation responses will be concise and to the point.

6. I am worried that the wording of my responses (e.g., reflection of feeling, clarification, and probing) may be confusing and hard to understand.

7. I feel that I will not be able to respond to the client in a non-judgmental way with respect to the client's values, beliefs, etc.

8. I feel I will respond to the client in an appropriate length of time (neither interrupting the client nor waiting too long to respond).

9. I am worried that the type of response I use at a particular time, i.e., reflection of feeling, interpretation, etc., may not be the appropriate response.

10. I am sure that the content of my responses, i.e., reflection of feeling, clarification, and probing, will be consistent with and not discrepant from what the client is saying.

11. I feel confident that I will appear competent and earn the respect of my client.

12. I am confident that my interpretation and confrontation responses will be effective in that they will be validated by the client's immediate response.

13. I feel confident that I have resolved conflicts in my personal life so that they will not interfere with my counseling abilities.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

14. I feel that the content of my interpretation and confrontation responses will be consistent with and not discrepant from what the client is saying.

15. I feel that I have enough fundamental knowledge to do effective counseling.

16. I may not be able to maintain the intensity and energy level needed to produce client confidence and active participation.

17. I am confident that the wording of my interpretation and confrontation responses will be clear and easy to understand.

18. I am not sure that in a counseling relationship I will express myself in a way that is natural without deliberating over every response or action.

19. I am afraid that I may not understand and properly determine probable meanings of the client's nonverbal behaviors.

20. I am confident that I will know when to use open or closed-ended probes and that these probes will reflect the concerns of the client and not be trivial.

21. My assessments of client problems may not be as accurate as I would like them to be.

22. I am uncertain as to whether I will be able to appropriately confront and challenge my client in therapy.

23. When giving responses, i.e., reflection of feeling, active listening, clarification, probing, I'm afraid that they may not be effective in that they won't be validated by the client's immediate response.

24. I do not feel that I possess a large enough repertoire of techniques to deal with the different problems my clients may present.

25. I feel competent regarding my abilities to deal with crisis situations that may arise during the counseling sessions—e.g., suicide, alcoholism, abuse, etc.

26. I am uncomfortable about dealing with clients who appear unmotivated to work towards mutually determined goals.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

27. I may have difficulty dealing with clients who do not verbalize their thoughts during the counseling session.

28. I am unsure as to how to deal with clients who appear noncommittal and indecisive.

29. When working with ethnic minorities clients I am confident that I will be able to bridge cultural differences in the counseling process.

30. I will be an effective counselor with clients of a different social class.

31. I am worried that my interpretation and confrontation responses may not over time assist the client to be more specific in defining and clarifying their problem.

32. I am confident that I will be able to conceptualize my client's problems.

33. I am unsure as to how I will lead my client towards the development and selection of concrete goals to work towards.

34. I am confident that I can assess my client's readiness and commitment to change.

35. I feel I may give advice.

36. In working with culturally different clients I may have a difficult time viewing situations from their perspective.

37. I am afraid that I may not be able to effectively relate to someone of lower socioeconomic status than me.

APPENDIX F: IRB Approval Letter

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board
4N-64 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** · rede.ecu.edu/umcirb/

Notification of Exempt Certification

From: Social/Behavioral IRB

To: Jaquelin Dodge Evans

CC: Paul Toriello

Date: 1/22/2020

Re: UMCIRB 19-000880
Counselor Anxiety and Self-Effiacy in Family Crises

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board
4N-64 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** · rede.ecu.edu/umcirb/

I am pleased to inform you that your research submission has been certified as exempt on 1/22/2020. This study is eligible for Exempt Certification under category # 2ab.

It is your responsibility to ensure that this research is conducted in the manner reported in your application and/or protocol, as well as being consistent with the ethical principles of the Belmont Report and your profession.

This research study does not require any additional interaction with the UMCIRB unless there are proposed changes to this study. Any change, prior to implementing that change, must be submitted to the UMCIRB for review and approval. The UMCIRB will determine if the change impacts the eligibility of the research for exempt status. If more substantive review is required, you will be notified within five business days.

Document	Description
Consent(0.02)	Consent Forms
Counselor Self-Estimate Inventory(0.01)	Surveys and Questionnaires
Demographic Survey(0.01)	Surveys and Questionnaires
Dissertation Proposal(0.01)	Study Protocol or Grant Application
Recruitment email(0.01)	Recruitment Documents/Scripts
State Trait Anxiety Inventory(0.01)	Surveys and Questionnaires
Survey in word format as it will appear to participants(0.01)	Surveys and Questionnaires
Vignette(0.01)	Surveys and Questionnaires

For research studies where a waiver of HIPAA Authorization has been approved, each of the waiver criteria in 45 CFR 164.512(i)(2)(ii) has been met. Additionally, the elements of PHI to be collected as described in items 1 and 2 of the Application for Waiver of Authorization have been determined to be the minimal necessary for the specified research.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

APPENDIX G: Amendment Approval Letter

Notification of Amendment Approval

From: Social/Behavioral IRB

To: Jaquelin Dodge Evans

CC: Paul Toriello

Date: 2/18/2020

Re: Ame1_UMCIRB 19-000880
UMCIRB 19-000880
Counselor Anxiety and Self-Effiacy in Family Crises

Your Amendment has been reviewed and approved using expedited review on 2/18/2020. It was the determination of the UMCIRB Chairperson (or designee) that this revision does not impact the overall risk/benefit ratio of the study and is appropriate for the population and procedures proposed.

Please note that any further changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must adhere to all reporting requirements for this study.

If applicable, approved consent documents with the IRB approval date stamped on the document should be used to consent participants (consent documents with the IRB approval date stamp are found under the Documents tab in the study workspace).

The approval includes the following items:

Document	Description
There are no items to display	

For research studies where a waiver of HIPAA Authorization has been approved, each of the waiver criteria in 45 CFR 164.512(i)(2)(ii) has been met. Additionally, the elements of PHI to be collected as

described in items 1 and 2 of the Application for Waiver of Authorization have been determined to be the minimal necessary for the specified research.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

APPENDIX H: Family Crisis Vignette

A foster mother calls into an after-hour crisis phone. She emotionally shares that her foster child (13-year-old female) has been expressing suicidal ideations, and has engaged in self-harm recently, which her therapist is aware of and working on with her in sessions. While the foster mother is explaining the concerns, you as the counselor hear the child yelling in the background with a loud male voice responding to the child. Upon asking what is currently going on in the home, the foster mother shares that the biological father of the child, and the child are engaged in an argument on the front porch. The foster mother shares that the child does not want to stay at the foster home and that the father is trying to explain that she has to per the legal guidelines of visitation as established by the Department of Social Services. The foster mother explains that the child has difficulty transitioning from the biological home back to the foster home. When gathering more information, the foster mother shares this child was the only one removed from the biological home, and the child has three additional siblings all younger. The foster mother also shares the biological mother is absent from the child's life. Furthermore, you find that the foster mother has one biological child in the home, an older male, and no partner. You then hear the child yell, "If you leave me here, I'm going to kill myself." Per agency policy you are required to respond face to face.