Current Psychology
https://doi.org/10.1007/s12144-020-00656-w

Counseling students' responsibility attributions: Race/ethnicity and trauma narratives

Kevin Richard[1] · Julie Koch[1] · Joseph Currin[1]

Abstract
How counseling students conceptualize clients' presenting concerns, and determine the solutions to those concerns, can negatively impact the effectiveness of the counseling process. Attribution bias damages therapeutic relationships especially when treating racial/ethnic diverse clients or clients with a history of trauma. This study assessed counseling students' attributions of problem cause and solution for diverse clients and clients with trauma narratives through hypothetical client vignettes. A total of 217 counseling students from counseling programs around the United States participated in the study. Two separate two-way factorial ANOVA's (CRF-*32*) were conducted to determine effects of client race/ethnicity and the addition of a trauma narrative on counseling students' responsibility attributions of problem cause and solution. The interaction between race/ethnicity and trauma narrative was not significant for problem cause or problem solution. The main effect of race/ethnicity was not significant for problem cause or solution. The main effect of trauma narrative was significant for problem cause but was not significant for problem solution. These findings suggest that information from a trauma narrative influences counseling students' views on their clients' presenting concerns by increasing their consideration for external factors while mitigating personal blame on the client.

Keywords Counseling students · Trauma narratives · Responsibility attribution · Diversity

Clinical Impact Statement

Specifically, data generated from this study provides empirical support for the incorporation of trauma specific training for counseling graduate students. The findings indicate that knowledge of traumatic experiences can help counseling students adopt a more empathic and trauma sensitive approach when conceptualizing the presenting concerns of their clients. Broadly, the results from this study provide encouragement for counseling clinics, hospitals, residential treatment centers, schools, and other human service industries to start adopting a trauma sensitive approach when providing services to clients/patients. Gaining knowledge of traumatic experiences, evidenced by this study, can foster greater understanding of client/patient behavior and mitigate negative personal bias from professionals providing services.

Counseling students go through an extensive amount of graduate training on their way to becoming competent mental health professionals. For counseling students, evidence based training is paramount for developing accurate diagnostic and conceptualization skills that can translate into effective clinical work with clients (Gauthier et al. 2010). Training comes in a variety of forms and modalities and new approaches can be implemented to enhance overall learning. For example, researchers on this topic endorse teaching counseling students enhanced theoretical and case conceptualization by emphasizing the contribution of broader contextual factors when diagnosing and conceptualizing clients' presenting concerns (Conyne and Cook 2004; Greenleaf et al. 2015).

Increasing knowledge about contextual factors is established by teaching students how to make connections between the clients' presenting concerns and the larger framework of their external environments (Williams et al. 2015). This approach utilizes an environmentally sensitive lens, and develops critical thinking in regard to salient historical information needed for accurate conceptualization of clients' presenting concerns (Williams et al. 2013). The degree to which counseling students are

✉ Kevin Richard
Kevin.richard10@okstate.edu

Julie Koch
Julie.koch@okstate.edu

Joseph Currin
Joe.currin@okstate.edu

[1] School of Community Health Sciences, Counseling and Counseling Psychology, 434 Willard Hall, Stillwater, OK 74078, USA

Published online: 25 February 2020

incorporating these important environmental factors can be assessed through *responsibility attributions*.

Responsibility Attributions

Responsibility attributions are counselors' beliefs about the causes of, and solutions to, their clients' problems. Researchers state that responsibility attributions influence the selection of counseling strategies, evaluation of treatment success, assessment of presenting concerns, counseling relationship, and overall quality of services delivered (Jackson et al. 2005; Kernes and McWhirter 2001). However, despite the influential role of responsibility attributions on therapy outcomes, the topic is relatively understudied for counseling students (Williams et al. 2013).

When individuals help themselves or others, their behavior is influenced by fundamental beliefs about blame and control (Brickman et al. 1982). For counseling students, attributing responsibility for problems and solutions can be mapped onto where they place blame and responsibility. For example, counseling students may emphasize the primary cause of clients' presenting concerns as either the external environment, or conversely, the internal disposition of the client (Morrow and Deidan 1992). Therefore, counselors have to decide to what extent a client's character contributes to his/her psychological distress versus the environmental constraints and pressures in which he/she lives (Berry and Frederickson 2015).

Brickman et al. (1982) developed the most widely researched theoretical framework on responsibility attributions in the helping professions. The attribution model created by Brickman and colleagues is built on a 2-dimensional structure that measures internal vs. external responsibility for helping and coping (Stepleman, Darcy, & Tracy, 2005). One dimension reflects internal (i.e., disposition) vs. external (i.e., environment) responsibility for problem cause, and the other determines internal (i.e., client) vs. external (i.e., counselor) responsibility for problem solution. This two-dimensional structure has been applied to numerous areas of research including alcohol and drug abuse (Bennet, 1995), suicidal behavior (Jack and Williams 1991), reactions to unemployment (Heubeck et al. 1995), counseling elderly and minority clients (Karuza et al. 1990), and cancer treatments (Avants et al. 1993). Despite the wide range of research utilizing this model, little is known about how inexperienced counselors' provision of therapy is influenced by the responsibility attributions they use with clients.

Trauma and Attribution

One factor that is not well understood in the literature is how knowledge of trauma influences counseling students' responsibility attributions. Trauma is defined as "an experience that creates a sense of fear, helplessness, or horror, and overwhelms a person's resources for coping" (Hopper et al. 2010, p. 80). In counseling and other human service fields, exploration of trauma is becoming standard practice given the substantial link between traumatic experiences and the presence of psychological distress (Courtois and Gold 2009; Levers 2012). Trauma is linked to a host of mental health disorders/distress including substance abuse, depression, anxiety, emotional instability, self-harm, suicide, psychosis, dissociation, anger, sleep deprivation, appetite change, negative self-identity, internalized guilt, shame, and attention deficits (Benoit et al. 2010; Courtois and Gold 2009; Gil-Rivas et al. 2009). Historically, therapists have treated these mental health symptoms and diagnoses without specific consideration for clients' traumatic experiences, or their *trauma narrative* (Bloom and Farragher 2013; Tuval-Mashiach et al. 2004).

A trauma narrative is a reported and detailed description of significant traumatic events a client has endured over his or her lifespan (Tuval-Mashiach et al. 2004). Practically, trauma narratives provide a synopsis of traumatic experiences that can provide counseling students with important autobiographical events that may significantly contribute to the distress being treated. Without trauma narratives, treatment orientations can tilt blame towards clients' internal dispositions while minimizing external experiences associated with trauma. Therapeutically, ignoring a history of trauma can engender feelings of mistrust and treatment incongruence between counselor and client (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005). Furthermore, counseling students are particularly vulnerable to committing this kind of conceptualization error because they have not had sufficient training on recognizing the impact of trauma on client stressors (Greenleaf and Williams 2009).

Racially/Ethnically Diverse Clients

Counseling students generally give greater weight to their own perspectives while minimizing the perspectives of their clients (Arnoult & Anderson, 1988). Counseling students' inability to mitigate their own reactions to clients can lead them to not feel confident in working with diverse racial/ethnic clients, even after completing multicultural training in their graduate programs (Dickson et al. 2010).

Previous studies show there are disparities in mental health care for racially and ethnically diverse clients (Agency for Health Care Research and Quality 2010; Harris et al. 2005). On average, racial/ethnic minorities have less access to mental health care and are more likely to terminate therapeutic services prematurely when compared to the majority population (Ojeda and McGuire 2006). The link between responsibility attributions and treatment success may play a role in these disparate outcomes of therapy effectiveness for diverse clients. Rosenthal (2004) found that counselors' assessing the presenting concerns of African American and White

clients via identical case vignettes demonstrated discriminate beliefs about the development of presenting concerns and likely outcomes of treatment. Rosenthal explained, "Multivariate analyses revealed that under the condition in which the client was portrayed as African American, counselors judged the client more negatively than when he was portrayed as European American" (p. 6).

While there are numerous explanations for why these disparities exist, one way of addressing this discrepancy is to assess how counseling students, who eventually become mental health professionals, conceptualize problem cause and solution of diverse clients' presenting concerns (Williams et al. 2013). Therefore, increased research on client conceptualization and counselor attributions can guide future training, while informing students on empirically supported therapeutic approaches for racially/ethnically diverse clients.

Current Study

Attributions that counseling students utilize to conceptualize the causes and solutions to their clients' problems have direct influence on the counseling process and efficacy of treatment, including symptom reduction, positive behavior change, and improving the quality of life (Hayes and Wall 1998). However, despite the influential role counselor attributions have on therapeutic success or failure, the topic is relatively understudied in counseling students, who may be especially susceptible to attribution bias (Williams et al. 2013).

There were two main research questions in this study. 1) Do counseling students use significantly different responsibility attributions based on the client race/ethnicity? 2) Are responsibility attributions used by counseling students significantly different when a trauma narrative was presented in addition to the original case scenario? We hypothesized that responsibility attributions would vary according to race/ethnicity and trauma history.

Method

Participants

The sample consisted of 217 counseling students who were enrolled in master's programs in the United States. The majority of participants identified within the age range of 20–29 (79.3%, $n = 172$), White (78.3%, 170), heterosexual (84.8%, 184), and female (84.3%, 183, see Tables 1, 2 and 3 for complete demographics). Participants were purposively sampled from counseling programs from different geographic regions in the United States in order to recruit a representative sample. In total, participants represented programs in 28 different states. This sample is representative of the counseling field in the US where the majority of counselors identify as female (Ray et al. 2016).

Table 1 Demographic Information of Participants (N = 217)

Characteristic	n	%
Gender		
Female	183	84.3
Male	32	14.7
Transgender	2	.9
Race		
American Indian/Alaska Native	2	.9
Asian	16	7.4
Black/African American	12	5.5
White	170	78.3
Biracial/Multiracial/Mixed	17	7.8
Ethnicity		
Hispanic/Latino(a)	27	12.4
Not Hispanic/Latino(a)	190	87.6
Sexual Orientation		
Heterosexual/Straight	184	84.8
Gay/Lesbian/Bisexual	28	12.9
Pansexual	2	.9
Asexual	2	.9
Abstinent	1	.5
Age		
20–29	172	79.3
30–39	27	12.4
40–55	17	7.8
55+	1	.5
Degree		
M.A.	103	47.5
M.Ed.	31	14.3
M.S.	83	38.2
School Accreditation		
CACREP	169	77.9
Non-CACREP	48	22.1

Measures

Demographic Form Participants completed a demographic questionnaire, which included questions regarding age, gender identity, sexual orientation, race, ethnicity, degree type, year in program, past trauma (i.e., sexual, physical, emotional, psychological, none), completion of a multicultural class, and program accreditation.

Client Vignettes Participants were randomly assigned to one of six case vignettes. Each vignette (see Appendix) depicted a male client with common presenting concerns (i.e., anxiety/depression symptoms) with behavioral descriptors of the

Table 2 Analysis of Variance (ANOVA) Tests of Between-Subjects Effects for Problem Cause

	df	SS	MS	F	p	η^2
Race/Ethnicity &Trauma Narrative Interaction	2	.955	.477	1.235	.293	.012
Race/Ethnicity	2	1.439	.720	1.862	.158	.017
Trauma Narrative	1	23.271	23.271	60.202	.000**	.222

Note: *$p < .05$; **$p < .01$

symptomology. The vignettes were identical, except for two aspects, race and trauma narrative. The vignettes depicted a White client, a Latino client, and a Black/African American client, with or without a trauma narrative. We used only one gender (male) in case vignettes to strengthen internal consistency and control of the variables.

The Attribution of Problem Cause and Solution Scale (APCSS) The APCSS was created by Stepleman et al., (2005). The measure loads participant responses into four distinct categories of responsibility attributions for problem cause and problem solution using a 7-point Likert-type scale. This measure asks participants to answer questions about clients broadly, and categorizes the responses into internal cause or external cause and internal solution or external solution. For the current study, the measure was slightly altered with permission of its author so that questions refer specifically to the "client" in the case vignette. We altered survey questions to match client vignettes, which were then reviewed by a panel of counseling experts. For example, the original survey asked, "I am responsible for the cause of my problems," which was changed to "The client is responsible for the cause of his problems."

We conducted factor and item analysis to assess if the altered items on the survey continued to load onto the two dimensions of the original theoretical model proposed by Brickman et al. (1982). We used principal-axis factor analysis with varimax rotation. We observed that items loaded onto two separate categories. No items demonstrated pattern coefficients of less than .4 or displayed pattern coefficients contrary to prediction as per the original theory. Stepleman et al. (2005) originally reported Cronbach's α values of .95 (cause) and .92 (solution). Internal consistency for the cause and solution scales from this study remained acceptable, with Cronbach's α values of .89 (cause) and .76 (solution) (Streiner 2003).

Procedure

Participants were recruited by contacting CACREP-accredited counseling programs and requesting the survey link be distributed to their students, posting the survey link to counseling student Facebook pages, and from purposive recruitment emails to counseling faculty. To increase student participation, we provided a random drawing for three 50-dollar gift cards. Research participants utilized an online link that directed them to the informed consent document via Qualtrics. After completing the demographic questionnaire, the participants were presented with a client vignette. The hypothetical client vignette was randomly assigned and differed by race/ethnicity (Latino, White, Black/African American) and by the addition of a trauma narrative (included or not included). The vignettes were randomly assigned to participants by incorporating a "randomizer" algorithm via the survey flow module in the Qualtrics program software.

Results

Statistical Assumptions and Preliminary Analyses

Data screening The data was manually screened to determine if participant demographics and the number of items completed met criteria for inclusion in the study. Incomplete surveys were rejected from the data analysis process. Of the 254 responses recorded, 217 met criteria for inclusion in the study. Group sizes were as follows: White, trauma narrative included ($n = 36$); White, trauma narrative not included (n = 36); African American/Black, trauma narrative included ($n = 42$); African American/Black, trauma narrative not included ($n = 32$); Latino, trauma narrative included (n = 32); and Latino, not trauma narrative included ($n = 39$).

Table 3 Analysis of Variance (ANOVA) Tests of Between-Subjects Effects for Problem Solution

	df	SS	MS	F	p	η^2
Race/Ethnicity &Trauma Narrative Interaction	2	.306	.153	.451	.637	.004
Race/Ethnicity	2	.100	.050	.148	.863	.001
Trauma Narrative	1	.001	.001	.002	.969	.000

Note: *$p < .05$ level; **$p < .01$

Data Coding Internal and external problem cause scores were combined for an overall problem cause score. Internal and external problem solution scores were combined to create an overall problem solution score. For problem cause, lower mean scores indicate more responsibility on external variables and higher mean scores indicate responsibility on internal variables (i.e., disposition). For problem solution, lower mean scores indicate more responsibility placed on external assistance to fix the client's problem, whereas higher mean scores indicate more responsibility placed on the individual to solve his/her own problems.

Findings

Problem Cause A two-way analysis of variance (ANOVA) was used to test the effects of trauma narrative and race/ethnicity on problem cause. The interaction between the two factors was not significant ($F(2,211) = 1.235$, $p = .293$) for problem cause. Due to the lack of significance, one-way ANOVAs were conducted to determine if simple main effects were present for the race/ethnicity groups and for trauma narrative groups independently (Kirk 2013). The one-way ANOVA for race/ethnicity was not significant ($F(2,211) = 1.862$, $p = .158$). However, for trauma narrative, the one-way ANOVA ($F(1,211) = 60.202$, $p < .001$) confirmed significant differences existed between the responsibility attributions used when a trauma narrative was provided with the original client vignette. The ANOVA had a medium effect size ($\eta^2 = 0.22$) and power analysis conducted via G*Power 3.1.9.2 software determined Power = .89. The observation of means for trauma ($M = 3.27$, $SD = 0.54$) and no trauma ($M = 3.93$, $SD = 0.70$) indicated that counseling students presented with a trauma narrative were more likely to attribute responsibility for the client's problems to external causes (e.g., environment) when compared to counseling students who were not provided the trauma narrative.

Problem Solution A two-way analysis of variance (ANOVA) was used to test the effects of trauma narrative and race/ethnicity on problem solution. The interaction between the two factors was not significant ($F(2,211) = .451$, $p = .637$). One-way ANOVAs were conducted to determine if simple main effects were present for the race/ethnicity groups and for trauma narrative groups independently. Neither ANOVA was significant (racial/ethnic groups, ($F(2,211) = .148$, $p = .863$); inclusion of trauma narrative ($F(1,211) = .002$, $p = .969$).

Exploratory Analysis We conducted post-hoc t-tests analyses to explore whether there were between-group differences based on participant characteristics. We found no significant differences based on gender or race/ethnicity of participants. Likewise, we did not find significant differences between participants enrolled in CACREP-accredited programs or those in non-accredited programs. Interestingly, we found no differences between participants who had or had not completed a multicultural counseling course.

Discussion

In this study, we sought to determine if the responsibility attributions utilized by counseling students when conceptualizing problem cause or problem solution would change based on the race/ethnicity of the client and/or the presence of a trauma narrative. No significant differences were found for problem solution attribution for either race/ethnicity of the client or the presence of a trauma narrative and there was not a significant interaction between race/ethnicity of the client and the presence of a trauma narrative for problem solution attribution. There was not a significant difference for problem cause attribution based on race/ethnicity, and there was not a significant interaction detected between the presence of a trauma narrative and the race/ethnicity of the client for problem cause. A significant difference was detected based on inclusion of a trauma narrative, demonstrating that counseling students attribute clients' problem causes as more external if there is a trauma narrative present, regardless of the race/ethnicity of the client.

Responsibility Attributions and Racially/Ethnically Diverse Clients

Results revealed that the responsibility attributions utilized by counseling students for problem cause or problem solution did not change based on the race/ethnicity of the client portrayed in the survey vignette. This is inconsistent with results of a prior study on responsibility attributions and problem cause where race/ethnicity of a hypothetical client was manipulated (Rosenthal 2004). Rosenthal found that counselors held African American clients more personally responsible for their presenting problems, minimized their potential for solving these problems, and gave greater consideration to White clients' environmental constraints in the development of mental health disorders (Rosenthal 2004). There may be several reasons why our study did not find similar results. One plausible reason is that since that study, in 2004, 13 years have passed. In that time, there has been an increase in multicultural sensitive training in counselor education programs (Bezrukova et al. 2016). The recent focus on multiculturalism and bias awareness has become more integrated into counselor education, which could explain why our participants did not perceive the hypothetical client's problems differently based on his race/ethnicity. Importantly, this finding highlights a positive shift in counselor perception when working with clients with diverse racial and ethnic backgrounds.

Responsibility Attributions and Trauma Narrative

Results revealed significant differences in how trainees attributed responsibility for the cause of the client's problems when a trauma narrative was known. Our results indicate that when counseling students were presented with an additional trauma narrative in conjunction with a case report detailing presenting concerns of a hypothetical client, they were more likely to give greater consideration to external variables when conceptualizing problem cause of a client. Gaining knowledge on past traumas, as evidenced by the data from this study, provides greater historical context for counseling students when conceptualizing their clients' presenting problems and can positively shift the perspective of the counseling student. Research shows that the greater the consideration of external variables for trauma afflicted clients, the more likely a counselor will demonstrate patience, empathy, and understanding of their clients' problems (Goodman 2015). Therefore, counselor education programs should be encouraged to incorporate specific training on gathering a trauma narrative when conceptualizing clients' presenting concerns, not only for the benefit of the clients, but also for the benefit of the counselor. As Bloom and Farragher (2013) noted, when a counselor asks, "What happened to you?" instead of "What's wrong with you?" (p. 50) a shift in blame immediately takes place and makes counselors more empathic while simultaneously increasing their understanding of client etiology.

Our results did not demonstrate differences in responsibility attributions for problem solution when the clients' trauma narrative was made known. There are several conceivable reasons for this finding. First, trauma informed training is not a widespread focus for graduate training programs (Courtois and Gold 2009). Therefore, it is plausible that the participants in the study had not been trained on evidence-based models for treating trauma-afflicted clients. Ideally, if the counseling students had been exposed to trauma informed treatment models, the data would have reflected the responsibility of problem solution being greater for the client and not the counselor when the trauma narrative was presented. For example, Seeking Safety, a well-researched treatment model for clients suffering from PTSD, does not hold clients accountable for past traumatic experiences, but does emphasize client empowerment and responsibility to create solutions for coping with trauma (Boden et al. 2012). Cognitive Processing Therapy (CPT), an evidence based manualized treatment for PTSD, utilizes narrated impact statements related to traumatic events. Through prescribed homework, the therapy encourages clients to be active in assessing their own cognitions and analyzing future distressing emotions by utilizing a healthier cognitive framework. Acceptance and Commitment Therapy (ACT), another empirically supported treatment for trauma-afflicted clients, instructs clients to accept responsibility for change through a combination of mindfulness and behavioral activation (Finlay 2015). The common themes of these treatment models highlight that presenting concerns related to trauma are not considered to be the fault of the client, but the solutions to the concerns are largely placed on the client to facilitate confidence and empowerment during the treatment process.

Implications

The findings of this study have several implications. First, this study adds novel information to the field of responsibility attributions for racial/ethnic diverse clients and trauma survivors, which is not represented in the current training literature. Past research has largely focused on the responsibility attributions related to clients of White or Black/African American racial backgrounds. This study attempted to incorporate additional racial/ethnic variables as well as the inclusion of a trauma narrative. To date, no other study has looked at counseling students' perceptions on trauma related to diverse clients. Therefore, the goal of this study was to fill a gap in the current literature, while also assessing for potential errors in counseling student conceptualizations for sensitive populations of clients (diverse clients and trauma survivors).

This study provides valuable information for counselor education programs. The importance of training students to identify trauma related symptoms in clients needs to be emphasized. The data from this study demonstrated a significant perception change related to presenting concerns by simply adding a trauma narrative to the psychosocial narrative. When greater environmental context is provided (i.e., trauma narrative), counseling students are able to recognize the development of mental health distress in their clients while decreasing personal blame on the client. Therefore, this additional knowledge can help increase counselor empathy, patience, and increase client retention rates (Cusack et al. 2006; Morrow and Deidan 1992; Strohmer and Shivy 1994).

Our findings also have broader implications for counseling practice in general. For example, the results from this study provide encouragement for counseling clinics, hospitals, residential treatment centers, schools, and other human service industries, to start adopting a trauma sensitive approach when providing services to clients/patients. As previous research has shown, clients from diverse racial/ethnic backgrounds, and clients with traumatic histories, are especially sensitive to personal blame for presenting concerns (Elliot et al. 2005). Therefore, systematic changes in approaching conceptualization with clientele can have large ramifications for treatment success across a multitude of human services. Utilizing trauma narratives, as evidenced by this study, is a start in the right direction.

Our findings also have implications for future research directions. Although this study provides preliminary information on counseling students' responsibility attributions for

diverse clients and trauma survivors, additional research is warranted on this topic. The client vignettes depicted only male clients; therefore, in future studies, researchers may want to manipulate the variables of race/ethnicity and trauma for female clients. In addition, the racial/ethnic categories in this study represented the three most prevalent racial/ethnic groups in the United State (White, Black/African American, and Latino), however responsibility attributions for other racial and ethnic groups should be studied as well. Our findings were inconsistent with previous research, so further studies are necessary for stronger conclusions about whether race of the client plays a role in how trainees conceptualize clients' problems. Mixed-methods studies that incorporate qualitative data could also add to the literature.

Limitations

Our results should be interpreted within the context of limitations of the study. The survey vignettes depicted only male clients. By representing a client of only one gender, the generalizability of our results is limited, particularly because our sample was largely White female. Although this sample is representative of the larger population of counseling students in the US, it is possible that this influenced the results. Future researchers should utilize vignettes that depict female clients, especially when considering that more females engage in therapy as clients than do males. Another potential limitation is the survey-based format of the study. Survey research is efficient in time management and cost, but presents threats to validity related to generalizability, incomplete responses, unacceptable responses, multiple submissions, and invalid responses (King et al. 2003).

Conclusion

It is important for counselor educators to understand and improve students' conceptualization and work with clients. This study provides valuable information about conceptualizing clients from diverse backgrounds as well as clients presenting with trauma. When counseling students were presented with a case scenario without knowledge of the client's prior trauma, they were more likely to assign personal blame for the client's problems. Conversely, when the counseling students were provided with the same case scenario and a trauma narrative, they were more likely to consider environmental influences for the development of the client's problems. These findings demonstrate the importance of teaching students to inquire, assess, and utilize trauma narratives when conceptualizing their clients' presenting concerns. With the inclusion of a trauma narrative, counseling students can learn to be more empathic, patient, and provide accurate diagnoses when working with future clients. This study demonstrates that perceptions of clients can be drastically altered in a positive way by adding a simple assessment of past trauma, which in turn, can improve the mental health treatment in the general population in whole.

Appendix

Client Vignette

John is a 32-year-old (White/Latino/African American) heterosexual male seeking therapy for anxiety and depression symptoms he has been experiencing over the last 6 months. John tells you that he has been experiencing these symptoms for longer than 6 months, but over the last 6 months, the severity of the symptoms increased to the point John felt he needed to seek help through counseling. John does not currently endorse any suicidal ideation but there have been times in his life where he thought about "not having to go on anymore." John reported that over the last 6 months he has been isolating in his house with little motivation to engage in tasks that he normally finds enjoyment in. John explains that he was fired from his job 6 months ago due to his anger and irritability, which led to conflicts with his co-workers and supervisor. He currently remains unemployed.

John reported that he struggles with his emotions quickly changing from sad, to happy, to angry, to irritable without understanding the reason for the changes. John explained that for most of his life, he remembers becoming easily angered with family, friends, and colleagues. John stated that he hasn't been able to keep a job for longer than a year and he is no longer interested in going out and finding a new job. Additionally, John explained that his co-workers at his most recent job "were not treating him fairly," and he was fired because nobody cared about him as an employee. John also explained that he feels he was fired because he is (White/Latino/African American) and his co-workers were discriminating against him.

John reported that he regularly experiences shortness of breath, racing thoughts, sweating, and feelings of losing control. John states that his symptoms have been a part of his life for "as long as he can remember" and limited his ability to build a strong support group of friends. Additionally, John explains that he has little friends because "nobody understands me" and because he is (White/Latino/African American). John stated he tends to spend a majority of time by himself because his symptoms are less severe when alone. John reported that he has never been in an intimate relationship and that he doesn't have any interest in finding a significant other.

John stated that he doesn't abuse any substances and he isn't taking any medication. John explained that he has always considered himself a healthy guy, but recently he has been putting on weight due to inactivity from not leaving his house. John reports that he showers infrequently and stays at home in

bed for most of the day. He attributes this to feeling "low." When John was working he was able to take care of himself, but now that he is unemployed, he has been relying on his parents to support him financially. John states that his parents are becoming increasingly impatient with his unemployment and are threatening to stop their financial support. Therefore, the combination of stressors in John's life has led him to you for treatment.

Trauma Narrative

John disclosed that when he was 8 years old, he was the victim of sexual abuse from his uncle. He states the abuse involved both sexual penetration and repeated fondling or inappropriate touching. John explained the abuse continued for 2 years until he was 10 years old. During the time of the abuse, John states that he always felt "unsafe" and "powerless" to do anything about what was happening. He states that he reported the sexual abuse to his parents, but they refused to believe him and decided not to report it to the authorities because his lies "would devastate the family." John states that since nobody would believe him; he remained silent about the abuse. Additionally, John's parents refused to let him speak with a therapist about the abuse because they were afraid he would say something that would lead to an investigation. Therefore, John reports he has never sought out therapy until now.

John states that two years after the abuse started, his family moved out of state away from his uncle, and that's when the abuse finally stopped. John explained that he didn't have to interact with his uncle after moving away, but he still has intrusive memories of the abuse. He stated that he still thinks about the abuse and has difficulty being alone in rooms with older men because it triggers his anxiety and racing thoughts. Additionally, John explained that he has night terrors where he dreams about the event happening and he wakes up covered in sweat with his heart racing. He states that he becomes angry randomly without being able to understand where it's coming from, and often feels guilt and shame after an outburst of anger.

References

Agency for Healthcare Research and Quality. (2010). *National healthcare quality report*. Rockville: U.S. Department of Health and Human Services. https://doi.org/10.1037/e308932005-001.

Avants, S. K., Margolin, A., & Singer, J. L. (1993). Psychological interventions and research in the oncology setting: An integrative framework. *Psychotherapy: Theory, Research, Practice, Training, 30*, 1–10.

Benoit, M., Bouthillier, D., Moss, E., Rousseau, C., & Brunet, A. (2010). Emotion regulation strategies as mediators of the association between level of attachment security and PTSD symptoms following trauma in adulthood. *Anxiety, Stress & Coping, 23*, 101–118.

Berry, Z., & Frederickson, J. (2015). Explanations and implications of the fundamental attribution error: A review and proposal. *Journal of Integrated Social Sciences, 5*, 44–57.

Bezrukova, K., Spell, C. S., Perry, J. L., & Jehn, K. A. (2016). A meta-analytical integration of over 40 years of research on diversity training evaluation. *Psychological Bulletin, 142*, 1227–1274.

Bloom, S. L., & Farragher, B. (2013). Restoring sanctuary: A new operating system for trauma-informed systems of care. Oxford University Press.

Boden, M. T., Kimerling, R., Jacobs-Lentz, J., Bowman, D., Weaver, C., Carney, D., Walster, R., & Trafton, J. A. (2012). Seeking safety treatment for male veterans with a substance use disorder and post-traumatic stress disorder symptomatology. *Addiction, 107*, 578–586.

Brickman, P., Rabinowitz, V. C., Karuza, J., Coates, D., Cohn, E., & Kidder, L. (1982). Models of helping and coping. *American Psychologist, 37*, 368–384.

Conyne, R. K., & Cook, E. P. (2004). *Ecological counseling: An innovative approach to conceptualizing person-environment interaction*. Alexandria: American Counseling Association.

Courtois, C. A., & Gold, S. N. (2009). The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*, 3–23.

Cusack, K. J., Grubaugh, A. L., Knapp, R. G., & Freuh, B. C. (2006). Unrecognized trauma and PTSD among public mental health consumers with chronic and severe mental illness. *Community Mental Health Journal, 42*, 487–500.

Dickson, G. L., Argus-Calvo, B., & Tafoya, N. G. (2010). Multicultural counselor training experiences: Training effects and perceptions of training among a sample of predominately Hispanic students. *Counselor Education and Supervision, 49*, 247–265.

Elliot, D. E., Bjelaajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma informed services for women. *Journal of Community Psychology, 33*, 461–477.

Finlay, L. D. (2015). Evidence-based trauma treatment: Problems with a cognitive reappraisal of guilt. *Journal of Theoretical and Philosophical Psychology, 35*, 220.

Gauthier, J., Pettifor, J., & Ferrero, A. (2010). The universal declaration of ethical principles for psychologists: A culture-sensitive model for creating and reviewing a code of ethics. *Ethics & Behavior, 20*, 179–196.

Gil-Rivas, V., Prause, J., & Grella, C. E. (2009). Substance use after residential treatment among individuals with co-occurring disorders: The role of anxiety/depressive symptoms and trauma exposure. *Psychology of Addictive Behaviors, 23*, 303–314.

Goodman, R. D. (2015). Trauma counseling and interventions: Introduction to the special issue. *Journal of Mental Health Counseling, 37*, 283–294.

Greenleaf, A. T., & Williams, J. M. (2009). Supporting social justice advocacy: A paradigm shift towards an ecological perspective. *Journal for Social Action in Counseling and Psychology, 2*, 1–14.

Greenleaf, A. T., Williams, J. M., & Duys, D. K. (2015). Awareness of counselor trainees on clients' social barriers. *Journal of Counselor Practice, 6*, 25–38.

Harris, K. M., Edlund, M. J., & Larson, S. (2005). Racial and ethnic differences in the mental health problems and use of mental health care. *Medical Care, 43*, 775–784.

Hayes, J. A., & Wall, T. N. (1998). What influences clinicians' responsibility attributions? The role of problem type, theoretical orientation, and client attribution. *Journal of Social and Clinical Psychology, 17*, 69–74.

Heubeck, B. G., Tausch, B., & Mayer, B. (1995). Models of responsibility and depression in unemployed young males and females. *Journal of Community & Applied Social Psychology, 5*, 291–309.

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*, 80–100.

Jack, R. L., & Williams, J. M. G. (1991). Attribution and intervention in self-poisoning. *British Journal of Medical Psychology, 64*, 345–358.

Jackson, S. A., Holt, M. L., & Nelson, K. W. (2005). Counselors' models of helping: Addressing the needs of the culturally different client in school settings. *Journal of Multicultural Counseling and Development, 33*, 205–216.

Karuza, J., Zevon, M. A., Gleason, T. A., Karuza, C. M., & Nash, L. (1990). Models of helping and coping, responsibility attributions, and well-being in community elderly and their helpers. *Psychology and Aging, 5*, 194–208.

Kernes, J. L., & McWhirter, J. J. (2001). Counselors' attribution of responsibility, etiology, and counseling strategy. *Journal of Counseling and Development, 79*, 304–313.

King, G., Murray, C. J., Salomon, J. A., & Tandon, A. (2003). Enhancing the validity and cross-cultural comparability of measurement in survey research. *American Political Science Review, 97*, 567–583.

Kirk, R. E. (2013). *Experimental Design* (4th ed.). Thousand Oaks, California: Sage.

Levers, L. L. (2012). An introduction to counseling survivors of trauma: Beginning to understand the context of trauma. In L. L. Levers (Ed.), *Trauma counseling* (pp. 1–22). New York: Springer.

Morrow, K. A., & Deidan, C. T. (1992). Bias in the counseling process: How to recognize and avoid it. *Journal of Counseling & Development, 70*, 571–577.

Ojeda, V. D., & McGuire, T. G. (2006). Gender and racial/ethnic differences in use of outpatient mental health and substance use services by depressed adults. *Psychiatric Quarterly, 77*, 211–222.

Ray, D. C., Huffman, D. D., Christian, D. D., & Wilson, B. J. (2016). Experiences of male counselor educators: A study of relationship boundaries. *Professional Counselor, 6*, 107–120.

Rosenthal, D. A. (2004). Effects of client race on clinical judgment of practicing European American vocational rehabilitation counselors. *Rehabilitation Counseling Bulletin, 47*, 131–141.

Stepleman, L. M., Darcy, M. U., & Tracey, T. J. (2005). Helping and coping attributions: Development of the attribution of problem cause and solution scale. *Educational and Psychological Measurement, 65*, 525–542.

Streiner, D. L. (2003). Starting at the beginning: An introduction to coefficient alpha and internal consistency. *Journal of Personality Assessment, 80*, 99–103.

Strohmer, D. C., & Shivy, V. A. (1994). Bias in counselor hypothesis testing: Testing the robustness of counselor confirmatory bias. *Journal of Counseling and Development: JCD, 73*, 191–197.

Tuval-Mashiach, R., Freedman, S., Bargai, N., Boker, R., Hadar, H., & Shalev, A. Y. (2004). Coping with trauma: Narrative and cognitive perspectives. *Psychiatry: Interpersonal and Biological Processes, 67*, 280–293.

Williams, J. M., Greenleaf, A. T., & Duys, D. K. (2013). Who's to blame? Client problems and the causal attributions made by counselors-in-training. *Journal of Counselor Preparation and Supervision, 5*, 6–17.

Williams, J. M., McMahon, G., & Goodman, R. (2015). Eco-webbing: A teaching strategy to promote critical consciousness and agency. *Counselor Education and Super-vision, 54*, 82–97.