# Emerging Leadership: Mental Health Counseling Competencies for School Counselor Trainees

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## Abstract

School counselors' training and clinical competencies for providing mental health counseling continues to be a point of debate regarding professional roles and identities. This study focuses on the eight counseling core competencies as defined by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). The research study compares the theoretical counseling competencies of school counselor graduates to clinical mental health counselor graduates as measured by the results of the Counselor Preparation Comprehensive Examination (CPCE). The data were retrieved from an archival database that included scores collected over 13 years. Participants include graduate students (*N* = 682) from a CACREP accredited counselor education program at one public university. A multivariate analysis of variance (MANOVA) was conducted to examine the significant differences between CPCE total scores and subscales based on program specialty (school counseling versus clinical mental health counseling). Results demonstrated significant differences between the group means for two of the subscales (Helping Relationships and Group Work), with students in clinical mental health counseling scoring higher than students in school counseling.


*Keywords:* mental health counseling; school counselor competencies; school counseling

## Emerging Leadership: Mental Health Counseling Competencies for School Counselor Trainees

School counselors' roles, identities, and competencies have been the subject of professional discussions and debate for many years (American School Counselor Association [ASCA], 2005; Cinotti, 2014; Zalaquett, 2005). Confusion and discrepancies surrounding their roles, identities, and competencies can have a negative impact on the school counselor, which in turn may lead to burnout and diminished effectiveness (Bardhoshi, Schweinle, & Duncan, 2014; Caple, 2018; Lieberman, 2004; Moyer, 2011; Walley & Grothaus, 2013). Moreover, the mental health needs of students have increased and consequently, school counselors are expected to provide more support (Collins, 2014; DeKruyf, Auger, & Trice-Black, 2013; Merikangas et al., 2010). However, school counselors' competencies in providing mental health counseling continues to be part of recent conversations in counselor education (Bardhoshi et al., 2014; Collins, 2014; DeKruyf et al., 2013).

Generally, school counselor competencies are determined by ASCA (2012) and by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016). Eight core competencies are required in the training of all counselors, regardless of specialty. The core content areas include: (a) human growth and development, (b) social and cultural diversity, (c) counseling and helping relationships, (d) group counseling and group work, (e) career development, (f) assessment and testing, (g) research and program evaluation, and (h) professional counseling orientation and ethical practice (CACREP, 2016). Although accredited by CACREP, school counseling training programs may have different structures and training

paradigms than those of clinical mental health counseling programs. Thus, the learning objectives and core competencies can vary significantly based on counseling specialty areas.

After graduation, school counselors typically work under the supervision of school administrators and principals, and no longer receive mandatory supervision from experienced school counselors. While ASCA and CACREP define competencies, identities, and roles of school counselors, ultimately school administrators (including principals) determine the role school counselors undertake in educational settings (DeKruyf et al., 2013; Janson, Militello, & Kosine, 2008). Principals' understanding of school counselors' roles and competencies have evolved over the years; however, there are still discrepancies between counselors' views and principals' views (Kirchner & Setchfield, 2005; Zalaquett, 2005; Zalaquett & Chatters, 2012). The school counselor's own professional identity also influences the role he/she decides to embrace (Brown, Dahlbeck, & Sparkman-Barnes, 2006; Hatch & Chen-Hays, 2008; Perfect & Morris, 2011). Given the increased demand for knowledge of students' mental health needs (Merikangas et al., 2010), school counselors are often able to offer brief "clinical-based interventions" with the goal of supporting children and adolescents' mental health (Collins, 2014, p. 415).

The purpose of this study was to explore the competencies learned or demonstrated by school counselors to provide mental health counseling. The premise of the researchers was that school counselors are required to demonstrate competencies that are comparable to clinical mental health counselors; therefore, they should have similar training in these areas. While practical competencies of counselors in training

are developed during their practicum and internship courses in their specialty settings, the eight theoretical core competencies listed above (CACREP, 2016) are taught during course work. Typically, these eight competencies can be measured by the Counselor Preparation Comprehensive Examination (CPCE). This assessment is utilized in most counseling programs as a final assessment before graduation (Center for Credentialing and Education, 2013). Since all core counseling competencies are the same, it can be inferred that counselors should be trained with similar theoretical counseling competencies regardless of program specialty. Counselor competencies also have an impact on counselor identity (Moss, Gibson, & Dollarhide, 2014). Feeling competent in providing mental health support can help school counselors develop a mental health provider identity (DeKruyf et al., 2013). The researchers of this study suggest that when completing a CACREP accredited program, counselor students regardless of specialty (school counseling or clinical mental health counseling), should show similar theoretical competencies on the CPCE exam. However, there are areas of needed improvement for school counseling programs in order to be competent to intervene with mental health crises in school settings.

## Literature Overview

As the field of school counseling has evolved in the past ninety years, the role of the school counselor has also undergone changes (Cinotti, 2014; DeKruyf et al., 2013; Lambie & Williamson, 2004). These rapid changes have resulted in role and identity confusion for school counselors. Lambie and Williamson (2004) believe that “school counseling roles have been vast and ever-changing, making it understandable that many school counselors struggle with role ambiguity and incongruence while feeling

overwhelmed” (p. 127). In addition to changes in the profession, school counselors may experience further role confusion based on school administrator’s expectations (Cinotti, 2014). School administrators tend to emphasize the educational, rather than the counseling, role of school counselors (Cinotti, 2014; DeKruyf et al., 2013; Janson et al., 2008; Liberman, 2004). This administrative philosophy can create greater struggles as school counselors develop their professional identity. This philosophy of school administration can impact a school counselors’ professional identity by limiting their ability to establish counseling as their focus in their work with students.

A school counselor’s professional identity influences the roles they may embrace in a school setting (Brown et al., 2006; DeKruyf et al., 2013; Hatch & Chen-Hays, 2008; Perfect & Morris, 2011). Both research and conceptual literature show evidence that school counselors tend to develop a double professional identity as both counselors and educators (DeKruyf et al., 2013; Holcomb-McCoy, Bryan, & Rahill, 2002). This “double-brimmed hat” (DeKruyf et al., 2013, p. 273) identity allows school counselors to embrace the educational component of working in a school setting, while focusing on the mental health competencies of their professional training.

**Student Mental Health Needs**

Schools are overwhelmed with the complexity of dealing with mental health crises on a daily basis. The mental health needs of students have increased dramatically in the last decade, with young people reporting higher levels of stress, depression, and suicide. Specifically, Wang, Hill, and Hofkens (2014) found that mental health interventions remain infrequent in schools, especially when related to peer victimization, bullying, and mental health crises during the middle school stage of

development. In fact, Wahl, Rothman, Brister, and Thompson (2019) found that the community and public hold stereotypical and negative beliefs about mental health conditions and students. Significant research conducted by the United States Department of Education in 2016 found that bullying, cyber bullying, and peer victimization continue to deepen the negative affects of suicidal ideation and items on suicide by youth populations in schools. Gini, Card, and Pozzoli (2018) further emphasize in their research that students may encounter stressful and traumatic experiences related to bullying and peer victimization which lead to increased mental health crises in school settings. Subsequently, teens are experiencing elevated stress levels that are similar to those exhibited by adults (Buthane, 2014). Additionally, 31% of teens reported that they feel overwhelmed, and 30% feel depressed or sad as a result of stress (Buthane, 2014). As teen stress statistics rise, the Centers for Disease Control and Prevention report that suicide rates among teens and young adults have nearly tripled since the 1940's (CDC, 2017).

With the rise of mental health crises in schools, now more than ever before, students need access to mental health interventions and support systems. Routinely, when school counselors become aware of a mental health need, they refer students to clinical mental health counselors within their community. Unfortunately, these referrals are often ineffective due to limited accessibility and lack of follow up by parents and guardians (Biolcati, Palareti & Mameli, 2018; Mills et al., 2006). In addition, evidence suggests that children and adolescents with mental health needs are more likely to access counseling services within the school setting (Biolcati et al., 2018; Kaffenberger & O'Rorke-Trigiani, 2013; Mills et al., 2006). Morin, Bradshaw, and Berg (2015) also

found that early intervention for mental health issues can help reduce the psychological stress and effects of victimization on youth mental health. With the rise of school violence, accessible mental health services for students have become a primary objective of school counselors and educational administrators (Fazel, Patel, Thomas, & Tol, 2014). To further elaborate, Roeser and Eccles (2014) found that schools are an ideal setting for assessment and treatment of mental health issues. School counselors and teachers can provide protective factors for students. In this context, Conner and Yeh (2018) stated in their research, “School counselors can play an integral role in bridging the gap in the unmet mental health needs by promoting culturally congruent counseling service for diverse students” (p. 4).

Research shows that school counselors are uniquely positioned to provide counseling services to students (Biolcati et al., 2018; DeKruyf et al., 2013; Mills et al., 2006). The ASCA National Model (2012) provides guidance for conducting mental health counseling within schools. ASCA (2012) encourages counseling to be planned, goal-focused, and short term in nature. The model explains that it is not within the professional role of the school counselor to provide long-term counseling to address psychological disorders. Instead, counseling should address the immediate needs of students, particularly those that may impede academic achievement (ASCA, 2012; Dameron, 2016). Many counseling theories, such as cognitive behavioral therapy (CBT), solution-focused therapy (SFT), motivational interviewing, and reality therapy fit the suggestions of ASCA, and have been proven to be effective in a school setting (Banks, 2011; Baskin & Slaten, 2013; Beesley, 2004; Hill, Ohmstede & Mims, 2012;

Santana & Rowland, 2016; Sklare, 2014; Thompson, Robertson, Curtis, & Frick, 2013; Ziomek-Daigle, McMahon, & Paisley, 2008).

## School Counselor Competencies

Knowing the increased mental health needs of students, and the unique position of school counselors to meet these needs, the question arises as to whether school counselors have adequate counseling competencies to do so. ASCA has a robust list of school counselor competencies that do include the admonition that school counselors should be able to "demonstrate and articulate an understanding of … counseling theories and techniques that work in school" (ASCA, n.d., p. 8). CACREP effectively regulates school counselor competencies through the process of accreditation. As mentioned above, CACREP counseling programs have eight core areas that are common for the training of school counselors, mental health counselors, and marriage, couple, and family counselors (CACREP, 2016). Preparation in these eight core areas is essential in CACREP-accredited counselor education programs regardless of specialty track, making both clinical mental health counselors and school counselors certified to offer mental health counseling in their respective settings (mental health or school). An examination (Counselor Preparation Comprehensive Examination) was developed by the National Board for Certified Counselors (NBCC) to assess student's competencies in the eight core areas of CACREP.

## The Counselor Preparation Comprehensive Examination (CPCE)

The Counselor Preparation Comprehensive Examination (CPCE) was developed to evaluate and assess preparation and mastery of knowledge of eight core areas that CACREP emphasizes as "fundamental to the counseling profession" (Schmidt,

Homeyer, & Walker, 2009, p. 228). The eight subscales for the CPCE are: (a) human growth and development; (b) social and cultural diversity; (c) helping relationships; (d) group work; (e) career development; (f) assessment; (g) research and program evaluation; and (h) professional orientation and ethical practice. The examination is widely used by CACREP-accredited and non-accredited programs (reportedly over 370 programs) to measure student learning outcomes as a single piece of programmatic assessment (Center for Credentialing and Education, 2013). Therefore, the CPCE exam serves as an efficient measure of counseling competency in the current study.

### Purpose of the Study

This study focuses on examining student learning outcomes based on two program specialties (school counseling and clinical mental health counseling) and seeks to answer the following research question: Are there significant differences in professional competencies between school counseling graduates and clinical mental health counseling graduates as measured by the CPCE (total scores and subscales) in counseling programs? Although CACREP accreditation standards require programs to prepare and assess students' learning across the eight CACREP core areas, counseling students receive different courses based on their specialty. Thus, it was hypothesized that for CACREP counseling graduate students, CPCE scores may differ in some of the subscales, based on selected, counseling specialty.

## Method

### Participants

Participants included 682 students who completed a Master of Arts degree (school counseling and clinical mental health counseling) from a CACREP accredited

program. The sample comprised 383 (56.47%) clinical mental health students and 299 (43.52%) school counseling students. Approximately 80% (*n* = 551) of the sample was female and 20% (*n* = 136) males. Participants ranged in age from 24 to 68 years (*M* = 40.48). Despite the sample being 80% Caucasian (*n* = 551), various ethnic backgrounds were represented: 117 (17%) Hispanic, 12 (1.7%) African American, 9 (1.3%) Asian/Pacific Islander 8 (1.2%) Native American/Alaskan Native, and 46 (6.7%) reported ethnicity as "other" or did not respond (see Table 1).

**Table 1**

*Participants' Demographics*

| Variable | Frequency | Percent |
|---|---|---|
| Female | 551 | 80 |
| Male | 136 | 20 |
| American Indian or Alaskan Native | 8 | 1.2 |
| Asian | 9 | 1.3 |
| Black or African American | 12 | 1.7 |
| Hispanic, Latino, or Spanish origin | 117 | 17 |
| Native Hawaiian or Other Pacific Islander | 1 | 0.7 |
| White | 551 | 80 |
| Other (or did not respond) | 46 | 6.7 |
| Clinical mental health counseling specialty | 383 | 56.47 |
| School counseling specialty | 299 | 43.52 |

## Procedures

The researchers used archival data to conduct this study. The data used for this study were retrieved from an archival database that was collected by a single public university's department of counselor education on a routine basis, for their CACREP assessment plan. The data were non-random, de-identified, coded, and archived. Data were collected from graduates over 13 years. This archived data set, which includes

student data obtained by the university for admission and graduation purposes, has been utilized in multiple studies exploring various constructs related to student learning outcomes after receiving institutional review board approval. The CPCE data for students were collected from various administrations based on students' anticipated graduation dates. All students completed the CPCE in the last semester of their program of study.

Any student applying for graduation was required to successfully pass the CPCE exam prior to graduation. Students who did not successfully complete the CPCE exam prior to their graduation date were required to re-take the exam. Students who failed to pass the CPCE on multiple attempts were not included in the study. Multiple exam scores recorded for students were not included in the statistical analysis, only initial scores were included for analysis. Administration of the examination followed current CCE requirements, and students were allowed four hours to complete the examination. A full-time faculty member sent completed exams to CCE for scoring.

**Measure**

The CPCE is a comprehensive examination aimed at assessing student's theoretical knowledge of fundamental counseling principles and practices (Center for Credentialing and Education [CCE], 2013; Haberstroh, Duffey, Marble, & Ivers, 2014; Schmidt et al., 2009). The CPCE is comprised of 160 multiple-choice questions covering the eight CACREP core areas. Each of the eight core areas is assessed by 20 items, of which 17 are scored for the CPCE Total composite score of 136. The CCE reports utilization of the exam by over 370 colleges and universities (CCE, 2014). Reliability of the CPCE Total score is reported to be $r$ = .87 with a standard error of

measurement of 4.63 (CCE, n.d. as cited in Schmidt et al., 2009). This assessment is generally utilized in many counseling training programs as an acceptable measure of outcome (CCE, 2013).

## Results

A multivariate analysis of variance (MANOVA) was used to analyze the two levels of the independent variable (clinical mental health and school counseling) and the dependent variables (CPCE Total score and subscales). The analysis sought to determine if there was a statistically significant difference on CPCE total score and eight subscales between program specialties. Descriptive statistics were calculated for program specialty, including group means and standard deviation for program specialty. Prior to analyses, investigators completed examination of univariate and multivariate assumptions, such as missing data, outliers, skewness, kurtosis, frequency, multicollinearity, normality, and homogeneity of variance-covariance matrices. All assumptions for MANOVA were met except for multivariate normality. Tests for multivariate normality of distribution showed that all variables had non-normal distribution. Therefore the researchers chose to interpret Pillai's Trace instead Wilks' Lambda (Mertler & Vannatta, 2010). The omnibus MANOVA results indicated significant differences between the two emphases (school counseling and clinical mental health): $F$(V=.028, $F$(9, 672) = 2.138, $p$ = .025).

Univariate ANOVAs were conducted for the total CPCE score and each of the eight subscales (see Table 2). Six of the eight subscales and the total score revealed non-significant results: Human Growth and Development subscale [$F$(1, 672) = 1.083, $p$ = .298, $\eta_p^2$ = .002]; Social and Cultural Diversity subscale [$F$(1, 672) = 3.214, $p$ = .073, $\eta_p^2$ = .005];

**Table 2**

*Results of the 2 x 9 (Specialty x CPCE Subscales and Total Scores) Follow-up Analyses of Variance (ANOVA)*

| | Specialty (CMHC, SC) | |
|---|---|---|
| | ***F*(df)** | **$\eta_p^2$** |
| Human Growth and Development | 1.083 (1, 672) | 0.02 |
| Social and Cultural Diversity | 3.214 (1, 672) | 0.05 |
| Helping Relationships | 4.831 (1, 672)* | 0.007 |
| Group Work | 8.555 (1, 672)** | 0.012 |
| Career Development | 0.082 (1, 672) | .000 |
| Assessment | 0.012 (1, 672) | .000 |
| Research and Program Evaluation | 0.878 (1, 672) | .001 |
| Professional Orientation and Ethical Practice | 3.212 (1, 672) | .005 |
| CPCE Total Scores | 2.877 (1, 672) | .004 |

*Note.* $*p < 0.05$, $**p < 0.01$

Career Development subscale [$F(1, 672) = .082$, $p = .775$, $\eta_p^2 = .000$]; Assessment subscale [$F(1, 672) = .012$, $p = .914$, $\eta_p^2 = .000$]; Research and Program Evaluation subscale [$F(1, 672) = .878$, $p = .349$, $\eta_p^2 = .001$]; Professional Orientation and Ethical Practice subscale [$F(1, 672) = 3.212$, $p = .074$, $\eta_p^2 = .005$]; Total CPCE scores [$F(1, 672) = 2.877$, $p = .090$, $\eta_p^2 = .004$].

Two of the subscales revealed significant mean differences: the Helping Relationships subscale [$F(1, 672) = 4.831$, $p = .028$, $\eta_p^2 = .007$] (cmhc $M = 12.353$; sc $M = 11.987$); and the Group Work subscale [$F(1, 672) = 8.555$, $p = .004$, $\eta_p^2 = .012$] (cmhc $M = 12.861$; sc $M = 12.340$). These results indicate that clinical mental health students have a slightly higher mean on two of the CPCE subscales than school counseling students. While these differences were statistically significant at the $p < .05$ level, the mean scores do not indicate a large disparity in subscale scores based on program modality (less than one half of a point). The partial eta squared scores on the two ANOVAs suggested that only 0.7%

(on the Helping Relationships subscale) and 1.2% (on the Group Work subscale) of the variance could be attributed to emphasis or program specialty.

## Discussion

In review of the results, the two significant differences were noted on the Helping Relationship and Group Work subscales. However, these differences are minimal and did not affect the total scores. Differences could also be attributed to other factors such as inequality of groups (there were more participants with a clinical mental health than school counseling specialty: *n* = 383 or 56.47% clinical mental health students and *n* = 299 or 43.52% school counseling students). Therefore, the current research study supports the assumption that theoretical knowledge of school counselors is comparable with that of clinical mental health counselors, at least in six of the eight core areas that are identified by CACREP as essential for providing mental health counseling. These results are consistent with CACREP accreditation core standards assessed by the CPCE, as the expectation is that all counseling students receive and demonstrate knowledge consistent with the eight core areas despite chosen specialty.

### Crisis Intervention and Individual Counseling

However small, the differences in two of the subscales (Helping Relationships and Group Work) may present some concerns for counselor education programs. These two areas focus on practical skills that counselors need to master in order to be effective in crisis/trauma response, mental health assessments and counseling, and group counseling. The results from the study demonstrate a need for counselor educators to integrate curriculum changes that reflect a more consistent pedagogy of mental health competencies for school counselor trainees. According to the results,

more training is needed in areas of helping relationships, such as individual counseling and crisis management, as well as in group work. A professional counselor's role and responsibility is to provide not only crisis assessment and referral, but also intervention (Wachter Morris & Barrio Minton, 2012). The school counselor is the main provider for crisis intervention with directly- and indirectly-affected individuals, leading and organization of the crisis responders involved with the school, and/or follow up services (James & Gilliland, 2013). Additionally, ASCA and the American Counseling Association report an ethical duty of professional counselors to engage in effective and best practices in crisis response and intervention. The overall role of each entity involved is to ensure safety, reduce trauma, and provide recovery resources (James & Gilliland, 2013). In 2009, and revised in 2015, ASCA took a stand on school counselors identifying mental illness within the school system (ASCA, 2015).

Today, the school counseling profession is experiencing several major challenges, including the overwhelming size of caseloads and the increase of violence in schools. Furthermore, Costello, He, Sampson, Kessler, and Merikangas (2014) demonstrate in their study that only 45% of young people with a mental health diagnosis are treated for their diagnosis, and of that 45%, only 24% receive services within their school. With increased training, more students with mental health disorders could be identified, which would lead to prompt interventions by school counselors and other professionals. Bauman, Toomey, and Walker (2013) state that youth suicides are "the third leading cause of death among young people in the U.S." (p. 341). In addition, school shootings and other forms of school crises have been highly publicized, causing a more dramatic focus on crisis intervention and the increased mental health needs of

students today (DeKruyf et al., 2013). However, crisis counseling is extraordinarily difficult to be reduced to a simple set of procedures. It is a form of intervention that requires the individual in the counseling profession to have “encyclopedic knowledge” (Dupre, Echterling, Meixner, Anderson, and Kielty, 2014, p. 92) of mental health disorders, family systems theory, ethics, and familiarity with community resources. Thus, the importance of school counselor training and preparation is paramount.

**Home Issues and Group and Family Interventions**

Furthermore, students often experience home issues that tend to have a high impact on students’ academics and behavior in school. Exposure to domestic violence, physical or sexual abuse, or substance use are only a few examples. Even more concerning, students who are exposed to parental substance use disorders are at a higher risk of long-term behavioral, social and psychological problems such as depression, anxiety, and conduct disorder, as well as ineffective coping skills (Lambie & Sias 2005). Students who live in a home where substances are used heavily are usually a part of a closed family system which discourages outside relationships to ensure the “family secret” is kept hidden (Lambie & Sias, 2005). As such, school counselors can benefit from clinical training in mental health assessment and crisis planning skills to help identify the needs of these impacted students. School counselors can offer group interventions or utilize brief and systems approaches to help students cope with their difficulties at home as well as other challenges. Typically, school counselors implement a model of counseling that incorporates collaborative family-school programs (ASCA, 2012). These programs are designed for school counselors to engage family members in a collaborative partnership with schools. Brief family systems approaches are a more

individualized intervention, which focus on eliminating the student's problem behaviors and family dysfunction (Sink, 2011). According to ASCA (2016): "School counselors enhance the collaboration of school-family-community stakeholders by being the catalyst through which these collaborations occur" (p. 53).

Group intervention strategies such as psychoeducational or support groups are effective as they create a safe environment for students to discuss issues or personal concerns, learn coping skills, process issues related to substance use, avoid feeling isolated, and build social skills (Corey et al., 2018). School counselors can implement these interventions with collaboration from the parents and family members.

School counselors can also use assessment skills and mental health competencies to identify and support students with behavioral issues. Behavioral issues can be described as students engaging in aggressive or violent behaviors such as hitting, kicking, bullying, verbal assaults, and threats. These behaviors are linked to later issues of adult substance use disorders, criminality, low socio-economic levels, unemployment, and domestic violence (Sink, 2011). Students exhibiting behavioral issues may already be expressing symptoms related to social/emotional developmental and mental health challenges. In addition, socioeconomic status (SES) has one of the largest impacts on a student's social/emotional development and academic success. SES largely determines the location of the student's neighborhood and the school they attend as well as indirectly provides social capital which is essential for academic success (Sirin, 2005). Although SES has an effect on resources at home, resources at school are also impacted, such as higher teacher-student ratios, materials, and extracurricular activities. SES also influences aspects such as educational access,

mental illness, exposure to violence, and resources. It is important to mention that although a low SES has been found to have a more negative impact, these issues can be mitigated not only through funding and additional resources, but also through effective school and mental health interventions. The causes of student behavioral issues are difficult to assess but they can be related to comorbidities, dysfunctional social learning, and/or neurobiological explanations. Increased training in mental health practices can assist school counselors in providing competent services and referral support (Sink, 2011).

**Training and Supervision**

Given the leadership role of school counselors (ASCA, 2012), training programs need to develop curriculum and teaching pedagogies that reflect the clinical competencies of mental health counseling in educational settings (Conner & Yeh, 2018). They further elaborate on the school counselor's role in collaborating with administrators, social workers, and teachers to assist in coping strategies related to healthy adaptive behaviors and mitigating symptoms of mental illness. As a cornerstone to addressing these gaps in the curriculum, counselor educators can incorporate an integrative approach to combining mental health and school counseling interventions and support systems. Cross-disciplinary collaboration between counseling specializations is beneficial for developing counseling competencies. These efforts oversee the problem from a broad and overarching perspective and allow for optimal and comprehensive evaluations of learning objectives in counseling programs. Despite some commonalities, counseling specializations differ from other helping professions for their orientation towards development, prevention, and wellness. To further elaborate on

these spec6ialized areas, Dupre et al. (2014) identified five emerging themes related to preparation of counselor trainees for mental health and crisis counseling: dealing with multiple crisis issues, complexity of crisis (i.e., clinical, systemic, and cultural), negative and positive outcomes relating to crisis counseling, necessity for crisis supervision, and the need/desire for clinical supervision post-licensure for the professional counselor. These findings solidify a need towards developing curriculum and courses that are integrated with learning objectives of mental health in school counseling.

Farhat (2016) found that the use of clinical supervision also has a profound effect on teaching leadership, which includes implementing skills pertaining to pedagogy as well as improvement, efficacy, and self-growth for counselor trainees. Counselor educators can support leadership initiatives for school counselor training methods. These can include advocacy for continuous mental health workshops on current issues in school settings. It becomes increasingly apparent that the leadership position of school counselors calls for counselor educators to analyze cross-collaboration with mental health experts and clinicians. Dupre and colleagues (2014) urge mitigating the risks of crisis counseling and promote counselor resilience in clinical supervision. Clinical supervision is the appropriate setting for preparing the counselor-in-training for a crisis and giving them the opportunity to have a seasoned gatekeeper guide them through the process.

Additionally, using transformational teaching strategies would be the way for educators to integrate advocacy-oriented training standards by creating assignments that are effective and experiential, and grounded in the community. This will encourage awareness among the students as they learn how to apply their knowledge. To further

illustrate successful teaching approaches, “Experiential learning activities that involve the immediate application of knowledge has a greater impact on student development than cognitive teaching strategies” (Moate and Cox, 2015, p. 380). These training methods can directly support cross-curricular pedagogy in mental health and school counseling. Counselor education programs are reviewing fieldwork and internship experiences for school counselors to include mental health placements. Although there is a dearth in the research literature, Primiano (2013) found through their qualitative analysis that school counseling training programs should be actively involved in mental health training for the students. The study also elaborated on the importance of mental health assessment skills for school counselors. It is further indicated that internship experiences and mental health workshops can solidify a school counselor’s approach to help students with mental problems. In addition, counseling courses can include role-play activities conveying the reality of mental health crises. These initiatives can strengthen the mental health competencies attained by students and interns in a school counseling program. Fieldwork experiences such as these can provide the foundation for competent mental health skills for school counselors.

**School Counselors’ Role in Supporting Mental Health Needs**

Due to the different leadership styles of administrators, the responsibilities of school counselors can vary significantly. Yet, it is important to emphasize that a school counselor’s ability to provide comprehensive mental health services should not be neglected as student needs and crises arise every day. As evidenced by the literature, students are more likely to engage in counseling services offered in a school setting, thus increasing the demand for school counselors to provide for the mental health

needs of their students (Kaffenberger & O'Rorke-Trigiani, 2013). However, many counselors feel uncomfortable with providing mental health counseling (Carlson & Kees, 2013). This happens even though the ASCA competencies (2012) include the same theories of counseling that are utilized by mental health professionals in a clinical setting and that CACREP (2016) requires that counselors master the same core counseling skills, regardless of specialty. Since all counseling students are required to master the same competency areas, both school counselors and mental health counselors should be equally trained to provide mental health counseling in their specialty settings. This is not to advocate that school counselors should take on the primary role of clinical mental health providers, but rather consider the “double-brimmed hat” approach (DeKruyf et al., 2013, p. 273), or dual identity, discussed earlier. Being competent with dual identities will equip school counselors to support students’ mental health needs.

It should also be noted that there continues to be stigma and marginalization of children and families seeking mental health counseling. In addition to the dual identity, given their multiple roles, school counselors in particular are in the perfect leadership positions to advocate for the needs of all students, especially underrepresented groups (Allen & White-Smith, 2014; Ratts & Greenleaf, 2017; Watkinson, Goodman-Scott, Martin, & Biles, 2018). Research demonstrates a need for a comprehensive approach in preparing counselors to be leaders and change agents, ethically responsible decision-makers, advocates for inclusive and supportive communities, facilitators, and collaborators (Allen & White-Smith, 2014; Ratts & Greenleaf, 2017; Watkinson et al., 2018). Furthermore, school counselors are charged with addressing issues of power,

privilege, and oppression within their school communities (Ratts & Greenleaf, 2017; Decker, Manis, & Paylo, 2016; Watkinson et al., 2018).

Positive mental health is a foundation for a successful student, both in academics and in choosing and pursuing a career. In fact, the ASCA Mindsets and Behaviors emphasize the attitudes, beliefs, and behaviors that students should acquire (ASCA, 2014). School counselors have the unique role of promoting students' college- and career-readiness by supporting students' social and emotional development. However, when feeling uncomfortable or less competent to provide mental health counseling, school counselors avoid providing these services. This study demonstrates that school counselors have many fundamental competencies to offer mental health counseling within the educational context of a school setting in order to promote emotional stability, which in turn promotes academic and career readiness. Thus, school counselors should make an effort to become more comfortable with mental health counseling and make it part of their dual professional identity. At times, the depth of counseling needed may be outside the scope of the school setting purposes, or may require longer, ongoing counseling. In these cases, referrals to outside service providers are considered a central part of best practices.

So, the question remains, if school counselors acquire similar counseling competencies comparatively to clinical mental health counselors, are there significant differences in the services they provide? These differences are of course determined by their specialty courses as well as fieldwork experiences in which they are engaged during their training. School counselors support students' mental health needs in a school setting in order to encourage conditions for productive learning and behavior.

However, school counselors are not able to feasibly address all underlying issues related to a student's distress, which in many cases are related to home life. Nevertheless, the school counselor is able to identify the trauma, crises, distress, assist the student with coping strategies during the school day, and make appropriate referrals for mental health counseling to explore the issues further. The school counselor's collaboration with other clinical mental health counselors will provide students with a congruent network of supportive systems.

Feeling supported to exercise their abilities in providing mental health counseling may result in school counselors' increased effectiveness in servicing students with mental health needs. A recognized identity as a mental health provider will also support school counselors in their efforts to educate administrators on how to utilize school counselors effectively. Instead of arguing whether they should focus on mental health needs of students or student achievement, school counselors would best benefit students by embracing a dual identity of mental health provider and educational leader, and supporting students holistically (Ziomek-Daigle et al., 2008).

**Limitations**

While the number of participants is from a large data set collected over 13 years, the students from this sample came from a single university, thus presenting limits to external validity and the generalizability of findings. Also, a homogenous participant pool consisting mostly of Caucasians and females restricts the generalization of the findings further. This limitation however, is one that is difficult to avoid, as this demographic typically reflects the professionals working in the counseling field.

Additionally, the use of CPCE raises questions of construct validity due to limited available literature supporting the assessment as a reliable measure of counselor effectiveness. Moreover, CPCE does not consider specific skills related to counseling specialties but is rather a standardized test measuring mastery of knowledge in core areas. Using only the CPCE to measure counselor outcomes also limits the reliability of the findings, as there are many aspects of the counseling profession that require more diverse and in-depth measurements (Haberstroh et al., 2014).

**Recommendations for Future Research**

Future researchers would make valuable contributions to the counseling field by examining the efficacy of CPCE. Expanding on the limited data of this assessment is necessary to establish its validity, reliability, and appropriate applications. Examining counselor competencies between specialties by focusing on measuring effectiveness of specific counseling skills rather than knowledge mastery of core content areas also may be an important future exploration. Finally, developing and utilizing additional measures to evaluate student learning as suggested by Barrio Minton and Gibson (2012), and Haberstroh and colleagues (2014) can add valuable information about the level of counselor preparation. Measures of self-efficacy, or objective measures of practical skills and competencies for school counselors would give more reliable results.

At Liberty University (the university where the authors were employed at the time of publication), master students regardless of specialty are trained together in all core courses (including practicum and internship courses) and only train separately for strict specialty courses. While students conduct their practicum and internship experiences at sites according to their specialty, they are placed together in the internship and

practicum courses for supervision, regardless of specialty. This gives all students an opportunity to learn and understand how each setting is different, and what unites counselors in their professional identity. Replication of this study in universities where student counselors are trained separately based on specialty may help strengthen the generalizability of the results.

Utilizing advanced evaluation methods, counselor educators can determine a better way to understand school counselor graduates and the acquisition of mental health competencies. In addition, future studies conducted in school settings may help establish the efficacy of school counselors in meeting students' mental health needs. Equally valuable are areas of research examining school counselors' perceived limitations in their ability to accommodate mental health needs within the school setting, as well as barriers to identifying as a mental health provider, and ways to overcome such barriers. Another area in need of examination is the degree to which school counselors can adopt a mental health provider identity and how that may impact the counselor's overall effectiveness. Understanding administrator perceptions and opinions about school counselors embracing the mental health provider role could also be important areas of future research. Finally, research determining how school counselors and clinical mental health counselors can find ways to use cross-curricular collaboration and become more familiar with each other's specialties in supporting children and adolescents can be another area for future exploration.

**Implications and Conclusions**

Embracing the mental health provider identity in conjunction with the educator identity may be the most logical step in the development of the school counseling

profession (Ziomek-Daigle et al., 2008). As DeKruyf and colleagues (2013) postulate, school counselors need to embrace a double identity of educator and mental health provider to meet the demands of today's school setting. School counselors should share the same CACREP competencies with clinical mental health counselors because they are trained in programs designed as a counseling specialty, rather than an education specialty. Many of the counseling theories in which school counselors are already trained can be adapted to provide mental health counseling support in schools. In addition, counseling approaches such as play and art therapy, as well as motivational interviewing, can also be modified for use in schools.

Adapting counseling approaches allows the school counselor to utilize their clinical skills set in reaching students who may not have access to mental health supports. Students who are unable to follow through and engage in referrals made by the school counselor should be prioritized in order to support otherwise unaddressed mental health needs. Since the primary role of the school counselor does not include diagnosing mental health issues, they may not be required to have training in identifying mental health disorders (ASCA, 2012). This could be one reason why school counselors are apprehensive to provide services to students who have a formal mental health diagnosis. In order to mitigate this limitation and demystify the diagnosing process, school counselors may benefit from additional workshops and training in this area. The purpose would be to familiarize the school counselor with information from the clinical mental health specialty so they could confidently attend to the mental health crisis in schools today.

There is an obvious absence of specialized school counseling training related to mental health offered at ASCA conferences (DeKruyf et al., 2013). Implementing adequate opportunities for training at local and national levels would affirm the need for school counselors to provide mental health crisis counseling. This additional training would also encourage the development of their dual identity and mental health competencies. Skill development through workshops and additional training will strengthen school counselors' competence in utilizing clinical skills while lessening the stigma that school counselors are unfit to provide mental health counseling. Advocating for cross-curricular training, and regular supervision with experienced school counselors and mental health providers would ensure competency in both specialty areas. This also would serve to bridge the gap between clinical mental health and school counseling training methods and curriculum development. In addition, increasing advocacy efforts within school administration graduate programs may help support a new direction in dual identities and collaborative roles. Thus, school counselor trainees will have the program support needed to embrace their mental health competencies and utilize these skills to provide mental health counseling and crisis intervention to students in educational settings.

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