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"If you really need it": Asian Indian American College Student Help-Seeking Behaviors

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This qualitative study examined perceptions among 18 to 22-year-old Asian Indian American college students towards mental health utilization within campus resources. This research seeks to fill the gap in Asian Indian American mental health utilization literature through studying barriers and messages received about mental health treatment. Findings, using semi-structured interviews, highlighted barriers to seeking help, commonalities towards mental health amongst students, and the critical thematic analysis of negative stereotypes that are associated with counseling.

Keywords: Asian Indian Americans, college students, mental health, utilization, barriers

College campuses are seeing a rise in mental health issues (Francis & Horn, 2017). Students on college campuses are seeking psychological services more than previous years and experiencing increased severity of their psychological symptoms (Flatt, 2013). Enrollment of the student population is decreasing on college campuses; however, the diversity of the students seeking services has increased (Chandras, Chandras, & DeLambo, 2013). With that being said, there is no doubt that college counselors need more information to meet the needs of the Asian Indian American (AIA) college student population. Through existing literature, we have found that there is a lack of research on the mental health needs of AIA college students. Our study aims to fill the gap in the mental health utilization literature for this demographic by analyzing barriers to mental health service utilization and messages received about mental health treatment in the AIA community.

Asian Indian American Population

According to the U.S. Census Bureau (2010), there are approximately 17 million Asian Americans in the United States. However, Lopez, Ruiz, and Patten at the Pew Research Center (2017) reported that the Asian American population has grown to 20.4 million people between 2000-2015. The Office of Management and Budget (OMB) defines Asian as "a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam" (Hoeffel, Rastogi, Kim, & Shahid, 2012). This definition describes the diversity of people identified as Asian in the world; however, it also seeks to highlight that they are often studied as one, or often focused on three predominant subgroups - Chinese, Filipino, and Japanese (Sue & Sue, 2016).

More specifically, the Asian Indian population in the U.S. is estimated to be growing. This is based on the Pew Research Center's (2017) findings that as of 2015, the number of Asian Indians has grown from 2.8 million to 4.0 million (a 20% increase). Given this large population size, it is surprising and alarming that research on the mental health issues of this minority group is relatively limited. The new millennium ushered an overall increase in published research on ethnocultural factors in mental health, and ethnic minorities' perceptions and utilization of mental health services within a college or university counseling center (Chandras, Chandras, & DeLambo, 2013); however, AIAs are still one of the most understudied Asian American groups within mental health literature (Congressional Caucus on India and Indian Americans, 2006; Masood et al. 2009).

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Existing literature on AIAs highlights some of the challenges college students are confronted with when discussing and utilizing mental health resources. College counseling center research noted that the majority of college students feel uncomfortable seeking services, yet service utilization is increasing (Flansburg, 2012). Stout and Nath (2013) stated that many AIAs have either neutral or positive views towards counseling, but are often not likely to seek help unless it is severe. Further, existing research highlights the barriers and high rates of stigma the AIA community faces in seeking support on campus in comparison to the general college student community. Stigma can play a major role in preventing students from seeking external resources. Argo (2010) found that AIA college students greatly underutilize mental health services surrounding them, even if the need for it is high because of this perceived stigma. This was so evident within Argo's study that three-fourths of the enrolled participants did not want their families to know they were going into counseling - the fear of "going outside the family with private matters" (p. 89).

Another factor that was identified was the shame and disgrace that comes with admitting to emotional problems within these families (Sue & Sue, 2016). These are ways that AIA college students differ not only from other races, but ethnic groups within the general Asian American population. It was found that in comparison to White college students, Asian Indian students were more reluctant when thinking about using counseling services (Loya, Reddey, & Hinshaw, 2010). When thinking about suicide, some studies have shown that even though the rates of suicide are lower in AIAs than other Asian Americans, the failure to meet parental expectations can still trigger depression and suicidality (Chandra, Arora, Mehta, Asnaani, & Radhakrishnan, 2016).

Given the diversity and potential value differences amongst Asian Americans compared with AIAs, it is vital to consider important variables and counseling implications for this specific population. To address this and the lack of literature in mental health for this demographic, our study dug deeper into mental health utilization amongst AIA college students.

This particular population continues to grow in higher education (Hune, 2002) with approximately 65% of Asians enrolled in postsecondary education in 2017, according to The Condition of Education (2019), yet the report fails to identify the specific number of AIA students within this sample. While extant literature has identified factors impacting mental health service utilization, few empirical studies are evaluating these factors' impact on AIA college student mental health. Therefore, in this study, we analyzed beliefs about mental health by exploring the voices of this underserved community. The counseling implications set forth are presented as this article progresses and findings are unraveled.

Rationale

During our review of mental health literature, we have found that very few researchers have examined various areas of the Asian Indian population. AIAs are often not classified individually in psychological research, but rather within the Asian American demographic as a whole. For example, studies examined differences amongst Chinese, Japanese, and Korean Americans, but often neglected the South Asian population in the U.S. which includes India (Nath & Ahmad-Stout, 2013).

This study sought to fill the gap in AIA mental health utilization literature. It adopts a qualitative approach in seeking barriers to mental health service utilization and the messages received about mental health treatment. Further, it aims to thematically describe negative stereotypes that are associated with counseling within AIA communities, colleges, and students.

Methodological Approach

Given the limited research on AIA college students' beliefs about accessing mental health services on campus, a qualitative approach was taken when recruiting for and developing this study. In addition, we wanted to explore the voices of this underrepresented group by using qualitative interviews to capture their experience in their own words. Bogan and Bilken (1992) emphasize that a qualitative approach integrates in-depth interviewing with descriptive data that helps us learn about themes that act as barriers to utilizing the provided mental

health resources on campus. The ability to represent individuals involved in this study by presenting their voices and experiences facilitates inductive reasoning to take place. Using a qualitative approach helps capture the participants' voice - a voice often obscured when categorized with other groups of South Asians and Asian Americans; individuals so often diverse from their own.

Methods

This study was designed to fill the gap in the AIA mental health utilization literature by analyzing barriers to mental health service utilization, and messages received about mental health treatment. Given the dearth of literature and lower rates of service utilization, the authors used thematic analysis to focus on the voices of this underserved group in college counseling centers. The interviewer identified as an AIA graduate student who positioned herself as being a part of the population studied.

Participants

The population from which a sample was obtained for this study (n=10) were English-speaking, self-identified AIA individuals who were between 18 and 22 years old, and residing in the United States. This sample of ten students interviewed was recruited via email and snowball sampling. For example, emailing South Asian organizations on campus, via Facebook, and having individuals forward the message to those that may be interested. The decision to focus on 18 to 22-year-olds was due to the traditional age of students typically enrolled in a four-year college. The inclusion criteria for this study were based on individuals identifying as AIA and college students. Exclusion criteria for this study were based on age and consent, such that anyone under the age of 18 and anyone who did not consent to participate was excluded from this study. Therefore, upon scheduling the virtual interview, participants were screened verbally for their age, whether they identified as AIAs, and if they were a college student.

Procedures

Prior to any recruitment, a university Institutional Review Board (IRB) approved recruitment materials and study procedures. Recruitment emails described the study's inclusion and exclusion criteria, the length of participation, and the purpose of the study to understand more about AIA mental health. Recruitment emails had an informed consent page attached, which described the purpose and design of the study, as well as the potential benefits and risks associated with participating in the study. Individuals who agreed to participate in the study after reading the informed consent responded to the email to schedule a virtual interview. Upon consent to participate in the study, subjects were asked to participate in the one-time completion of a virtual interview where the interviewer used a semi-structured interview protocol to ask questions about their awareness of their university counseling center, beliefs about counseling, and family messages about mental health. Each interview took approximately 30-45 minutes to complete. Participants did not receive any compensation for their participation.

Transcription and Analysis

Once all data was collected, the interviews were transcribed verbatim by the authors. Following this step, the authors collaborated to code the data and developed a "start list" of domains evidenced by the data (Hill et al., 2005). Then, using the participants' words, the authors collaboratively identified core ideas present in the data and characterized data utilizing frequency labels. The thematic analysis of the transcribed interviews followed the six phases outlined by Braun and Clarke (2006).

Trustworthiness

Regarding credibility, we used investigator triangulation. The first and third authors were engaged in the study design. Themes were identified by all authors. Finally, we utilized peer debriefing by having an outside colleague question our themes (Nowell, Norris, White, & Moules 2017). Researchers separately coded and then met to assess the similarity of themes and question the appropriateness of the themes. This study focused on a specific context: AIA traditional college students in the mid-Atlantic region of the United States. We do not assume that this can be generalizable to other populations but view this as a starting point to explore possible barriers to service utilization in this population. We maintained an

adequate audit trail as recommended by Lincoln and Guba (1985) for the confirmability of this study. The authors engaged in a reflexive process by questioning potential biases being a part of the population or an outsider. This reflexive process, audit trail, and outside reviewer reinforce the dependability of this study (Nowell, Norris, White, & Moules 2017).

Positionality

First Author. Growing up in an Asian Indian household and being a graduate student myself while conducting this study, I quickly learned that my upbringing and family dynamic was different than many of my classmates. As I grew up, it highlighted the importance of open conversations around mental and behavioral health within marginalized populations. My interest in investigating this topic stemmed from wanting to use my personal experiences and encounters around mental health to execute a study that primarily focused on the challenges and barriers AIA college students face in regard to mental health utilization.

Second Author. I identify as cisgender biracial woman, African American and Jewish. At the time of this study, I served as teaching faculty and the first and second authors' faculty mentor. Prior to becoming faculty, I worked in a college counseling center where I saw students with mental health needs – some of which my clients identified as AIA college students. I approached this study as someone who is not a part of the AIA culture and community. However, I am a counseling psychologist who specializes in multicultural issues in counseling and psychology.

Third Author. I identify as cisgender African-American male**.** At a very young age, I lost my mother and siblings to a house fire. I was too young to understand the impact psychological trauma had on me from this experience and it forced me to quickly learn about death, grief, and how to move on at an early age. Years later, I remember having a conversation with my father where he described feeling tired of being punished by a higher power for the decisions he had made with his life. In high school, he passed away and the way I viewed death and grief was revisited. These personal experiences specifically have highlighted for me why I find the need for those within minority cultures to understand the importance of mental health.

Results

The interviews focused on the barriers affecting AIA college students' use of mental health services on campus. The thematic analysis yielded 3 principle themes. This includes, but is not limited to, beliefs towards counseling, traditional values, and coping styles.

Participants indicated that parental influence played a significant role in participants' views and beliefs regarding counseling and the need to seek counseling. The traditional values many parental figures have affected the way AIA college student views mental health or mental health resources. Additionally, AIA college students in our study verbalized that they felt they were expected to cope on their own in ways that were both proactive and distractive, as obtaining help outside of the home may be against the culture.

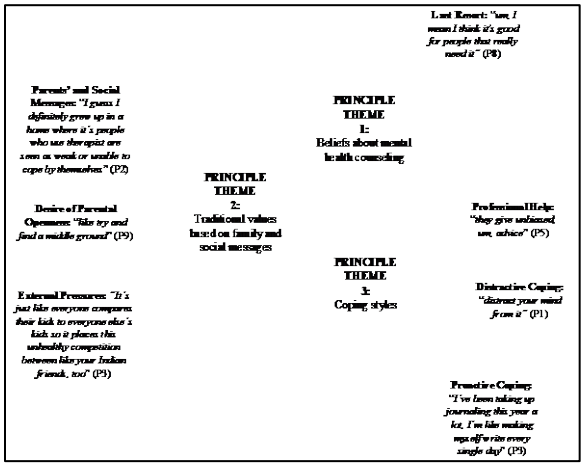
Principle Theme 1: Beliefs about Mental Health Counseling

Throughout every interview, participants described their beliefs about mental health counseling as a last resort and described their generation as being more open to it than their parents' generation. All but one participant described their early experiences struggling with mental health as showing a sign of weakness. Many of those participants reported structure and mental fortitude being highly valued and integral to maintaining and sustaining mental health. Though the majority of participants agree that counseling is a good service to have readily available, only three had disclosed having participated in some form of counseling: "they give unbiased, um, advice" (P5. See Figure 1).

Professional Help. Participants who did utilize counseling as a means of mental care reported they view the counselor as an individual who is "an expert in people" (P4); someone who will give an "unbiased opinion" (P5). This perspective highlighted that the role of the counselor is viewed as the person who gives advice from a different perspective, who takes a

different approach, and who teaches others “how to become a better person” (P6). Many participants like this one: “it’s better for someone who's trained, like this is their job to take on this kind of stuff” (P2), expressed that the counselor is the one who can help with the issue and alleviate the “severe impact” (P6) on that person. However, most participants reported counseling as a last line of defense in upholding their mental health.

Figure 1.



In this study, we found that 8 out of 10 individuals identified as having a good grasp on their psychological well-being and viewed counseling and other mental health services as not needed or unnecessary. However, for participants who reported seeking help, they reported being confronted with extended waiting periods prior to being able to see a counselor: “you know if there is a bunch of students, um, who want to or who are currently receiving counseling and they can't get to you in a timely manner then, um, that's a barrier” (P6). On the contrary, the majority of participants viewed the service of counseling in a positive manner; however, it was still a reactive versus a proactive approach. Essentially, participants viewed counseling as a service intended to fix a problem, but not to prevent or maintain mental stability: “mental health is definitely something that if you need help for it, to go for it” (P1).

Last Resort. A few examples of psychological thresholds include weeks of feeling “depressed” (P10), high levels of stress caused by pressure to perform well academically (P3), and anxiety (P3). We defined threshold as a point at which juggling psychological stressors for participants becomes too difficult. Many of our participants reported feeling positive about the utilization of counseling services; however, only for those individuals who are “in need” (P1). Furthermore: “um, I mean I think it's good for people that really need it” (P8) emphasizes a participant conveying counseling is a good resource for an individual who may get to a point that “needs” it versus “wants” to utilize resources.

While this may be more common, it may further perpetuate the stigma within the AIA college student community that only those who lack mental fortitude require mental health services. The participants that did seek counseling waited until they hit a psychological threshold: “so I guess in that case like I would go to a counseling service if it would happen like multiple days in a row or weeks in a row” (P2). Participants that had not received mental health services reported that they never “felt,” or “had ever been told” they were “in need of counseling” (P1).

Finally, participants felt their generation of AIA peers was shifting in their perspective from their parents’ generation's views about mental health services. In particular, college students in this sample named the *traditional ideology* and expressed the explicit belief that their generation was more open to talking about mental health. A separation from the traditional ideology of the generation before them has created a difference of opinion between parent and child. While many of our participants expressed positive views towards counseling and mental health overall: “more kids are becoming accustomed to the idea that or the concept of if you need help you can go and seek it” (P1), there is still social and parental acceptance of their beliefs that is highly valued and desired. It seemed it would be beneficial to be able to change the traditional mindset to view mental health as a factor of importance expressed by a participant: “one thing that is different between older generations and younger generations of like between kids and their parents is that more kids are being accustomed to the idea” (P1).

Principle Theme 2: Traditional values based on family and social messages

Traditional values greatly impact the participants and their perception of counseling. Some participants

noted that they confide in family more often and assumed that things will get better on their own: "I usually talk to my really close friends or my sisters about, you know, if I'm down and about for like a few days I would let them know this has been happening for a few days and I don't know, recalibrate myself" (P10). Traditional values came in the form of external pressures, parental messages, and social messages that therapy "is not something that is the norm" (P6). However, it is important to note that many participants expressed a desire to talk about these issues with their parents more.

External Pressures. Several participants shared their experience with psychological distress brought on by depression, social anxiety, and ADHD combined type. In addition, 90% of participants reported psychological distress due to perceived external expectations to perform at the highest academic level. The participants described this need to perform well academically as a major source of anxiety and mental anguish. Some of the individuals described difficult memories of parents forming unhealthy competitions and pitting their children against one another in an attempt to see which child performed highest academically as one student explained: "it's just like everyone compares their kids to everyone else's kids so it places this unhealthy competition between like your Indian friends, too" (P3).

It was also reported from our sample that the pressure to succeed, to get into an Ivy League college/university, pursue a degree in the medical or STEM fields, and the pressure to be involved in several programs such as gifted programs, and SAT prep programs began with the influence of high achievers - their parents. The pressure to perform at a high level begins at a young age and is expected throughout many aspects of one's life: "don't put so much pressure on your kid" (P8). Our participants reported that their parents would react positively to counseling as long as it is of an academic nature.

Desire for Parental Openness. Participants whose feelings were not validated by their social and parental supports reported repeated use of outside sources to aid with stabilizing their mental health. Mental support from a friend, authority figure, roommate, sibling, or someone the participant felt close to were all highly valued. In many cases, mental support from the participant's social group was the first to be reported. The ability to discuss issues that affected their mental health without being labeled as "weak" (P2) allowed participants to change their personal perspective on the topic of mental health. This remained true for those who reported seeking counseling as mental support, as well. Though many participants reported having their social group as a support system, many desired to have a connection of this nature with their parents. Participants expressed a desire for their parents to become more open-minded and: "like try to find a middle ground" (P9).

When an issue is causing individual stress or anxiety and it is brought to their parents/caretakers, many participants reported wanting their issue to be "worked on" and not "dismissed right away" by their parents. These ideals signal a shift in the mindset of how to assist individuals in college struggling with mental health within the AIA community. Many participants responded in a positive manner when their parents were able to be open-minded.

The importance of parents being open-minded was something we learned to be similar amongst the current generation of AIAs who participated in this research study. Some reported that with advancements in technology and new platforms for social interaction, a change in tradition is essential in keeping up with the modern world.

Parents' and Social Messages. Participants' parents' perception of mental health significantly influenced and, in some cases, acted as a barrier to help-seeking behaviors and utilizing university counseling centers. Based on the participants' report, the pervasive language around the discussion of mental health within families discourages those suffering from mental or emotional distress to seek help: "I feel like… being an Indian parent. I feel like they don't… don't believe in counseling ultimately" (P9).

Participants described their parents' use of terminology such as "crazy" and "psycho" when describing those who are dealing with mental disorders. Those dealing with psychological distress such as anxiety, stress, or confusion were referred to

as “weak-minded,” “having low mental fortitude,” or “in need” (P8) of counseling.

A few participants discussed elevated levels of anxiety when socializing with unfamiliar peers of their own culture. In an attempt for participants to conform, those that hold beliefs about mental health contrary to those they learned growing up, reported withholding these views when interacting with AIAs they did not know as one student explained: “I guess I definitely grew up in a home where it’s people who use therapists are seen as weak or unable to cope by themselves” (P2). It was even reported that going out of their way to avoid interaction with other AIAs altogether was used to alleviate social anxiety. According to our sample, the utilization of mental health services was not indicative of individuals who possessed stable mental functioning.

Many participants discussed how they would handle the topic of mental health differently from how their parents did in generations to come. The participants explained seeing themselves as being the turning point of an adapting culture, setting the trend for a new age of AIA by undoing the beliefs that stigmatize, ostracize, and polarize those who seek mental health services.

Principle Theme 3: Coping

The research identified many similar coping behaviors participants reported implementing to maintain mental fortitude during times of psychological distress. Coping was separated into two categories: proactive and distractive. This refers to behaviors applied to achieve psychological balance and proper mental functioning. It is not the intention of this research to conclude the effectiveness or longevity of any particular behavior.

Distractive Coping. “Distract your mind from it” (P1) was identified as either prolonging the issue causing mental instability or taking the participants' attention away from the issue to achieve proper functioning. Some examples of distractive coping included working out, procrastination, taking their mind off “it,” disconnecting, watching videos/TV/internet, finding the inner motivation to push through, and rewarding oneself. One participant mentioned, “I try to immerse myself in like a lot of social activities” (P3) and another described: “I go through sometimes videos of funny things or something that makes me laugh” (P1).

Proactive Coping. Proactive coping was identified as involving the participant directly with the issue causing distress. Utilization of counseling services, journaling, having someone to talk to: “I usually talk to people whose company I enjoy” (P10), talking about the issue aloud to self, and prayer were some of the proactive coping styles participants disclosed. One student stated: “I’ve been taking up journaling this year a lot, I’m like making myself write every single day” (P3). Additionally, another participant stated utilizing meditation as an “on and off” resource:

> …meditating, so ever since then like I've been on and off of like meditating. I've been on it again just when I've had to like, you know, especially during final exams I just meditated a lot and I feel better than ever. (P8)

As described before, the most frequently reported response was only seeking counseling with a psychologist/counselor when participants disclosed dealing with large amounts of prolonged mental disruption. For example:

> …um, I think that's only happened to me once, thankfully, and that's the time last semester when I did reach out to [counseling services] and I think it was at a point when I realized that I didn't want to put too much on my friends. (P2)

If it came to dealing with small to relatively moderate levels of psychological distress lasting a matter of days, having someone to talk to was the number one reported response from participants: “…other than that, I just, talk it out. Whether it be with close friends or family members” (P6), and then was followed by working out and meditation.

Discussion

The aim of our study was to highlight the individual experiences, perceptions, and utilization of mental health and mental health resources within the AIA college student community. Our thematic analysis of participant responses highlighted that

beliefs about mental health counseling, traditional values based on family messages, and the ways students coped were all key principles and components that impacted mental health utilization.

Beliefs about Mental Health Counseling

Many participants expressed their views towards counselors and the university counseling center. Participants were in fear they could get prescribed medication which impacted their inclination to utilize on-campus resources. Therefore, the perception that counselors will "automatically assume and immediately prescribe medication" (P8) was identified as a barrier to the help-seeking process. Often, we found that participants' awareness of mental distress occurs in response to a psychological threshold which their current coping mechanisms can no longer handle. Our results indicate that this community may require outreach efforts to discuss the purpose of counseling. Though participants described that the need for counseling is high and individuals have temporary ways to cope and manage their psychological well-being, they often do not seek or utilize mental health resources that may be available to them. These early experiences cultivated a language around mental health that taught those of the AIA community that mental health is an individual effort, involving the resiliency to overcome mental instability without the aid of outside resources.

Traditional Values Based on Family and Social Messages

Our findings suggested that parents' perception of mental health significantly influenced the participants' likelihood in seeking or utilizing the university counseling center. As many participants expressed, these influences often act as a barrier because it can be viewed negatively when one is going outside of the home and family for further help. Additionally, the availability of social supports within participants' family and friend circles led the individual to seek out these people as supports and discouraged care seeking (Corrigan, Druss, & Perlick, 2014).

Furthermore, lack of knowledge and the need for parents to be open-minded were factors that were important in getting the older generation's mindset to shift towards a positive view of mental health. This was particularly important because it was found that AIA families have an increasingly negative perception of mental health, counseling, and using external resources. AIAs born in the U.S. have adjusted more to the culture and notion of utilizing mental health resources in comparison to their immigrant parents or older family members (Chandras, Chandras, & DeLambo, 2013).

Coping Styles

The participants in this study often found themselves dealing with psychological distress alone or by seeking family/friend support, similarly to what was mentioned above. When alone, proactive coping findings that seemed to have a positive affect were journaling, visiting the counseling center for a few of the participants, and meditation. Most often, participants confided in family, friends, and other peers.

The results indicated that proactive coping styles were personal ways of navigating mental health issues being faced. Participants taking a proactive approach journaled, reported visiting the counseling center, meditated, or confided in peers. A lot of these students initially also turned to family members to resolve mental health problems (Nath & Ahmad-Stout, 2013). This aligns well with our research findings that individuals and students do not turn to counseling centers because they may utilize their family or peers as a resource. As Yeh (2000) mentioned, AIAs endorsed coping practices that resulted in speaking with familial and close social circles rather than seeking out professional assistance, such as counselors.

Some participants resorted to a more distractive coping approach. These individuals often immersed themselves in extracurriculars at school, watching television or comedic videos, and usually waited until their symptoms reached an unbearable threshold before seeking help. The themes identified in this study lend themselves for consideration to future quantitative studies in this population.

Implications for Practice

The findings of this study highlight the importance of mental health counseling and education in the AIA college student population. These results can help support counselors in practicing in a multiculturally competent way with individuals and clients of the AIA background. Particularly, by identifying particular barriers AIA students may be facing when discussing mental health with others. Based on the findings of this study, we recommend that counselors explore a client's perceptions of mental health counseling and seek to minimize these barriers to accessing services. This research points to a need for more outreach to the AIA community on college campuses to discuss the potential benefits of mental health counseling. Further, the participants highlight a desire for openness and how to talk with their family and peers about their mental health needs. We can encourage counselors to ask clients about these topics to assess the helpfulness of having a conversation about traditional values, family concerns about mental health, and counseling. This is particularly important before making a referral where the client may need to use their parent's insurance to receive services.

Limitations of the Study

This study is not generalizable as it has a small sample size and is only intended to be a starting point for identifying the beliefs about mental health in the AIA college student population. The study focused on conducting interviews virtually; therefore, did not allow for the option of completing the interviews in-person. The study was limited to college students in the Mid-Atlantic region from larger universities in which only three universities were represented. This resulted in the study being limited to the experiences of AIAs enrolled in only large, college campuses. Lastly, there is a possibility for self-selection bias to influence the data as participants were self-selected to participate in the study. However, despite the fact that this study cannot be generally applied, it is believed mental health professionals and anyone working with this population can find this information useful. They may utilize the findings as they work to find more representation for this underrepresented population.

Future Research

First and foremost, future research should seek to fill the gap in literature specifically on the AIA population as a single ethnic group versus being combined with various Asian ethnic backgrounds. A mixed-methods design would expand upon this research by exploring service utilization, counseling beliefs, and coping styles at a broader level with college students. Additionally, expanding the sample size to represent a larger group of individuals and their experiences would allow for increased findings. For example, this could allow for an increase in additional themes that may not have been highlighted within this particular sample. Due to the smaller sample size, we are unable to generalize these findings to the broader population. However, if we were able to expand our sample size in future research we could explore where similarities and differences lie to be able to generalize to other AIA individuals. Lastly, parental involvement around mental health utilization was key for many of the participants. However, very little parental involvement was present during the study. A future study exploring the beliefs of parents and older generations could illuminate what exists in the gap between the view of mental health treatment present in this culture, and actual mental health practice.

Conclusion

As described, there is a dearth of literature published exploring AIA mental health utilization and messages received about mental health treatment. The participants discussed stigma, parental support, and lack of communication as barriers to seeking help from external resources. The beliefs about counseling, traditional values based on family messages, and ways of coping play an integral role in how and when students take the approach to seek help from said resources, if at all. These ten participants provided valuable perspectives on why mental health resources may not be utilized often. It also began to shed light on what we can aim to do as mental health professionals to break down this barrier when working with and researching the AIA population.

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Back to Basics: Establishing a Foundation for Spiritual/Religious Integration in Counseling and Counselor Education

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We describe the importance of redefining the differences between spirituality and religion based on several changing issues within the counseling profession, aspects of national issues impacting the counseling field regarding religious freedom, public policy, and related concerns. Using the Association for Spirituality, Religion and Values in Counseling (ASERVIC; 2009) guidelines and the American Counseling Association (ACA; 2014) Code of Ethics, we clarify the basics of ethical and competent integration of spirituality and religion in counseling. We conclude with an application discussion for counselors, supervisors, and counselor educators.

Keywords: spirituality, religion, basics

In 1961, after suffering a brutal defeat in the previous season, the Green Bay Packers met for the first day of training camp (Maraniss, 1999). Focusing on the basics of the game, Coach Vince Lombardi began the camp by holding up a ball and telling the players, "Gentlemen, this is a football." He continued to focus on basics throughout the pre-season camp, and the team went on to win five of the next seven NFL championships (Maraniss, 1999). Counseling scholars have found that although clinicians acknowledge the importance of considering religion and spirituality in counseling, those same clinicians report low frequency of utilizing spiritual/religious interventions (Cashwell et al., 2013; Giordano, Prosek & Hastings, 2016). We support Coach Lombardi's focus on basics, and hope that this paper will help counselors, supervisors, and educators more confidently integrate spirituality and religion in counseling.

Defining Terms

The terms spirituality and religion can often be hard to clarify. Taken from the Merriam-Webster Dictionary (n.d.), *religion* is defined as "a personal set or institutionalized system of religious attitudes, beliefs, and practices." Note that this definition focuses on outward, external behaviors, rather than feelings or emotions. *Spirituality* is defined as a commitment to a religion, the state of being spiritual (affecting the spirit) or sacred matters, concerned with religious matters, or relating to spiritualism, supernormal beings, or phenomena (Merriam-Webster Dictionary, n.d.). Spirituality can also be defined as "the quality or state of being spiritual" and/or searching for meaning without a belief in a higher power (Merriam-Webster Dictionary, n.d.). The key difference is that religion describes external behaviors, rules, protocols, rituals, etc., while spirituality describes internal feelings, motivations, commitments, and thoughts about a connection to things bigger than the self, life-meaning and purpose, and to related existential ideas and questions (Senreich, 2013).

Giordano, Prosek, and Lankford (2014) posited that operationally defining spirituality and religion is often a difficult task, pointing out that the literature frequently puts spirituality and religion in opposition to each other. Also, such an oppositional

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stance promotes spirituality as having more positive connotations and religion as having more negative connotations, such as confining people with rules. In that article, the authors emphasized keeping the focus on the sacred: "Religion is a means by which individuals search for meaning through a relationship with the sacred. Spirituality, in its essence, is the most salient function of religion as it encompasses the process of searching for the sacred" (p. 55). Spirituality is seen as notably individualized, all-inclusive, and encompassing a personal sense of transcendence and meaning, while religion is more readily associated with institutions, organizations, doctrines, and creeds.

Regardless, spirituality and religion are deeply personal processes for individuals and the ways they find and make meaning in their lives. Some researchers have sought to draw a line of distinction between spiritual and religious disciplines (Hall, Dixon & Mauzey., 2004; Walker, Gorsuch, & Tan, 2004), but there may be more overlap than initially posited as they both refer to seeking that which is "sacred" and personally transcendent (Pargament & Mahoney, 2005). Senreich (2013) suggested that to remain fully inclusive of diverse clients, counselors should embrace the broadest and most personalized (for clients) perspective of spirituality.

Rationale for Focusing on Basics

The United States continues to be known as a religious nation. The Pew Research Center's Religious Landscape Study (2014) indicated that approximately 70% of U.S. adults identified as being members of a Christian faith tradition. This percentage is consistent with previous studies of similar types. However, it is notable that from 1998 to 2008 the number of individuals identifying as *spiritual, but not religious* (SBNR), increased to 14% (Ammerman, 2013; Pew Forum, 2008), and in just six more years, 22% of U.S. adults in 2014 identified as SBNR (Pew Research Center, 2014). Most recently, the Pew Research Center (2019) conducted a new study with over 35,000 nation-wide participants and found that only 65% of Americans surveyed identified as Christian, down considerably from past surveys; yet, those individuals identifying as "religiously unaffiliated," including people who describe their faith identity as agnostic, atheist, or "nothing in particular" increased to 26% from 17% as surveyed in 2009 (Pew Research Center, 2019, para. 1). Many people now view religion as a more limited construct that addresses the institutional side of life, sometimes restricting and inhibiting potential, but in contrast, spirituality has come to denote individual expression that speaks to the broad boundaries of human capacity (Ammerman, 2013; Pew Research Center, 2014). Thus, the notion that people can be spiritual without being religious or religious without being spiritual is no longer an unfamiliar ideology (Pargament, 1999) as these two constructs overlap, yet convey distinctly unique aspects.

Professional Issues and Public Policy

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2017) acknowledged spirituality as a key component of wellness, pointing to the importance of expanding a sense of purpose and meaning in life. Counseling scholars agree that spirituality is integral to the overall quality of life and that, in addition to being a characteristic of wellness, it may also be utilized as a coping strategy for large numbers of clients (Adams, Puig, Baggs, & Wolf, 2015; Dobmeier & Reiner, 2012; Gill, Barrio Minton, & Myers, 2012; Linscott, Randolph, & Mayle, 2016). Additionally, experiences of spiritual and/or religious abuse have been reported to result in significant mental health issues (Matthews, 2017; Super & Jacobson, 2011; Ward, 2011). Thus, whether utilized positively for maintaining the quality of life, coping with life's difficulties, or negatively as a source of difficulty, spirituality and religion should not be ignored when conceptualizing treatment for clients of counseling services. Therefore, the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) developed specific *Competencies* (2009) for addressing guidelines that complement, not supersede, the values and standards espoused in the American Counseling Association (ACA; 2014) Code of Ethics.

The increasing incidence of religion-based values conflicts in counseling supports the need for counselors to be aware of the basics of spiritual and religious integration (Kaplan, 2014; Rose et al., 2019). The growing number of legal cases involving religion-based referrals and recent state-level conscience clause legislation (i.e., states that have passed or are expected to pass *conscience clauses* in regulations that would

permit discrimination against LGBTQI+ persons; Kaplan, 2014; Rose et al., 2019) conflict with counseling's broader Code of Ethics (ACA, 2014) and set the stage for counselors and counselor educators to become polarized, even to taking sides based on their personally held beliefs. As of 2019, according to Rose et al., 14 states within the U.S. had passed conscience clauses that permitted counselors, or any business/professional, to deny treatment or services to individuals based on counselor-held personal beliefs, including permitting refusal of service to LGBTQI+ individuals or anyone else the counselors deem to be in opposition to their beliefs, in particular, based on religious beliefs. Rose et al. (2019) indicated there are an additional 12 states with failed legislation permitting this kind of conscience clause, with eight of those states having pending legislation to try to implement such a clause again. Indeed, ACA (2016) moved its 2017 annual conference from Nashville, TN to San Francisco, CA as a direct protest of the passing of an anti-LGBTQI+ "religious freedom" conscience clause in Tennessee. It seems likely that the more polarized we become as a discipline, the less likely we are to follow ASERVIC's (2009) call to integrate spirituality ethically into the processes of counseling, supervision, and education.

Development of the ASERVIC *Competencies*

A focus on the basics is enhanced with a contextual understanding of the development of the ASERVIC *Competencies* (2009). For example, Cashwell and Watts (2010) reported that the goal of the 1995 inaugural "Summit on Spirituality" was to develop a set of competencies that would support and guide mental health professionals when counseling clients from diverse religions and spiritual backgrounds. The members of the summit were first challenged by the ongoing difficulty of operationally defining spirituality and religion (Cashwell & Watts, 2010; Giordano et al., 2014). Over a span of four years, the *Competencies* were drafted, revised, and finally submitted for approval to ASERVIC. The *Competencies* were then endorsed by both ASERVIC and the ACA and published in the *Journal of Counseling and Development* (Cashwell & Watts, 2010; Miller, 1999). The developed *Competencies* document emerged at a time when the counseling profession was strongly divided over the legitimacy of spiritual and religious interventions as being efficacious in the counseling process (Cashwell & Watts, 2010). Years of confusion and disagreement over the intent of the document led to a second summit in 2007. This second summit yielded a newly revised list of competencies that were presented to ASERVIC (Cashwell & Watts, 2010). In May 2009, the ASERVIC board voted unanimously and approved, endorsed, and copyrighted these revised competencies (Cashwell & Watts, 2010).

The *Competencies* (ASERVIC, 2009) are comprised of 14 items divided into six categories, including (a) culture and world-view; (b) counselor self-awareness; (c) human and spiritual development; (d) communication; (e) assessment; and (f) diagnosis and treatment. The preamble attempts to resolve previous confusion about the importance of spirituality and religion in counseling by providing a clear purpose for how the competencies are to be utilized, emphasizing that they

> are guidelines that complement, not supersede, the values and standards espoused in the ACA Code of Ethics. Consistent with the ACA Code of Ethics (2005), the purpose of the ASERVIC Competencies is to 'recognize diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts' (p. 3). These Competencies are intended to be used in conjunction with counseling approaches that are evidence-based and that align with best practices in counseling. (p. 1)

Given the emphasis many clients place upon the importance of spirituality and religion to their overall wellness, the ethical responsibility of counselors to protect client welfare (ACA, 2014), and the clear dictum for best practices outlined above, all counselors, supervisors, and educators are compelled to demonstrate competency in religious and spiritual integration. In their Delphi study of expert counselor educators specializing in spirituality and religion, Adams et al. (2015) indicated the use of the *Competencies* (2009) by counselors was an effective tool for counselors to incorporate spirituality and religion efficaciously into clinical work and begin their training. A unified commitment to incorporating them should further strengthen the likelihood of the

ongoing integration of spirituality and religion into the field of counseling.

Applying the Basics

To be sure, counselors must understand the differences between clients' individual interpretations of their own spirituality and religion to competently incorporate them into counseling (ACA, 2014; ASERVIC, 2009). Counselors should be prepared to join with clients who have different spiritual and religious beliefs and, most importantly, to recognize when they should refer a client to a more specialized provider, such as a spiritual director or faith-based counselor (Snodgrass, McCreight, & McFee, 2014). The notion that counselors should be well versed in many spiritual and religious norms does not mean that they are required to be *experts* in those norms or beliefs. Indeed, it is critical for counselors first to be attuned to the importance of spiritual and religious influences in the lives of their clients (ASERVIC, 2009). Snodgrass et al. (2014) urged counselors to help clients identify appropriate referrals when the counselor is ill-equipped to help the client, and to then take steps to educate themselves in preparation for future clients (ACA, 2014). Consistent with ACA guidelines, counselors, educators, and supervisors should acknowledge that their mutual call is to be inclusive of the diversity of individual and social expressions, skeptics and believers, as well as the spiritual and the religious. At the same time, they need also to be prepared to recognize personal limitations as clinicians and refer when necessary, while they address those limitations within their clinical practice towards working effectively with all clients different from themselves (Pargament, 1999; Senreich, 2013; Snodgrass et al., 2014). Thus, the primary call of the *Competencies* and ACA Code of Ethics seems clear that counselors/educators/supervisors should work to develop mastery of skills needed to work with a diversity of clients in spirituality and religion. That said, part of being an efficacious clinician is the recognition of limits to each one's expertise and a commitment to work with clients to connect them to those individuals who may better help them in some situations (e.g., referral to a spiritual director or consultation with a spiritual leader).

Common Clinical Interventions Grounded in Spirituality

Although the literature reviewed so far indicates many counselors still feel unsure or unprepared to integrate spirituality and religion in counseling, many are already using spiritually-based interventions without realizing it. Indeed, more and more researchers are contributing to a growing body of literature regarding the efficacy of spiritual and religious disciplines, such as mindfulness-based activities, as empirically sound clinical interventions (Brown, Marquis, & Guiffrida, 2013; Giordano et al., 2014; Pan, Deng, Tsai, & Yuan., 2015). For example, it is commonplace today for counselors to utilize deep breathing, guided imagery, or meditation as counseling interventions for issues as diverse as stress reduction, anxiety coping, and anger management (Brown et al., 2013; Giordano et al., 2014; Pan et al., 2015). Such tools are written about routinely in the field of counseling. For example, other counselors may be incorporating or referring clients for yoga or focusing on particular diet regimes such as the Ayurvedic tradition as adjuncts to counseling (Barnett & Shale, 2012; Berger, 2015). All of these practices mentioned, and many others that might be classified under complementary and alternative modalities (CAM), as well as those coming from the mindfulness-based perspective, have roots in spirituality or religion (Barnett & Shale, 2012; Berger, 2015). For example, yoga is a practice derived from Hinduism and deep breathing and meditation practices derive from Buddhism, Hinduism, and other Eastern religions (Barnett & Shale, 2012; Berger, 2015). If counselors already incorporate many spiritually and religiously related practices, such as these already noted, how much more of a leap is it to incorporate specifically identified/intended spiritual and religious interventions, such as prayer or use of ritual following proper training?

For Counselors

Several national surveys over the past 15 years (Harris Interactive, Inc., 2006; Pew Research Center, 2015; University of Pennsylvania, 2003) have continued to demonstrate the strong relevance of spirituality and religion in the lives of clients, which reinforces the need to include these topics in counseling. Pan et al. (2015) reported that while studies support the value of spirituality in counseling, these types of interventions are

frequently "met with suspicion" among mainstream clinical practices (p. 544). An important skill to keep in mind when integrating spirituality and religion into counseling is one of *attitude* as a counselor. Attitude connects to being conscious of ethical mandates (ACA, 2014; ASERVIC, 2009) to refrain from imposing personal values on clients, regardless of whether those values support beliefs or practices of spirituality and religion or not. Primarily, it is essential to address spirituality and religion in counseling according to the needs and determination of the client in order to utilize a client-focused (Cashwell & Young, 2020a) and wellness (SAMHSA, 2017) perspective congruently. Omitting spirituality and religion could be seen as a disservice to clients; thus, intakes, assessments, treatment plans, and on-going clinical interventions should include a client-focused emphasis on spirituality and religion (Adams, 2012; Cashwell & Young, 2020a; Young, Wiggins-Frame & Cashwell, 2007).

With the perspective of client salience in mind, it is important to ask all clients about their interests and connections, currently and formerly, with both spirituality and religion. As was emphasized earlier, numerous authors who contribute to Cashwell and Young's (2020a) most recent book on integration state that counselors should inquire about the level of importance that spirituality has in a client's life via initial assessments and through on-going clinical evaluation and intervention. The Cashwell and Young text in its most recent update would serve as a good resource for counselors as they develop intake assessments and other clinical tools to gather and explore the value spirituality and religion have in a client's life. At the simplest, counselors can add questions to their intake forms asking questions like: Is spirituality or religion important to your life? What value do you place on spirituality and religion in improving your mental health? Would you like to explore your spirituality or religion within counseling sessions? Explain your spirituality or religious faith (e.g., Buddhist, Spiritual but Not Religious, Christian). Far from being definitive, these example questions show how easy it can be to incorporate exploration of these topics within an intake process.

Counselors also need to intentionally refer to integration resources provided in the scholarly literature. There are many spiritual models of development that offer a theoretical perspective of spiritual integration that counselors can explore as part of their on-going training; for example, those developed by Fowler, Washburn, Gennia, and others (Foster & Holden, 2020). Since theoretical models can have some limitations, counselors can also turn to more concrete models of integration; one good example of an applied clinical model of spiritual integration for counseling is the Face-Spirit model (Horton-Parker & Fawcett, 2010), which explores ways that counselors can *implicitly* engage in techniques internal to the counselor (e.g., counselor focusing, prayer, meditation) and *explicitly* engage in techniques directly with the client in the session (e.g., engaging in rituals, prayer, or sacred text reading). The Face-Spirit model provides many concrete techniques counselors can use when working with clients' spirituality in sessions, such as creating a spiritual genogram with the client or using spiritual metaphors or developing sacred rituals (all explicit tools) to help a client cope with grief and loss. Horton-Parker and Fawcett (2010) and other authors, such as Dailey (2010), also encourage clinicians to develop methods to include collecting spiritual and religious information/interest via the intake process to be used in treatment plans and case conceptualization development, as was mentioned earlier. Examples of more formal spiritual assessment tools include the RCOPE or Brief RCOPE (Pargament, Feuille, & Burdzy, 2011), which measure religious coping to life stressors for individuals experiencing grief, trauma, and other significant stressors in life. These two assessment tools have been extensively tested for validity and reliability in relation to measuring the role religion can play in helping someone cope with significant life stressors (Pargament et al., 2011). These approaches represent examples of tools available to counselors who seek them out within the literature. Despite the availability of these and other resources, though, clinicians rarely use them according to past and more recent literature (Giordano et al., 2016; Walker et al., 2004).

With such a discrepancy noted among counselors, contemporary clinicians, working to attend to a truly diverse population, including aspects of religion and spirituality, must acknowledge their personal limitations and seek ways to address them through personal counseling, clinical supervision, and continuing education so as not impose their own beliefs or values on clients, but instead to work within those of the client

(ACA 2014; ASERVIC, 2009; Young & Cashwell, 2020a). By doing so, counselors can embrace a proactive broaching strategy when bringing up spirituality/religion with clients, rather than waiting for clients to mention such issues, and to resist the fear of discussing these important topics openly and with respect, including referral if needed (Cashwell & Young, 2020a; Stewart-Sicking, Deal, & Fox, 2017).

For Clinical Supervisors

Clinical supervisors with more than 10 years' experience may have received their initial training in the previous eras of "don't talk about religion." Therefore, both new and experienced supervisors should take time to review the *Competencies* (ASERVIC, 2009) in-depth and make a plan for receiving any necessary education and training to utilize them with supervisees. Additionally, supervisors should embrace learning about spirituality and religion as a necessary part of their multicultural competence (Hull, Suarez, & Hartman, 2016). In this manner, supervisors will become appropriate role models for their students and supervisees.

The ACES *Best Practices in Clinical Supervision* (2011) document designed to provide "more specific guidance for their everyday supervisory practice than can be included appropriately in a code of ethics" (Preamble, para. 3) calls for clinical supervisors to remain current in scholarly literature and trends in supervision. When working with supervisees, supervisors should facilitate the assessment of the *Competencies* (ASERVIC, 2009), and work closely with their supervisees, providing both support and accountability as they learn to integrate spirituality ethically into their clinical work. Just as counselors are called to keep up on their own ethical incorporation and balance their own beliefs and values around spirituality and religion, supervisors need to do the same to remain efficacious counselors and models for their supervisees (Hull et al., 2016). Supervisors needing additional support to do so are encouraged to explore the same recommendations listed above for counselors. Supervisors, thus, should work to integrate spirituality into their supervision sessions with supervisees and openly explore the development and growth of supervisee competence with using spirituality and religion along the lines of recommendations for counselors as developed above, and counselor educators as noted below.

For Counselor Educators

Attending to spirituality and religion in the field of counseling also extends to the role of the counselor educator. ASERVIC, by example, emphasizes a "commit[ment] to the infusion of spiritual, ethical, and religious values in counselor preparation and practice" (ASERVIC History, 2017). In the most recent national survey of the counseling profession concerning spirituality and religion, Young, et al. (2007) indicated that educating counselors to work with spiritual and religious issues effectively was essential for counselor educators. Although it is time to update this study, its conclusions still seem as accurate today as they did in 2007. In the same report, the authors stated that ACA members have responded positively to the use of the ASERVIC (2009) *Competencies* and have spoken of the need for additional training in working with clients' presenting with spiritual and religious issues (Young et al., 2007). Indeed, most counselors in the study (47% of 505 participants) reported receiving some training in issues of religion and spirituality in their coursework, a figure that means over half of all participants did not receive any formal training in these issues within their counseling program of study (Souza, 2002; Young et al., 2007).

Young et al. (2007) concluded that inconsistent curricula, and, oftentimes, a complete lack of integrative training results in counselors reporting uneasiness when considering how to address spiritual or religious issues in sessions. Subsequently, due to a perceived uncertainty and confusion as to how to address spiritual and religious issues ethically in counseling, Young et al. (2007) found many counselors (43.5%; N= 505) may avoid broaching these topics altogether There is also evidence indicating the potential for clinicians to pathologize spiritual and religious beliefs when they are unfamiliar with how to clinically approach these topics (O'Connor &Vandenberg, 2005). Young et al. (2007) stated that this could result in "misdiagnosis and inappropriate treatment goals" (p. 45). Affirming this stance, Bohecker, Schellenberg & Silvey. (2017) suggested that the Council for Accreditation of Counseling and Related Programs (CACREP) should add spirituality and religion as an additional required core counseling area.

Educators can take one clear step towards rectifying this dilemma by infusing spirituality and religion into every possible relevant course, just as we do with other issues of cultural diversity, social justice, and advocacy. Nearly any course in the counseling curriculum, at all levels of training (i.e., undergrad minors and majors in counseling or human services, master's courses, doctoral courses) is an appropriate place to discuss the ethical incorporation of spirituality and religion with clients and to help students explore how to navigate their own barriers to doing so. Discussions need to stress balancing students' personal views and beliefs with ethical standards not to impose them in clinical work. In addition to embedding spirituality and religion in the broader curriculum, specific courses could be developed as electives, such as a specific spirituality in counseling course.

For Researchers

Based on the literature discussed, it is paramount that counselor educators identify ways in which spirituality and religion can be formally and consistently integrated into counselor training programs (Young et al., 2007). Cashwell and Young (2020b) wrote:

The counseling profession is at an interesting stage regarding the integration of religion and spirituality…the importance of this domain within the counseling process is clearly recognized, yet a substantial need remains for more writing on and training in methods for doing this competently. Collectively, counselors seem to have recognized the need for shelter, but they are still building the house. (p. 360)

The identification of this dilemma presents the impetus for additional empirical inquiry exploring the barriers experienced by counselor educators that inhibits integrating training in spirituality and religion into counselor training programs (Young et al., 2007). Counseling scholars are thus encouraged to be intentional about a focus on ethical, spiritual, and religious integration and support empirical inquiry to help accomplish that goal. Efficacy studies examining types of assessment questions and integration models would be most useful to counseling students, practitioners, and supervisors. Continued qualitative work exploring student and supervisee learning experiences/integration could inform the development of best practices for educators and supervisors when working with students and supervisees.

Conclusion

Some counselors have developed a rich history of using both spiritual and religious interventions in their work (Brown et al., 2013; Pan et al., 2015). We conclude from their work that more counselors, educators, and supervisors should build upon this history, as some have demonstrated through the increased use of spiritually-based interventions such as mindfulness-based activities like yoga, deep breathing, meditation (Brown et al., 2013; Giordano et al., 2014; Pan et al., 2015), many of which have become commonplace tools in our work without us even realizing their origins in spirituality or religion. We stress the importance of counselors' understanding the differences and interconnections of spirituality and religion in their own and clients' lives. These differences should be addressed in counseling, supervision, and counselor education spheres with respect to inclusivity, diversity, and client-first perspectives. Just as counselors are called to broach other issues of diversity in counseling (e.g., affectional orientation, ethnicity, disability), all professional counselors, supervisors, and educators are called to do so with spiritual and religious issues (ACA, 2014; ASERVIC, 2009). We should not shy from this basic obligation, especially considering the potential benefit for clients.

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JPCA Test to Earn CE Credit

Note: Earn 1.5 Free Continuing Education Credits by reading selected articles in this issue. Read the articles identified below and answer 8 of the 10 questions correctly to earn 1.5 CE credit.

"If you really need it": Asian Indian American College Student Help-Seeking Behaviors (pp. 4-14)

1. In the current study, AIA college students described experiences that contributed to the development of which of the following principle themes?
☐ a. Beliefs about mental health counseling and Coping
☐ b. External pressure, Professional help, Academics
☐ c. Beliefs about mental health counseling, Traditional values, Coping
☐ d. Professional help and Academics

2. Nath & Ahmad-Stout (2013) described studies examined differences amongst _____, but not _____.
☐ a. Chinese, Japanese, Korean Americans; South Asian
☐ b. Chinese, Japanese, Pakistani; South Asian
☐ c. South Asian, Chinese; Korean Americans
☐ d. South Asian, Cambodian; Japanese

3. One of the limitations of the current study is:
☐ a. The sample only consisted of males
☐ b. The sample size was small
☐ c. The sample size consisted of Mid-West AIA college students
☐ d. The sample consisted of randomly selected male and female AIA college students

4. For the purposes of this current study, "threshold" was defined as:
☐ a. a point at which juggling psychological stressors for participants becomes too difficult
☐ b. a strip of wood, metal, or stone forming the bottom of a doorway and crossed in entering a house or room
☐ c. the transition from high school to college
☐ d. a point at which juggling physical stressors for participants becomes too easy

5. Many participants responded in a/an ____ when their parents were able to be _____.
☐ a. ambivalent manner, listeners
☐ b. negative manner, open-minded
☐ c. ambivalent manner, helpful
☐ d. positive manner, open-minded

Back to Basics: Establishing a Foundation for Spiritual/ Religious Integration in Counseling and Counselor Education (pp. 15-25)

6. Which of the below is not part of definitions for spirituality?
☐ a. The search for meaning without a belief in a higher power
☐ b. Commitment to a religion
☐ c. Internal feelings, motivations, or thoughts to something bigger than self
☐ d. Rules, behaviors, and protocols

7. Which of the following is true about religion within America today according to studies cited?
☐ a. The number of people identifying as spiritual but not religious is on the decline
☐ b. Alternative and new religions are on the increase
☐ c. The number of people identifying as Christian has remained relatively stable
☐ d. One cannot be religious without being spiritual

8. Which association has competencies all counselors should follow to become skilled with addressing spiritual issues with clients, students, or supervisees?
☐ a. ALGBTIC
☐ b. ASERVIC
☐ c. AVERSICA
☐ d. ACSSW

9. Which of the following is not a sufficient reason to address spirituality or religion with clients, students, or supervisees?
☐ a. Increasing incidences of religion-based conflicts in counseling
☐ b. The counselor's interest in spirituality or religion
☐ c. The client's interest in meaning and purpose in life
☐ d. ACA Ethics Code mandates

10. What does salience relate to when exploring spirituality and religion with clients?
☐ a. How important the topics are to the individual client
☐ b. The counselor's or counselor-in-training's level of expertise on these topics
☐ c. The spirituality upbringing of the counselor
☐ d. It is a stage of development on the Face-Spirit model of spiritual integration

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

Feedback

Please rate the following items according to the following scale:

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

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

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