Exploring Clinical Mental Health Counselors-in-Training Experiences Preparing to Counsel Clients with Intellectual Disability

by

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Abstract

This phenomenological study explores the perceptions and experiences of counselors-in-training as it relates to their preparation to provide counseling services to individuals with intellectual disability. Semi-structured interviews were completed with participants who are currently enrolled in a masters-level, CACREP-accredited clinical mental health counseling program within the United States. Using a hermeneutic phenomenological approach, this research seeks to better understand how counselors feel about providing counseling services to individuals with intellectual disability, as well as what their preparation to provide these services has been like in their training thus far. The goal of this study was to have ten counselors-in-training complete the interview process, then utilize inductive coding to identify themes from the data. Implications for counselors and counselor educators, as well as the relevance of the research findings are discussed.

Acknowledgements

As I type this, with my first born daughter laying on my chest sleeping, the first thought that comes to my mind is: What a special physical representation of what I consider the most important part of being a counselor and counselor educator - being a human being first, with real-life dreams, struggles, emotions, and personal roles such as “wife, mom, daughter, friend” that allow me to empathize with my clients and students from a place of humility and honor; then, a counselor, researcher, teacher, mentor, advocate, etc. Being proud of my human-ness is one of the greatest areas of growth I have experienced through my doctoral experience.

The second thought I have is: Wow, this truly was a labor of love from more people involved than just myself… you know what they say, “sleep when the baby sleeps… write your dissertation when the baby is writing their dissertation…” (kidding, of course). The opportunity to seek my doctoral degree simply would not have been possible without the support and care I received from so many people, to whom I owe so much gratitude, admiration, and love. Thank you to my partner, family, friends, mentors, chair, committee, outside reader, instructors, and peers for believing in me and in many ways, taking a chance on me through the resources you have given to me to complete this journey. I truly cannot express my gratitude enough.

In addition to my support system, I want to thank those who have trusted me to hold space and walk along the healing and growth process with them: My clients, their support systems, my students, and the individuals with disabilities (including my sassy, intelligent, passionate sister, Chelsea), who have informed so much of my work to increase access to quality mental health services for all. It is truly their experiences, motivation for growth, self-advocacy,

and resilience that deserve to be celebrated more than anything. I promise to do my part to continue this important work we have started together.

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Chapter 1: Introduction and Literature Review

The term "intellectual disability" describes a particular condition in which an individual's adaptive behavior and intellectual functioning are considered more limited than that of their typically developing/neurotypical peers (American Association on Intellectual and Developmental Disabilities, n.d.). The American Psychiatric Association's fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; 2013) identifies intellectual disability diagnosis using the following criteria: (1) Deficits in intellectual functioning (reasoning, problem-solving, planning, abstract thinking, judgment, academic learning, experiential learning; usually measured by IQ tests scoring at or below 70) and (2) Deficits or impairments in adaptive functioning (communication, social skills, personal independence at home or in community settings, school/work functioning). Intellectual disability is typically identified in individuals meeting the above criteria before the age of 22 (American Association on Intellectual and Developmental Disabilities, n.d.). There is currently no comprehensive study to measure the prevalence of adults with intellectual disability in the United States. Estimates based on data from the National Health Interview Survey and Census data predict that every 9.5 per 1,000 adults born between the years 1980 and 1999 in the U.S. are diagnosed with an intellectual disability (Benevides et al., 2024).

People with intellectual disability have a higher chance of experiencing mental health related concerns than their neurotypical peers, with studies showing individuals with intellectual disability are three times more likely to experience a co-occurring mental health related diagnosis (Bradley et al., 2019; Evans et al., 2012; Scott & Havercamp, 2014). However, current research suggests that mental health services available, from clinicians that feel competent in treating this population across the United States, are not meeting the need for services (Cooper et

al., 2007; Einfeld et al., 2011; Einfeld & Tonge, 1996; McCarthy & Boyd, 2002; Walton et al., 2022).

Recent literature suggests that individuals with intellectual disability continue to face stigma when it comes to receiving mental health care, even in places such as emergency departments when there is a lack of appropriate community-based mental health services, resulting in mental health needs of individuals with intellectual disability escalating towards being considered a crisis (Spassiani et al., 2017). Mason and Scior (2004) name that diagnostic overshadowing acts as a barrier to treatment rooted in stigma against this population. Mason and Scior (2004) define diagnostic overshadowing as a state of bias that impacts providers' tendency to attribute instances of crisis, such as self-injurious behavior, to the intellectual disability itself rather than the potential diagnosis of a co-occurring mental illness or related symptomology. Furthermore, in their 2017 qualitative study, Spassiani and colleagues interviewed individuals with intellectual disability and their families regarding their experiences seeking mental health care from emergency departments when in a state of crisis. Participants reported feeling disrespected or dismissed by emergency personnel when attempting to access emergency related mental health care, in addition to noting concerns about the staff appearing unprepared to support individuals with intellectual disability in crisis related to their mental health. Similarly, there are indications in the literature that the quality of mental health services for individuals with an intellectual disability could be lower than services provided to those without a diagnosed intellectual disability (Krahn et al., 2006; Sheehan et al., 2015; Weiss & Lunsky, 2010).

Discourse on the topic of mental health services for individuals with intellectual disability often raises the question of whether or not professionals in fields like clinical mental health counseling are prepared to help this group of people. Prior literature suggests that mental health

professionals may have limited confidence, knowledge, and skills to work with individuals with intellectual disability (Man et al., 2016; Weise & Troller, 2017) as well as insufficient training in working with this population (Weise & Troller, 2017). Specifically, when providing mental health services to a person with an intellectual disability versus a person without an intellectual disability, Weise and Troller (2017) found that mental health professionals felt less confident in the following areas of clinical practice: 1) recognizing when a patient may have a mental disorder; 2) communicating effectively; and 3) understanding potential adverse side effects of psychotropic medication.

To further investigate the perceptions and experiences of counselors-in-training as it relates to their preparation to provide counseling services to individuals with intellectual disability, this study utilized semi-structured interviews with participants who were enrolled in a masters-level, CACREP-accredited, clinical mental health counseling program within the United States. At the conclusion of the study, implications for counselors and counselor educators related to preparing counselors to work with individuals with intellectual disability, as well as the relevance of the research findings are discussed. The following literature review section will explore a brief historical overview of experiences of individuals with intellectual disability in the United States, applicable legislation, the current state of counseling services for individuals with intellectual disability, and the ethical and accreditation standards that relate to the teaching of skills needed to provide services to this population.

Brief Historical Perspective of Intellectual Disability in the United States

Institutionalization of Individuals with Intellectual Disability

Looking at the treatment of individuals with disabilities within the United States from a historical perspective, there are numerous movements that have been responsible for fighting

against practices that have been exclusionary in nature against this population (i.e., protests against the Eugenics Movement (Smart, 2009), the Civil Rights Movement and the Disability Rights Movement). During World War I in the early 1900s, people who had been born with a developmental or intellectual disability were institutionalized, with over 30 states passing laws enforcing institutionalization by the year 1914 (Stroman, 2003). In the 1940s, the establishment of the National Mental Health Foundation exposed the abusive conditions that were occurring in institutional settings in which individuals with disabilities had been required to reside (Browning, 1998). In 1962, President John F. Kennedy called for deinstitutionalization of individuals with disabilities and increased services offered by community agencies to aid in this transition (Shorter, 2000). Two years later, the *Vocational Education Act* was passed (P.L. 88-210), encouraging educational systems and vocational rehabilitation to work together to integrate careers and educational experiences for individuals with disabilities. When the *Social Security Act* was amended in 1965, Medicare and Medicaid were established, implementing subsidized health care for elderly Americans and individuals with disabilities, which increased access to vital services for these individuals.

Legislation Addressing Disability Rights

Section 504 of the Rehabilitation Act (1973) was the first piece of legislation in history that specifically addressed the rights of people with disabilities at the federal level, and guaranteed protection from discrimination while section 705(20) stated that individuals with disabilities could not be denied or excluded from activities that receive federal financial assistance (29 U.S.C. 115). The 1990s saw two landmark laws established which changed the way services for individuals with disabilities were viewed: rather than being seen as an act of charity, these services became necessary and integrative according to the *Americans with*

Disabilities Act of 1990 (ADA) and the *Individuals with Disabilities Education Act* of 1990 (IDEA). Following the disability rights movement, which established the Americans with Disabilities Act in the 1990s, the *21st Century Cures Act* (Public Law 114-255) identified the need for states and community programs alike to establish and provide community systems of care for individuals with co-occurring disorders such as intellectual disabilities and mental health conditions.

The Call to Action: Mental Health Services for Individuals with Intellectual Disability

As a result of the *21st Century Cures Act* (Public Law 114-255), the National Association of State Mental Health Program Directors (NASMHPD, 2017) created a white paper entitled *The Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System,* which noted that individuals with intellectual disabilities are estimated to be more than three times higher at risk for having a diagnosed mental health condition including diagnoses such as major depressive disorder, bipolar disorder, anxiety disorders, impulse control disorders, major neurocognitive disorders, and stereotypic movement disorders (Bradley et al., 2019). As noted by Evans and colleagues (2012, p. 1,098), "People with intellectual disability (ID) experience higher rates of major mental disorders than their [peers without intellectual disability], but in many countries have difficulty accessing appropriate mental health services." Scott and Havercamp (2014, p. 552) note that stress for individuals with intellectual disabilities was "...significantly correlated with both mental illness and severity of behavior problem[s], with each additional stressor increasing the odds of poor mental health by 20%." Through the identification of these co-occurring conditions, it is important for counseling professionals to examine the ways in which the field aims to meet the need to provide individuals with intellectual disabilities mental health services.

Current State of Counseling Services for Individuals with Intellectual Disability

Application of Rehabilitation Counseling Specialty

The American Rehabilitation Counseling Association (ARCA) was founded as part of the American Counseling Association (ACA) in 1957. Rehabilitation Counseling is a specialty area of counseling that was designed to focus primarily on disability advocacy and vocational rehabilitation counseling for individuals with disabilities. Unfortunately, even with specialized rehabilitation training programs being developed to provide education specifically in serving populations including individuals with disabilities, research suggests that mental health services over the last two decades provided to people with intellectual disabilities (Dekker & Koot, 2003; Einfeld et al., 2006; McCarthy & Boyd, 2002) does not match the prevalence rates of mental illness in this population (Cooper et al., 2007; Einfeld et al., 2011; Einfeld & Tongue, 1996; McCarthy & Boyd, 2002). Additionally, when an individual with an intellectual disability presents for mental health services, their disability may not be the source of the pathology they are seeking to treat and instead may be focused more on the mental-health related concerns that all mental health professionals should be versed to treat as part of their training.

Limitations for Current Mental Health Services

In Marshall and colleagues' (2024) content analysis study investigating keywords found in the articles published between 2016 and 2020 across six counseling-related academic journals , nothing related to persons with disabilities appeared as a top keyword in any of the journals reviewed. While the literature remains limited when it comes to investigating the attitudes and self-efficacy levels of clinical mental health counselors providing therapy services to individuals with intellectual disabilities in the United States, prior studies investigating health accessibility as it relates to services for people with intellectual disabilities have identified a lack of

specialized services and ineffective service collaboration as deficits in services for this population (Buckles et al., 2013). Whittle et al.'s (2018) research identified barriers for access to mental health care for individuals with intellectual disabilities: limited and scarce resources, logistical and geographical issues, organizational barriers, silo-ing of service sectors, competing service models, failure of interagency communication, inconsistent eligibility criteria, transition, unclear referral pathways, difficulty identifying need, lack of help-seeking, diagnostic overshadowing, misidentification of mental disorders, clinical knowledge deficits, severity of intellectual disability, and social determinants. Another potential barrier to the provision of counseling services to individuals with intellectual disabilities is the discovery that support staff working with individuals with intellectual disability report experiencing considerable amounts of stress (Hatton et al., 1999) and that as a result, coping and social support are impacted when exploring the experiences of these staff members (Devereux et al., 2009).

Application of Ethical Codes and Standards

2024 Council for Accreditation of Counseling and Related Educational Programs Standards

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) incorporates diversity and inclusion as part of their teaching practices in preparation programs as noted in their 2024 standards in section 2 standard B.1., which states, "The program objectives reflect current knowledge and projected needs concerning counseling practice in a diverse, multicultural, and global society with marginalized populations." Additionally, section 3 of CACREP's 2024 standards outlines foundational counseling curriculum requirements for the content area of courses that relate to the treatment of traditionally marginalized populations, such as individuals with intellectual disability, through the following standards by stating, "Counselor

education programs must document where and in what manner each of the numbered standards listed below is covered in the curriculum:

> "…the role and process of the professional counselor advocating on behalf of and with individuals receiving counseling services to address systemic, institutional, architectural, attitudinal, disability, and social barriers that impede access, equity, and success" as it relates to professional counseling orientation and ethical practice (section 3.A.4.);
>
> "…the effects of historical events, multigenerational trauma, and current issues on diverse cultural groups in the U.S. and globally… the effects of stereotypes, overt and covert discrimination, racism, power, oppression, privilege, marginalization, microaggressions, and violence on counselors and clients… disproportional effects of poverty, income disparities, and health disparities toward people with marginalized identities…principles of independence, inclusion, choice and self-empowerment, and access to services within and outside the counseling relationship…. And strategies for identifying and eliminating barriers, prejudices, and processes of intentional and unintentional oppression and discrimination" as it relates to social and cultural identities and experiences (section 3.B.4, 5, 7, 8, and 9);
>
> "…models of psychosocial adjustment and adaptation to illness and disability" as it relates to lifespan development (section 3.C.8);
>
> "…strategies for improving access to educational and occupational opportunities for people from marginalized groups" as it relates to career development (section3.D.11);
>
> "…. theories and models of counseling, including relevance to clients from diverse cultural backgrounds… culturally sustaining and responsive strategies for establishing and maintaining counseling relationships across service delivery modalities… strategies

> for adapting and accommodating the counseling process to client culture, context, abilities, and preferences … developmentally relevant and culturally sustaining counseling treatment or intervention plans" as it relates to counseling practice and relationships (section 3.E.1, 7, 11, and 13).

Counselor educators who adhere to CACREP's teaching standards are called to help facilitate growth in the areas of multicultural sensitivity and social advocacy as listed above. The CACREP standards used to guide accredited programs across the country tend to be more descriptive than prescriptive, offering little to no guidance to counselor education programs on how to incorporate their standards into coursework, or what courses should be taught. Adams et al. (2018) suggest that attention should be directed towards the areas in which action can be taken to create change rather than focusing on feelings of hopelessness. One method for addressing this change is integrating social justice issues in counseling courses that do not solely focus on multiculturalism and/or diversity as a topic. However, others suggest that a single multicultural course design that addresses the multicultural competencies may be a more effective approach to increasing the level of competence and openness in interacting with diverse populations (Celinska & Adams, 2016).

American Counseling Association Code of Ethics (2014)

Similarly, the ACA Code of Ethics (2014) notes the importance of advocacy and cultural competency in multiple sections, including Section A.2.c, Developmental and Cultural Sensitivity; A.4.b., Personal Values; C.2.a., Boundaries of Competence; and C.2.f., Continuing Education. Section A.2.c. asks counselors to utilize language that is appropriate for developmental level and cultural competence when engaging in practice, and to adjust practices as necessary to fit these needs. Section A.4.b. asks counselors to be aware of and avoid imposing their own values, attitudes, beliefs, or behaviors onto others while respecting diversity and

seeking training in areas they are not competent in. While Section C.2.a. asks counselors to practice only within their areas of competence, this does not mean counselors are exempt from working with diverse populations based on race, ethnicity, religion, sexual orientation, gender identity, or ability/disability status. Section C.2.f. asks counselors to recognize the need for continued education by embracing counseling humility and maintaining awareness of current issues within the field. With both the combined service needs identified for this historically marginalized population, as well as the values instilled into the counseling profession by ACA and CACREP, it is important to explore the ways in which counselors perceive their scope to provide services to individuals with intellectual disabilities.

Solutions Proposed by Literature

Teaching Practices to Increase Knowledge

Following Whittle et al.'s systematic analysis of literature on the subject in 2018, the following were identified as enablers for access to mental health care for individuals with intellectual disability: Innovative models of service delivery, clear referral pathways, established protocols, single point of access, interagency collaboration, education on the subject, capacity building, and up-skilling and training service providers. This impacts the field of counselor education as it includes a call to continue to help fill the current gap in increasing education on the subject of working with this population. Additionally, Walton et al.'s 2021 scoping review found that an increase in mental health related staff training in working with this population could benefit this population as it relates to increasing timely services and appropriate treatment.

In looking at what persons with intellectual disability view as important in their mental health care professionals, Weise et al. (2018) identified several critical areas. Participants reported that they believe mental health professionals should be adaptable, able to

communicate (on a developmentally appropriate level and without rushed time constraints), and work with a person's support network to reach identified goals. The findings also suggest the importance of a mental health clinician's ability to build rapport and trust with this population by demonstrating respect and suggest that people with intellectual disability could present as valuable educators and peer workers in teaching these attributes.

While no two clients may present the same way in neuro-typically developing populations, the same is true regarding those with intellectual disability and will still need to be met with the same, person-centered applications. To begin to implement educational practices that help counselors-in-training feel more prepared to work with this population, it is important to first take inventory to identify what counselors-in-training currently perceive to be working in preparing them to work with this population, if anything at all, as well as how prior exposure to this population might impact their confidence in working with this population.

Current Recommendations for Teaching Practices from the Literature

In Kelley et al.'s 2023 systematic review of the literature investigating empirically reviewed training on mental health care for direct support professionals serving individuals with intellectual disability, the authors discovered only fifteen articles. While the training programs noted were associated with some positive outcomes for those direct support professionals and/or individuals with intellectual disability, there were large limitations to those studies, including small sample sizes and lack of replication of training to further explore efficacy, highlighting this area as a largely understudied area of practice (Kelley et al., 2023). The most used frameworks guiding training programs for direct support professionals in Kelley et al.'s 2023 systematic review of the literature included a review of the biopsychosocial model and

implementation of cognitive behavioral therapy-based conceptualization and interventions, including third-wave cognitive therapy approaches such as dialectical behavioral therapy.

Hay and colleagues (2023) conducted a systematic review of the literature investigating interventions to improve the attitude, knowledge, and confidence of healthcare professionals, including primarily medical doctors and nurses, in treating patients with intellectual disability post-1980 that were published in English. In their study, all ten articles found included interventions using a theoretical component that consisted of reading materials, seminars, and/or didactic lectures, with 30% of the articles and interventions reviewed including some form of an experiential portion. Four of the ten articles and interventions utilized interactive components such as group discussions, workshop-style activities, or exercises, while two of the ten articles and interventions utilized an immersive component such as site visits or home visits, including contact with families or individuals with intellectual disability. Of the articles and interventions reviewed, 40% reported effectiveness in changing perceived confidence and attitudes, along with 60% reported achieving improvement in healthcare professionals' knowledge or skills based on Kirkpatrick classification scoring (Hay et al., 2023). Those four articles noted to have included interactive components as part of the intervention were the same four articles included in the 40% noted above reporting effectiveness in changing perceived confidence listed above (Hay et al., 2023).

Statement of the Problem

Present literature supports the need for greater implementation of training and education for clinicians working with individuals with intellectual disabilities to mitigate bias and increase competent services (Man et al., 2016; Weise & Troller, 2017). To determine how counselor education programs might address this, more is to be explored regarding current interventions in

counseling training programs related to working with individuals with intellectual disability, as well as counselors'-in training perception of the effectiveness of these interventions. As it stands, although CACREP's 2024 standards outline requirements including multicultural training and preparedness in each of their eight core areas, the way they ask programs to go about meeting these standards is more descriptive than prescriptive. It is up to programs to decide how to structure courses and syllabi as they relate to fulfilling the standards, with most programs opting for a 60-credit hour requirement. With all CACREP requires their programs to cover in coursework materials, and without explicit requirements on how to incorporate pedagogy preparing counselors to work specifically with this population, counselor educators must get creative on infusing teaching practices that prepare counselors to be competent in working with this population as to not discriminate against potential future clients solely based on their disability status. Therefore, data informing counselor educators on effective teaching practices in this area could be useful in identifying how counseling programs can infuse interventions to prepare counselors to feel more confident in working with individuals with intellectual disability.

Importance of Study

The findings from this study will add to the existing literature by informing counselor educators of what is currently perceived by clinical mental health counselors-in-training as helpful in preparing to work with individuals with intellectual disability. Outcomes could inform counselor educators on which teaching interventions are viewed by counselors-in-training as most beneficial in preparing them to work with this population, as well as what counselors-in-training would like to experience in addition to current practices to prepare for providing these mental health services. By investigating these perceptions, the gaps in current

literature can be addressed from the perspective of those currently preparing to work with diverse populations, including providing counseling services to individuals with intellectual disability.

Purpose of Study

This study explores clinical mental health counselors-in-training perception of preparedness in working with individuals with intellectual disability. This study used a semi-structured interview protocol rooted in a phenomenological approach to address this focus. Specifically, the data collected from the semi-structured interview process in this study aims to explore the experiences of counselors-in-training by addressing the following: (1) How would participants describe the training their programs have implemented related to working with individuals with intellectual disability? (2) What, if anything, do participants perceive to be helpful in preparing to work with this population of individuals with intellectual disability in the counseling field?

Summary

Chapter 1 of this dissertation focuses on identifying current gaps in the literature as it relates to best practices for training counselors to work with individuals with intellectual disability, as well as proposing the goal of this study, which is to aid in exploring counselors-in-training perspectives of their educational experiences to provide counseling services to this population. Although prior literature has identified an increased risk for individuals with intellectual disability to be diagnosed with a co-occurring mental health condition than those without an intellectual disability (Bradley et al., 2019; Evans et al., 2012; Scott & Havercamp, 2014) along with a lack of availability of quality mental health services (Cooper et al., 2007; Einfeld et al., 2011; Einfeld & Tongue, 1996; McCarthy & Boyd, 2002; Walton et al., 2022),

there is still room to explore how the mental health field might increase competent, quality services for this population moving forward. Chapter 2 will outline the research methods proposed to collect and analyze the experiences of counselors-in-training as it relates to their education on providing services to individuals with intellectual disability.

Chapter 2: Research Methods

Description and Rationale for Qualitative Design

Prior studies have identified a need for greater quantity and quality of services for individuals with intellectual disability (Cooper et al., 2007; Einfeld et al., 2011; Einfeld & Tongue, 1996; Krahn et al., 2006; McCarthy & Boyd, 2002; Sheehan et al., 2015; Weiss & Lunsky, 2010). This study addresses a gap in the literature by asking counselors-in-training what they perceive to be helpful in preparing to work with this population, as well as the context around their personal experiences with this population. This study also explores counselors'-in-training attitudes towards and perceived preparedness in counseling people with intellectual disability, while contributing qualitative findings to a field in which qualitative studies only accounted for approximately 15% of articles published across six counseling related journals from the years 2016-2020 (Marshall et al., 2024). To understand counselors'-in-training perception of preparedness, a semi-structured interview approach rooted in hermeneutic phenomenology was selected, as each individual counselor-in-training enters their counseling programs with unique experiences and backgrounds that have the ability to influence the phenomenon being investigated by this study: their perspectives and perception of preparedness to provide mental health services to individuals with intellectual disability (Ramsook, 2018; Fuster, 2019).

Phenomenology

While the interview protocol for this study included questions about each individual's unique background and experience, a phenomenological approach was chosen over a narrative-based approach to explore the larger phenomena through lived experiences of preparation of counselors-in-training to provide services to individuals with intellectual disability (Creswell,

2014). Phenomenology in this context is less concerned with cause and effect, seeking instead to gain an in-depth understanding of the experiences of those preparing to work with this specific population to inform the current literature of where further intervention might be needed to improve services for individuals with intellectual disability (Creswell, 2014). Interviewees' experiences and rich data combined in this study will aid in creating an understanding of what counselors-in-training might need to better prepare them to work with this population and what is already working well in preparing them.

Hermeneutic Phenomenology

Hermeneutic phenomenology focuses on how the lived experiences of participants might explain a broader phenomenon (Fuster, 2019). While the phenomenological approach centers on the larger phenomenon at hand, hermeneutic phenomenology still poses that each individual participant has their own unique life story and interpretation that contributes to the understanding of phenomena as a whole (Ramsook, 2018). As a result, each individual's experiences add to the meaning they associate with specific phenomena (Fuster, 2019). This approach is appropriate for this study as it aims to take into consideration how counselors'-in-training prior exposure to and contact with individuals with disabilities, specifically intellectual disability, plays a role in their perceptions and attitudes of preparedness to provide services to this population alongside their training. This approach allows the researcher and participants to consider how experiences with individuals with disabilities, or lack thereof, might contribute to meaning-making and perception of preparedness in working with this population as the overall phenomenon.

Paradigmatic Commitments

Epistemology. The researcher asserts that knowledge is gained through a social constructivist lens, meaning the learning process is largely impacted by the influences and

experiences around us (Vygotsky, 1978). In this study, learning will occur between interviewer and interviewee during the data collection process to answer the research questions posed while honoring the knowledge each interviewee has to offer from their own contact with persons with disabilities/educational experiences with others.

Ontology. The researcher views the interviewee/participant as the expert on their own experiences and as such, believes interviewees hold the richest data related to preparedness in working with various populations. Additionally, data found in the literature review portion of the study has been taken into consideration from the perspective of individuals with intellectual disability to define what "quality services" are in this context. As a result, member checking post-data collection is important to the reporting process to ensure the participant feels as though their experiences and shared information are accurately represented in the data; this is also in line with hermeneutic phenomenological methods (Ramsook, 2018).

Axiology. The researcher believes there is value in understanding the experiences of counselors-in-training to further inform counselor educators on what is needed to prepare counselors-in-training to provide quality counseling services for individuals with intellectual disabilities. By asking those directly preparing to work with this population what is needed to support them, we can identify what is most valuable to implement while considering the resources counselor educators possess.

Epoché

Combining the researcher's paradigmatic commitments as well as the traditional approach of hermeneutic phenomenology, all data collected centers the participants' lived experiences and perceptions while the researcher will aim to address and set aside their own knowledge, experiences, and opinions through epoché (Moustakas, 1994). In seeking to achieve

epoché, the researcher engaged in identifying reflexivity by exploring personal beliefs, biases, and inclinations before collecting data (Creswell, 2014). Additionally, as recommended by Tracy's (2010) "big-tent" criteria, the researcher utilized member-checking and triangulation to support the validity of findings from the research study. Triangulation was conducted by having an external reviewer read through the findings and provide feedback to the researcher. This reviewer consisted of a peer auditor who is familiar with the field of counseling and the qualitative approach used in this study and who can audit research decisions and interpretations. Member-checking took place at the end of the data analysis process by asking each participant to review the findings and provide feedback to ensure their experiences are portrayed correctly from their viewpoint. Member-checking helped to prevent the researcher's bias from misinterpreting experiences of participants.

Reflexivity Statement

I, the researcher, approached this study as an able-bodied, White female while acknowledging my own privileges as such. I also take into consideration potential biases I hold as someone who is the sibling of an individual with a physical disability, as a counseling clinician working with individuals with various disabilities, and the impact my experiences have had working at the post-secondary level in inclusive higher education for over six years, causing me to be very aware of where gaps currently exist in my community's mental health care for individuals with disabilities. These potential biases may include assigning more positive or optimistic views of implementing mental health counseling for the disability community than other colleagues as a result of my experiences. I recognize my perspective is not the only perspective in working with this population, and as an able-bodied individual, I cannot speak on behalf of the intellectual disability community to state what is or is not desired of counselors

providing them services. Also, having been exposed to individuals with disabilities throughout my lifetime, I cannot speak from my own experience on what individuals who have not been exposed to this population may need to feel comfortable and confident in working and interacting with this population. To minimize any potential bias in the interpretation of participants' responses, member checks and peer review of themes were conducted upon completion of the coding process.

Procedures

Participant Selection

Participants for this study included masters-level, CACREP-accredited clinical mental health counseling students at various universities across the United States. Participants were adults ages 18 and older, students who were enrolled in their master's level program at the time of the interview process, attended part-time or full-time, and may or may not have experienced prior exposure or contact with a person with an intellectual disability.

To ensure participants qualified for inclusion in the study, they were asked to complete a brief demographics questionnaire via a Qualtrics survey (Appendix E), which was reviewed by the Principal Investigator (PI). The Qualtrics survey began with an information letter about the study and asked participants if they agreed and consented prior to moving forward with completing demographic information for the study. This demographics questionnaire found in Appendix E aided in ensuring they met the participant criteria listed above. When it was determined they met all inclusion criteria, the PI reached out to the participants using the contact information provided in the survey. At the end of the survey, participants had the option to select their own pseudonym for the study or opt to have one assigned to them by the PI.

Creswell (2014) suggests that for a phenomenological study, a reasonable sample size should consist of three to twenty-five participants. Additionally, Ramsook (2018) emphasizes that based on a hermeneutic phenomenological approach, it is up to the primary investigator (PI) to determine sample size based on purposive sampling and resources for the study at hand. Considering time and resources, including incentive for the study from the departmental grant awarded to the PI for the study, the PI is sought a sample size of ten participants while keeping in consideration that the number could have varied slightly depending on when saturation was reached (Saunders et al., 2018). Questions were added during the semi-structured interview process as part of the hermeneutic circle to better understand phenomena occurring for participants (Gadamer, 1975). Such questions included asking participants to define how an intellectual disability is diagnosed using DSM-5 TR criteria to reduce any misunderstanding during the interview process, and asking participants if there was anything they would like to add to the data at the end of the interview after answering the questions listed in the interview protocol. Each participant was asked to complete an individual, one-on-one interview, which is the method of data collection recommended when using a hermeneutic phenomenological approach to assist the researcher with identifying each individual's interpretation of their experiences (Fuster, 2019; Ramsook, 2018). Using the departmental grant funding awarded, which totaled $500, each participant was given a $50 e-gift card to Amazon.com upon the completion of their demographic questionnaire and their one-hour interview.

Participant Recruitment

Upon approval from the institution's Institutional Review Board (IRB), participants for the study were recruited through purposive sampling. Purposive sampling was chosen following recommendations by Fuster (2019) and Ramsook (2018), outlining the process for hermeneutic

phenomenological approaches to ensure participants meet the thick description requested to investigate specific phenomena for the study. Recruitment included using a counseling listserv through Cesnet-L. In addition, emails, including recruitment requests, were sent to program coordinators of CACREP-accredited clinical mental health counseling programs at academic institutions across the United States (Appendix B).

Program coordinators' contact information for each program was obtained using CACREP's website, cacrep.org, which provides a list of CACREP-accredited programs along with contact information for program coordinators. Emails were sent to both CACREP-accredited clinical mental health counseling program coordinators as well as recipients of emails through Cesnet-L. These emails included information explaining the purpose of the study, the voluntary nature of the study participation, anonymity potential harm, as well as an information letter (Appendix A) and the primary investigator's email address with a link to the initial demographics screening questions used to determine eligibility to participate. The PI did not have any direct contact or communication with the potential participants prior to them completing their demographics questionnaire and consent document, as the PI asked counselor educators/coordinators who receive the initial email to forward the invitation email to their students.

Interview Protocol

The primary investigator (PI) conducted one-on-one semi-structured interviews via secure password-protected Zoom meetings. A total of twelve questions and sub-questions were created with the goal of eliciting the experiences of counselors-in-training preparing to work with individuals with intellectual disability (Appendix E). The semi-structured interviews were thought to last approximately 45 to 60 minutes but tended to last 20 to 40 minutes, with the

average interview time of 30 minutes. The process of creating the semi-structured interview protocol followed guidance from hermeneutic phenomenological approaches, including questions that allowed for thick description to be included in answers as well as background about participants' unique lived experiences (Fuster, 2019; Ramsook, 2018). The questions were peer-reviewed by counselors familiar with CACREP's program standards to ensure the language used is developmentally appropriate for counselors-in-training who are in the beginning stages of their counselor education programs or their practicum and internship portions in the later stages of their programs. Additionally, questions were examined by peers to reduce bias by ensuring they are not leading.

Data Analysis

Once interviews concluded, the researcher saved recorded audio from the interviews to a secure, password-protected Box.com account under the participant's pseudonym. The researcher then utilized the software program NVivo to transcribe and code themes occurring within the interviews to identify larger phenomena that may be present in the data. Artificial Intelligence (AI) was used through the automated transcription process within NVivo. The researcher ensured close attention to including thick description in coding procedures, as thick description adds to the context of individuals' experiences related to their meaning-making from a hermeneutic lens (Ramsook, 2018).

Data was coded inductively, allowing themes to emerge from the lived experiences of counselors-in-training (Creswell, 2014; Fuster, 2019; Ramsook, 2018). The first stage of analysis included identifying significant statements related to research questions posted in the study, followed by the second stage of organizing these statements into groups of similar themes through repetition and shared experiences (Creswell, 2014). Once the researcher categorized

these themes with supporting quotes from the interviews, the researcher shared the findings with the peer auditor and members for member-checking to commence to ensure the lived experiences of participants were accurately reflected in the themes identified in the research (Creswell, 2014). During this process, the peer reviewer reported, “The chosen themes feel very much in line with your interview structure and participant responses.” One suggestion was made to add sub-themes for the third and fourth themes identified: Diffusion of responsibility and desire for further training, which the author modified in the findings section of this dissertation as a result of this feedback. Ten out of ten participants approved the themes derived following coding of their interview transcripts during member checking, with only one participant (participant pseudonym “Anne,”) providing additional feedback which stated, “Excellent! Very interesting to read through all of the responses and information you put together.”

While chapter 2 set a foundation for the structure of this study, chapter 3 of this dissertation will describe the background of each participant from the study. Each description will include the participant’s prior exposure to individuals with disabilities as well as their current placement for their internship experience. Additionally, the next chapter will describe the themes that emerged during and after the interview processes.

Chapter 3: Findings

Participant Descriptions

For the data collection process, ten masters-level counselors in training attending CACREP accredited programs completed interviews about their experiences preparing to provide counseling to future clients. Interview questions were narrowed down to discuss participants' experiences preparing to work with individuals with disabilities, and more specifically, intellectual disability. These participants joined their interviews virtually via the Zoom platform, while physically located across the United States. The following is a brief description of each participant, including their prior exposure to persons with disabilities and current placement for their practicum and internship portions of their higher education training.

Eleanor is a 22-year-old White woman who attends her graduate counseling program through hybrid in-person and online elements. She is a second-year student, attending her program full time and is currently providing counseling services at an outpatient community-based mental health center as part of her internship experience. Eleanor shared she does not identify as a member of the disability community herself but has had exposure to the disability community through class lessons and recent work experience in the last five years. Eleanor shares she is currently providing services to individuals with intellectual disability at her internship placement.

Janet is a 24-year-old White woman who attends her graduate counseling program in-person. She is a third-year student, attending her program full time and is currently providing counseling services at an outpatient community-based mental health center as well as a private practice location as part of her internship experience. Janet shared although she has a medical condition, she does not identify as a member of the disability community herself but has had

exposure to the disability community through a family member having a disability, knowing acquaintances with disabilities, being exposed to lectures in classes covering disability topics, and having past work experience that spans within the last five years and beyond working with individuals with disabilities. Janet shares she is not currently providing counseling services to individuals with intellectual disability at her internship placement.

Tahini is a 24-year-old White woman who attends her graduate counseling program hybrid through online and in-person elements. She is a third-year student, attending her program part time and is currently providing counseling services at an outpatient community-based mental health center as part of her internship experience. Tahini shared that while she does not identify as a member of the disability community herself, she has had exposure to the disability community through lectures in classes covering disability topics. Tahini shares she is unsure if she has/is providing counseling services to individuals with intellectual disability at her internship placement.

Loreli is a 43-year-old White non-binary individual who attends their graduate counseling program hybrid through online and in-person elements. They are a third-year student, attending their program full time and is currently providing counseling services at an outpatient community-based mental health center as well as a private practice location as part of their internship experience. Loreli shared that they do identify as a member of the disability community themselves and has had exposure to the disability community through a family member having a disability, knowing acquaintances with disabilities, and having recent work experience within the last five years working with individuals with disabilities. Loreli shares they are not currently providing counseling services to individuals with intellectual disability at their internship placement.

Rory is a 26-year-old White woman who attends her graduate counseling program online. She is a second-year student, attending her program full time and is currently providing counseling services at a private practice location as part of her internship experience. Rory shared she does not identify as a member of the disability community herself and does not list any prior exposure to individuals with disabilities. Rory shares she is unsure if she has/is providing counseling services to individuals with intellectual disability at her internship placement.

Emily is a 24-year-old Black woman who attends her graduate counseling program hybrid through online and in-person elements. She is a third-year student, attending her program part time and is currently providing counseling services at a private practice location as part of her internship experience. Emily shared although she has a medical condition, she does not identify as a member of the disability community herself but has had exposure to the disability community through knowing acquaintances with disabilities, being exposed to lectures in classes covering disability topics, and having past work experience that spans within the last five years and beyond working with individuals with disabilities. Emily shares she does currently provide counseling services to individuals with intellectual disability at her internship placement.

Kate is a 24-year-old White woman who attends her graduate counseling program online. She is a second-year student, attending her program full time and is currently providing counseling services at a university counseling center as part of her internship experience. Kate shared she does not identify as a member of the disability community herself but has had exposure to the disability community through lectures in classes covering disability topics and having past work experience within the last five years working with individuals with disabilities.

Kate shares she is unsure if she has/is providing counseling services to individuals with intellectual disability at her internship placement.

Anne is a 46-year-old White woman who attends her graduate counseling program hybrid through in-person and online elements. She is a third-year student, attending her program full time and is currently providing counseling services at an elementary school and telehealth clinic as part of her internship experience. Anne shared she does not identify as a member of the disability community herself but has had exposure to the disability community through a family member having a disability, knowing acquaintances with disabilities, and having past work experience that spans within the last five years and beyond working with individuals with disabilities. Anne shares she is currently providing counseling services to individuals with intellectual disability at her internship placement.

Nick is a 23-year-old White man who attends his graduate counseling program hybrid through online and in-person elements. He is a second-year student, attending his program full time and is currently providing counseling services at a university counseling center as part of his internship experience. Nick shared although he has a medical condition, he does not identify as a member of the disability community himself but has had exposure to the disability community through knowing acquaintances with disabilities, being exposed to lectures in classes covering disability topics, and having past work experience within the last five years working with individuals with disabilities. Nick shares he is not currently providing counseling services to individuals with intellectual disability at his internship placement.

Jess is a 24-year-old Native American female who attends her graduate counseling program online. She is a second-year student, attending her program full time and is currently providing counseling services at a university counseling center as part of her internship

experience. Janet shared she does not identify as a member of the disability community herself but has had exposure to the disability community through a family member having a disability, knowing acquaintances with disabilities, and being exposed to lectures in classes covering disability topics. Jess shares she is currently providing counseling services to individuals with intellectual disability at her internship placement.

Table 1: Participant Demographics

Pseudonym	Age	Gender	Race	Disability Identity	Program Setting	Year in Program	Internship Site Placement	Prior Contact with Individuals with ID	Provision of Services to Individuals with ID
Eleanor	22	Woman	White	No	Hybrid	2	CMH	Yes	Yes
Janet	24	Woman	White	No	In person	3	PP & CMH	Yes	No
Tahini	24	Woman	White	No	Hybrid	3	CMH	No	Unsure
Loreli	43	Non-binary	White	Yes	Hybrid	3	PP & CMH	Yes	No
Rory	26	Woman	White	No	Online	2	PP	No	Unsure
Emily	24	Woman	Black	No	Hybrid	3	PP	Yes	Yes
Kate	24	Woman	White	No	Online	2	UCC	Yes	Unsure
Anne	46	Woman	White	No	Hybrid	3	ES & PP	Yes	Yes
Nick	23	Man	White	No	Hybrid	2	UCC	Yes	No
Jess	24	Woman	Native American	No	Online	2	UCC	Yes	Yes

Note. Under "Internship Site Placement," CMH stands for Community Mental Health, PP stands for Private Practice, UCC stands for University Counseling Center, and ES stands for Elementary School.

Themes

All participants selected to participate in this study completed an interview lasting between 20 to 40 minutes. During these interviews, participants answered questions describing their unique experiences in their masters-level counseling programs as it related to preparation to provide counseling services to individuals with intellectual disability. Data analysis following the interviews aimed to answer this study's two research questions: (1) How would participants describe the training their programs have implemented related to working with individuals with intellectual disability? (2) What, if anything, do participants perceive to be helpful in preparing to work with this population of individuals with intellectual disability in the counseling field? The coding process and themes identified from the interview transcripts were discussed and verified with the peer auditor throughout the coding process and reviewed with participants for member checks. Following this process, four themes emerged: (a) Diagnostic confusion, (b) Advocacy for access, (c) Diffusion of responsibility, and (d) Desire for further training. Coding used to determine these four themes can be viewed in Table 2.

Table 2: Coding Results

Theme Derived	Code	Definition	Sample Quote
Diagnostic Confusion	Correct Dx	Used when participants correctly identified DSM-5-TR criteria for an ID diagnosis	“It's anyone that has like, adaptive behavior difficulty, like in living independently or their employment, usually with IQ being below the norm. It can be mild, moderate, severe.”
Diagnostic Confusion	Incorrect Dx	Used when participants incorrectly identified/were unable to identify DSM-5-TR criteria for an ID diagnosis	"ID is things that are affecting your brain, like your cognitive ability... so like having autism for example. That can be considered an intellectual disability rather than being paralyzed.”
Advocacy for Access	Positive Outlook on ID	Used when participants made favorable statements regarding individuals with ID	“They have innate worth and offer so much to relationships and just the world."
Advocacy for Access	Belief in Access	Used when participants made statements affirming the need for accessible mental health services for individuals with ID	“If someone has ID and a dog bit them and they’re [experiencing] trauma, I don’t believe that there’s any reason why an ID would counter indicate [effectiveness of] EMDR… as long as they are able to do the regulation skills and tolerate the processing.”
Diffusion of Responsibility	Barriers	Used when participants identified barriers for individuals with ID to access mental health care	“I think overall the biggest challenge is the stigma surrounding people with ID. There is a lot of infantilization of them.”

Diffusion of Responsibility	Personal Perception: Positive	Used when participants reported a positive perception of their confidence and/or preparedness to provide services to individuals with ID	"So, for me, because of my background, I think it's important, I feel very inclusive. I want to try and create those opportunities."
Diffusion of Responsibility	Personal Perception: Negative	Used when participants reported a negative perception of their confidence and/or preparedness to provide services to individuals with ID	"I don't think it's fair to the client for me to provide services, because on a scale of one to ten on how confident I feel, my confidence level would be like a four right now because of the lack of trainings and specific teaching on it."
Desire for Further Training	Lack of Interventions	Used when participants mentioned areas they perceived as lacking from their academic programs to prepare them to work with individuals with ID	"I think the only time ID was covered in my program was in the assessment class, and they basically told us how Autism is diagnosed and that it is usually other specialists that do it."
Desire for Further Training	Desired Interventions	Used when participants mentioned interventions they believe could have been helpful to prepare them to work with individuals with ID	"Because it isn't really something we can do role plays on, it would help to see someone with ID in like videos or to read about actual experiences in a book."

Note. Intellectual disability is referred to as ID; Diagnosis is referred to as Dx; Treatment is referred to as Tx.

The first two themes identified answer the first research question while the third theme address research question number two. The fourth theme addresses both research question one and two. Theme one, diagnostic confusion, touches on the potential lack of preparation counselors in training experienced in their graduate programs as it relates to research question one. Theme two, advocacy for access, reviews how counselors in training perceived lessons on the ethical code and preparation to serve diverse populations as part of their graduate programs as it relates to research question one. Theme three, diffusion of responsibility, identifies who the participants perceive to be responsible for providing services to individuals with intellectual disability, as it relates to what they believe to be helpful in preparing to work for this population (specifically, who should prepare to work with them) as it relates to research question two. Theme four, desire for further training, outlines where participants felt their graduate training might have lacked in preparing them to work with this population and what they believe would help them to feel more confident and prepared to provide services to this population to answer both research questions one and two.

Diagnostic Confusion

The first theme that emerged from the data exposed what could be contributing to feelings of hesitancy and inadequacy when it comes to providing services to individuals with intellectual disability: Confusion on what an intellectual disability actually is. During the interviews, seven of the ten participants were unable to correctly answer the question "How is an intellectual disability defined in the DSM-5-TR (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition)?"

A majority of participants were able to differentiate an intellectual disability from a physical disability. For example, Janet stated an intellectual disability is "things that are affecting

your brain, like your cognitive ability... so like having autism for example. That can be considered an intellectual disability rather than being paralyzed." While Janet was correct that an intellectual disability impacts cognitive function, not all individuals on the autism spectrum qualify as having an intellectual disability; although, the two diagnoses can co-occur. Rory described an intellectual disability as "ADHD (Attention-Deficit/Hyperactivity Disorder), where someone really can't focus on things." The interviewer then clarified that while ADHD can co-occur with an intellectual disability, not all individuals with ADHD have an intellectual disability. Kate, Nick, and Tahini also described an intellectual disability as diagnoses that fall under the category of learning disabilities, such as dyslexia and ADHD, as well as autism spectrum disorder which is considered a developmental disability.

Advocacy for Access

A theme of advocacy for access to mental health services for this population was present throughout participant interviews, covering contributing factors to access such as discrimination, stigma, and consideration of collateral information to aid in treatment planning for services. While some participants felt they lacked competence to provide services themselves to individuals with intellectual disability at the time of their interviews, each of the ten participants shared positive remarks affirming their belief that individuals with intellectual disability should somehow have access to mental health services. Loreli stated, "If someone has intellectual disability and a dog bit them and they're [experiencing] trauma, I don't believe that there's any reason why an intellectual disability would counter indicate [effectiveness of] EMDR… as long as they are able to do the regulation skills and tolerate the processing."

When discussing future plans for work as a counselor, the interviewer asked interviewees about their likelihood to provide services to individuals with intellectual disability in their

desired counseling setting. Tahini expressed, “I would hope to work at a practice that would not discriminate in any way.” Janet stated, “I would not in any way be like, ‘Oh I really don’t want to see clients that have a disability.’”

When identifying considerations for services for individuals with intellectual disability during the interview process, Rory defended the population of individuals with intellectual disability against stigma that may exist in the clinician community by stating, “[People with disabilities] may be pathologized… not fitting into nice, neat boxes and [others] may see that as a problem when it’s just a difference in how we experience the world.” Jess stated, “I think overall the biggest challenge is the stigma surrounding people with intellectual disabilities. There is a lot of infantilization of them.” Anne and Nick provided statements of high regard for those with intellectual disability, stating respectively, “[People with intellectual disability] have innate worth and offer so much to relationships and just the world,” and, “[People with intellectual disability] have such kind hearts… it is shocking to see that sometimes people with higher cognitive functioning are not able to be kind.”

Additional considerations for providing individuals with intellectual disabilities counseling included the importance of including their support system in the planning of services. Nick shared a desire to gain information from parents, employers, and/or teachers of the individual with an intellectual disability to better understand presenting concerns. When discussing what she would like to know further before providing mental health services to an individual with intellectual disability, Emily stated,

> I would want to know what their family system and history look like as well as other relationships in general. How do they feel [about their disability] on a society level and visual level, and all of those layers? What are they doing to support themselves now, and

> do they have accommodations or modifications? … I feel like that all puts the puzzle pieces together when you are sourcing for referrals or supports and stuff.

Similarly, Kate expressed a desire to know how much the individual believes their disability affects them in their day-to-day life to identify next steps in services. Loreli reiterates the importance of collaboration in treatment planning, stating "if they say their goal is to become independent, I would love to work with someone else like a social worker on that in supporting independence skills and knowing what types of folks do that, then have them sign a release of information."

Diffusion of Responsibility

Throughout the ten interviews conducted, participants considered whose responsibility it is to provide counselors in training with information needed to serve the population of individuals with intellectual disability: Was it solely the responsibility of their university counseling programs, or are they called to independently seek training as a result of their code of ethics? Janet considered whether or not referral would be appropriate if an individual with an intellectual disability sought mental health services through her, stating "Where does it come in, the piece with me needing to refer? Because in [our program] we talk so much about how important it is, that willingness to see clients from diverse backgrounds but we also can only provide services within our scope." Loreli shared, "as long as intellectual disability is considered a 'special population,' [providing mental health services] is going to be considered a niche thing, you know?" Emily reinforces this idea through her response,

> I feel like a misconception about working with individuals with intellectual disability is that it has to be this separate thing… their disability may not be their presenting concern. It's like I get where you are trying to encourage people to become knowledgeable about

specific populations, but at the same time their disability may not be related to what they want to work on.

Potential Barriers to Services. As the interviewer and interviewees explored considerations for providing mental health services, participants pointed out potential barriers to provide services and the need for clinicians to mitigate these roadblocks to accessing services, which may contribute to difficulty in taking responsibility to provide services. Eleanor identified that many individuals with intellectual disability rely on health plans that fall under Medicaid and Medicare through previously funded federal services for individuals qualifying for disability services, which clinicians would need to accept to alleviate possible financial burden for clients with intellectual disability.

Further identifying barriers to communication in the counseling room, Anne reports concerns about needing to apply counseling theories on an appropriate developmental level due to the deficit in intellectual functioning for this population, stating "[Some counseling theories] don't translate well for a lot of people. We even see this when counseling younger people." Nick echoes this sentiment, stating,

> I think I'd have to do some self-work and research on [the client]'s specific situation because I'm aware of how unique people's needs are, understanding the developmental levels and what might be appropriate. So, like, I'd look into, do we need to do an expressive arts or play modality, or are we ready for talk therapy? … I think there may be barriers in communication. There might be things that are very clear in my head that I want to communicate, but things that may not come across as intended.

Perception of Competency and Preparedness. When addressing personal feelings about competency and preparedness to provide services, participants fell into one of two camps:

those who felt confident expressed how their prior experiences with individuals with disabilities made them feel prepared, while others with little to no exposure expressed a sense of nervousness. Anne reports, “If you don’t already have some kind of proximity to people [with disabilities], certain things just may not register with you.” Janet stated that as a result of having a family member with a disability, she tries to be aware of her tone and enunciation in a developmentally appropriate way when talking with an individual who has an intellectual disability. Additionally, she states “When using sarcasm, for example, or looking for social cues, I have to be aware that that can be harder to read for certain people. Sometimes as clinicians we need to adjust based on our clients.” Kate says her exposure to individuals with disabilities in her personal life allowed her to “have less judgement towards people because you never really know what someone is going through.”

Eleanor reports that when interacting with clients with disabilities, she felt like “there was more pressure, like it made me more nervous and question what I was doing. I don’t feel prepared myself to provide services to [individuals with intellectual disability].” Jess stated, “I think it depends on what resources I have available and the severity of the intellectual disability if I could provide services or not.” Loreli stated, “If I had [a client with an intellectual disability] I would be nervous because I would worry whether or not I was practicing within my scope… if I’m a bad person for not providing services. I would have to investigate and get support.” Rory stated, “I don’t think it’s fair to the client for me to provide services, because on a scale of one to ten on how confident I feel, my confidence level would be like a four right now because of the lack of trainings and specific teaching on it.”

Desire for Further Training

Lack of Interventions. The fourth theme identified in this study covers what participants felt were missing from their training when it came to increasing preparedness and confidence in working with individuals with intellectual disability, as well as what they would have desired to increase their sense of preparedness and confidence. While some participants shared instances in which their program provided a class lecture or seminar on considerations for counseling individuals with disabilities in general, only two of the ten participants report experiencing a lecture on counseling individuals with intellectual disability specifically. Even within these lectures, zero of ten participants report any material on counseling individuals with intellectual disability being presented over the course of the full class period or longer. Tahini reports, "Even though I took a class covering diverse populations, it was much more focused on diversity of ethnicity." Anne said, "I think the only time intellectual disability was covered in my program was in the assessment class, and they basically told us how Autism is diagnosed and that it is usually other specialists that do it." Eleanor stated, "When disability was mentioned, it was more interwoven in other classes, but never the main subject." Loreli said,

> When we talked about intellectual disability, it was covered for like five minutes in our diagnosis class, but that was it. We never talked about what special training was needed to work with [individuals with intellectual disability]... If we were going to talk about what disabilities were covered the most, and we ranked them, I think intellectual disability would be ranked the lowest.

Emily shared:

> A lot of conversation about not only people with disabilities but what their different stages of life are like are missed because it seems like disability was offered more as an

elective focus rather than being embedded in the natural course of the degree plan. I feel like it should be a topic covered for everyone, regardless of your track.

Desired Interventions. During the interview process, participants shared the desire for the following interventions to be implemented based on what they deem as helpful to grow in confidence and preparedness to provide counseling services to individuals with intellectual disability: (a) Watching documentaries featuring people with disabilities (specifically intellectual disability), (b) Reading text or articles about best practices for providing counseling services to this population, (c) Introducing disability identity in case studies and conceptualization practiced in classes, (d) Broaching ableism and privilege as it relates to disability and ability identity for counselors, (e) Placing students at practicum and internship sites in which they are exposed to working with people with intellectual disability, and (f) Providing students with supervisors with experience working with individuals with different types of disability (including intellectual disability). Eleanor shared, "Because it isn't really something we can do role plays on, it would help to see someone with [an intellectual disability] in like videos or to read about actual experiences in a book." Jess echoes the desire to learn from lived experiences, sharing "Instructors could share videos, articles... anything like that." Tahini also shared a desire for verbal presentation, videos, articles, or hearing verbally from classmates' experiences to learn more about working with individuals with intellectual disability, or any disability in general. Tahini said,

> I just think you could dedicate like a whole class in every topic to what that aspect of counseling would look like with a person with an intellectual disability. Like, show videos of what it looks like to diagnose a person with an intellectual disability, just working with a person with an intellectual disability.

Loreli shared, “If we are going to train people to work with this population, then you need to, I guess, like expose them to the population for real... you have to actually work with a person to know what their struggles are. We didn’t do a lot of videos in my school.” Kate reiterates the importance of the application piece for training, sharing “I’m not a learning by lecture kind of person, I want to actually be able to practice it.”

Janet shared, “I really liked in one of our classes doing an inventory checklist of things that, like, you don’t even realize could be considered a disability. That was a really good conversation.” Anne also touched on the importance of this reflection for counselors in training by stating, “I think it is important to ask counselors like, ‘What is your schema when it comes to working with this population?’”

Summary

This chapter described findings from the research completed for this study to better answer the two research questions: (1) How would participants describe the training their programs have implemented related to working with individuals with intellectual disability? (2) What, if anything, do participants perceive to be helpful in preparing to work with this population of individuals with intellectual disability in the counseling field? The experiences and thoughts shared by the ten participants helped identify four major themes, including: (a) Diagnostic confusion, (b) Advocacy for access, (c) Diffusion of responsibility, and (d) Desire for further training. Participants explored not only what they perceived to be helpful and/or unhelpful in their own training, but how counseling programs and counselors in training might better equip themselves to provide services to individuals with intellectual disability through seeking and implementing more training with considerations for this population included.

Chapter 4: Discussion

Discussion of Research Findings

The findings of this research study aimed to address the roots of the lack of quality mental health services for individuals with intellectual disability discussed in earlier chapters of this dissertation by asking those who are in training to provide these services how they perceive their preparation from their training programs, as well as their own thoughts related to providing services to this population. In order to answer the research questions posed in this study, semi structured interviews were conducted from a social constructivist lens with ten participants who were completing their practicum and/or internship portion of their master's level counselor education program. Through the completed inductive coding process, four themes emerged to better understand the counselors' experiences of the in training during their time in their programs as it relates to applying counseling skills to working with individuals with intellectual disability. The four themes that emerged are: (a) Diagnostic confusion, (b) Advocacy for access, (c) Diffusion of responsibility, and (d) Desire for further training. This chapter will discuss those findings, implications for the field of counselor education, limitations of the study, as well as recommendations for future research on this topic.

Current literature demonstrates a gap in understanding how to improve the quantity and quality of mental health services provided to individuals with intellectual disability (Man et al., 2016; Weise & Troller, 2017). This research aimed to address this gap by asking those presently preparing to enter the workforce as counselors what they perceived as helpful and/or unhelpful when it comes to applying their skills in the counseling room to potential clients diagnosed with an intellectual disability. The findings within this study can be applied to counselor education through better informing counselor educators and the CACREP program governing body on how

to implement teaching practices and content that may increase trainees' preparedness and confidence to provide counseling services to individuals with intellectual disability to address the gap in quantity and quality for these services in the United States (Cooper et al., 2007; Einfeld et al., 2011; Einfeld & Tonge, 1996; McCarthy & Boyd, 2002; Walton et al., 2022). Participants' answers overall revealed a belief across all ten interviews that this population deserves access to quality mental health care, even though there is still a need for discussion on who is responsible for preparing counselors to provide these quality services, and how to do so within training programs.

Diagnostic Confusion

The confusion demonstrated in interviews regarding the diagnostic criteria for an intellectual disability can be considered a contributing factor to a lack of confidence in practitioners, as this lack of clarity makes it more difficult to identify how an intellectual disability actually impacts the day-to-day experiences of those diagnosed. Additionally, confusion about these symptoms may further contribute to inaccurate stigma around the diagnosis or cause assumptions that overlook the needs of those diagnosed with an intellectual disability (such as clinicians not identifying the deficits in adaptive behavior functioning in those they are treating).

This speaks to a deficit in trainee preparedness, despite CACREP requiring a diagnostic course to be implemented in counselors' masters-level training. This confusion is additionally depicted through responses in their demographics survey, as three of the ten participants stated they were unsure if they had treated an individual with an intellectual disability at their internship site. It is worth noting that the three participants who did correctly define an intellectual disability according to DSM-5-TR criteria noted in their demographics survey

responses that they had prior exposure and contact with persons with an intellectual disability in their family, through work experience, or through knowing an acquaintance with an intellectual disability. Further need for training on diagnosis and application of interventions specific to this population reiterates the suggestions found in Kelley and colleagues' (2023) systematic review of the literature, which recommended a review of the biopsychosocial model and implementation of cognitive behavioral and dialectical behavior therapies.

Advocacy for Access

Although some participants report a current lack of confidence and/or preparedness to work with those with an intellectual disability, all ten participants expressed the desire for mental health services to be accessible for this population. Discussion related to advocacy for access included identifying potential barriers to services, which was also identified in the literature reviewed prior to this study, such as: (a) Lack of financial means to pay out of pocket for services, leaving many within this community relying on federally funded insurance programs such as Medicaid and Medicare, and (b) Barriers in communication, such as lack of training on implementing developmentally appropriate language, or how and whether to include the client's support system in treatment planning to set realistic and person-centered goals for therapy. Individuals with intellectual disability shared in Weise and colleagues' study (2018) that they also value mental health care professionals who are able to communicate on a developmentally appropriate level while working with their support network to identify goals. While participants expressed the belief that these services should be provided, and these barriers should be mitigated for services, considerations on who should be responsible for addressing these leads us into the next theme: Diffusion of responsibility.

Diffusion of Responsibility

While sharing their thoughts on individuals' access to services, participants considered whether their programs were to blame for a lack of perceived preparation to provide counseling services to individuals with intellectual disability, or if it was their own responsibility to seek out training as it relates to the American Counseling Association Code of Ethics (2014). Participants also mentioned considering if it was "cruel," "mean," or "wrong" that this population may not be considered their "niche" to learn about when prioritizing continuing education outside of their training programs. Ultimately, despite their differing personal thoughts and feelings on seeking further training to work with this population themselves, after their participation in these interviews, all participants were able to identify suggestions on what their programs could implement in the future to help prepare counselors to work with this population based on what they perceive to have been helpful during their training experiences.

Desire for Further Training

During the interview process, participants were able to identify six recommendations collectively for counseling programs to implement to better prepare counselors in training to provide services to individuals with intellectual disability. These recommendations included: (a) Watching documentaries featuring people with disabilities (specifically intellectual disability), (b) Reading text or articles about best practices for providing counseling services to this population, (c) Introducing disability identity in case studies and conceptualization practiced in classes, (d) Broaching ableism and privilege as it relates to disability and ability identity for counselors, (e) Placing students at practicum and internship sites in which they are exposed to working with people with intellectual disability, and (f) Providing students with supervisors with experience working with individuals with different types of disability (including intellectual disability). These suggestions are supported by Hay and colleagues' (2023) systematic review of

literature, which identified interventions such as increased reading materials, implementation of seminars and didactic lectures, group discussions, workshops, and immersive learning components.

Limitations

Limitations for this study include the small participant size, the potential impact of the interviewer's biases and life experiences, and low diversity in the sample pool as it relates to race, ability/disability identity, and gender identity. While this study focused on the experiences of ten counselors in training, this does not mean their experiences expressed through the themes that emerged accurately represent all counselors in training. However, Tracy's text (2010) states that transferability of findings can be achieved when it comes to qualitative research. With this in mind, it is the author's hope that exploring the experiences of these ten participants can help aid future discussions and research on this topic as it relates to improving access to services for individuals with intellectual disability at the source of counselors' training experiences. Despite methods implemented to utilize triangulation and trustworthiness, there is always the possibility present that the life experiences of the researcher could have impacted findings in some way, as noted in the author's reflexivity statement. Additionally, there is the possibility of social desirability that could have impacted participants' responses to interview questions, affecting themes derived from the data; although the effort to maintain anonymity of participants was made to reduce the chance of this occurring. Finally, because the sample pool involved in this study included eight women, one man, and one non-binary participant; over 80% of the participant pool identifying as White; and 90% identifying as members outside of the disability community, one should note that a more diverse participant pool could result in different emerging themes.

Recommendations for Future Research

This study focused on the experiences of counselors in training as it relates to preparation they may have received in their master's level programs to counsel individuals with intellectual disability. As noted in the limitations section, including a participant pool from more diverse backgrounds may better educate the field on experiences and desires as it relates to the training processes discussed in this study. Studies conducted in the future might also want to include the perspectives and experiences of counselor educators as it relates to CACREP standards and infusing intersectional considerations in class content, including developmental considerations and disability identity applied for individuals with an intellectual disability. Future research should also seek out the thoughts of individuals with intellectual disability on what they perceive as helpful to increase their access to quality mental health services to include their perspectives in the conversation. It may also be beneficial to include participants who are currently practicing licensed and counseling in the mental health field in future research to gain perspectives from those with more experience. Future research may also investigate effective pedagogical approaches to enhance students' attitudes and competencies. For example, research may seek out participants with intellectual disability to be part of creating video case studies for use in counselor training programs, to test the effectiveness of these visual and audio samples for counselors-in-training in increasing their perception of preparedness and confidence to counsel this population. Finally, while this study utilizes a qualitative approach to discuss participant experiences, it may be worth utilizing quantitative measures to further explore perceptions of preparedness, confidence, and self-efficacy in providing services to individuals with intellectual disability, both before and after implementing some of the recommendations noted in this

dissertation to discover what works and what does not in instructing counselors in training to provide these services.

Implications for Practice and Counselor Education

As supported by previous literature (Hay et al., 2023; Kelley et al., 2023), in order to better prepare counselors to feel more competent and confident in providing mental health services to individuals with intellectual disability, it is recommended that counselor educators work to infuse more intersectional-focused teaching strategies in the classroom that apply considerations for this population to routine theories and skills taught in counseling courses. In this study, participants specifically reported a desire for increased teaching interventions that include (a) Watching documentaries featuring people with disabilities (specifically intellectual disability), (b) Reading text or articles about best practices for providing counseling services to this population, (c) Introducing disability identity in case studies and conceptualization practiced in classes, (d) Broaching ableism and privilege as it relates to disability and ability identity for counselors, (e) Placing students at practicum and internship sites in which they are exposed to working with people with intellectual disability, and (f) Providing students with supervisors with experience working with individuals with different types of disability (including intellectual disability) to increase their confidence and competence levels when providing services to individuals with intellectual disability. By infusing these techniques in classes already established in counseling programs through CACREP recommendations, this would not ask programs to adopt additional courses to students' already packed schedules but rather allow for psychoeducation and considerations related to serving this population to be discussed in class sessions that already occur throughout a typical semester. As a result of these infused inclusive teaching practices, it is the author's hope that the quality and quantity of services for this

population could increase due to a rise in counselors' confidence and competence levels exiting their masters-level counselor training programs. This speaks to future research that can be conducted as well that focuses on measuring the efficacy of each teaching intervention mentioned by this study's participants, as the literature in this area is quite limited, specifically relating to knowledge on serving individuals with intellectual disability.

Conclusion

This research study was conducted to better understand what counselors in training perceive to be helpful in preparing to provide services to individuals with intellectual disability. Ten counselors enrolled in the second or third year of their masters level training programs, who are participating in the practicum and/or internship phases of their education, completed semi-structured interviews that resulted in the identification of the following four themes: (1) Diagnostic confusion, (2) Advocacy for access, (3) Diffusion of responsibility, and (4) Desire for further training. Through sharing their experiences and perceptions, these ten participants have contributed to the literature by helping readers better understand what those preparing to enter the workforce may need to improve quality and quantity of mental health services provided to those diagnosed with intellectual disability.

Chapter 5: Manuscript

Abstract

This phenomenological study explores the perceptions and experiences of counselors-in-training as it relates to their preparation to provide counseling services to individuals with intellectual disability. Semi-structured interviews were completed with participants who are currently enrolled in a masters-level, CACREP-accredited clinical mental health counseling program within the United States. Using a hermeneutic phenomenological approach, this research seeks to better understand how counselors feel about providing counseling services to individuals with intellectual disability, as well as what their preparation to provide these services has been like in their training thus far. The goal of this study was to have ten counselors-in-training complete the interview process, then utilize inductive coding to identify themes from the data. Implications for counselors and counselor educators, as well as the relevance of the research findings are discussed.

Introduction

Prevalence of Intellectual Disability and Mental Health Concerns

The term "intellectual disability" describes a particular condition in which an individual's adaptive behavior and intellectual functioning are considered more limited than that of their typically developing/neurotypical peers (American Association on Intellectual and Developmental Disabilities, n.d.). The American Psychiatric Association's fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; 2013) identifies intellectual disability diagnosis using the following criteria: (1) Deficits in intellectual functioning (reasoning, problem-solving, planning, abstract thinking, judgment, academic learning, experiential learning; usually measured by IQ tests scoring at or below 70) and (2) Deficits or

impairments in adaptive functioning (communication, social skills, personal independence at home or in community settings, school/work functioning). Intellectual disability is typically identified in individuals meeting the above criteria before the age of twenty-two (American Association on Intellectual and Developmental Disabilities, n.d.). There is currently no comprehensive study to measure the prevalence of adults with intellectual disability in the United States. Estimates based on data from the National Health Interview Survey and Census data predict that every 9.5 per 1,000 adults born between the years 1980 and 1999 in the U.S. are diagnosed with an intellectual disability (Benevides et al., 2024).

People with intellectual disability have a higher chance of experiencing mental health related concerns than their neurotypical peers, with studies showing individuals with intellectual disability are three times more likely to experience a co-occurring mental health related diagnosis (Bradley et al., 2019; Evans et al., 2012; Scott & Havercamp, 2014). However, current research suggests that mental health services available, from clinicians that feel competent in treating this population across the United States, are not meeting the need for services (Cooper et al., 2007; Einfeld et al., 2011; Einfeld & Tonge, 1996; McCarthy & Boyd, 2002; Walton et al., 2022).

Literature Review

Recent literature suggests that individuals with intellectual disability continue to face stigma when it comes to receiving mental health care, even in places such as emergency departments when there is a lack of appropriate community-based mental health services, resulting in mental health needs of individuals with intellectual disability escalating towards being considered a crisis (Spassiani et al., 2017). Mason and Scior (2004) name that diagnostic overshadowing acts as a barrier to treatment rooted in stigma against this population. Mason and

Scior (2004) define diagnostic overshadowing as a state of bias that impacts providers' tendency to attribute instances of crisis, such as self-injurious behavior, to the intellectual disability itself rather than the potential diagnosis of a co-occurring mental illness or related symptomology. Furthermore, in their 2017 qualitative study, Spassiani and colleagues interviewed individuals with intellectual disability and their families regarding their experiences seeking mental health care from emergency departments when in a state of crisis. Participants reported feeling disrespected or dismissed by emergency personnel when attempting to access emergency related mental health care, in addition to noting concerns about the staff appearing unprepared to support individuals with intellectual disability in crisis related to their mental health. Similarly, there are indications in the literature that the quality of mental health services for individuals with an intellectual disability could be lower than services provided to those without a diagnosed intellectual disability (Krahn et al., 2006; Sheehan et al., 2015; Weiss & Lunsky, 2010).

Discourse on the topic of mental health services for individuals with intellectual disability often raises the question of whether or not professionals in fields like clinical mental health counseling are prepared to help this group of people. Prior literature suggests that mental health professionals may have limited confidence, knowledge, and skills to work with individuals with intellectual disability (Man et al., 2016; Weise & Troller, 2017) as well as insufficient training in working with this population (Weise & Troller, 2017). Specifically, when providing mental health services to a person with an intellectual disability versus a person without an intellectual disability, Weise and Troller (2017) found that mental health professionals felt less confident in the following areas of clinical practice: 1) recognizing when a patient may have a mental disorder; 2) communicating effectively; and 3) understanding potential adverse side effects of psychotropic medication.

Current State of Counseling Services for Individuals with Intellectual Disability

Application of Rehabilitation Counseling Specialty

The American Rehabilitation Counseling Association (ARCA) was founded as part of the American Counseling Association (ACA) in 1957. Rehabilitation Counseling is a specialty area of counseling that was designed to focus primarily on disability advocacy and vocational rehabilitation counseling for individuals with disabilities. Unfortunately, even with specialized rehabilitation training programs being developed to provide education specifically in serving populations including individuals with disabilities, research suggests that mental health services over the last two decades provided to people with intellectual disabilities (Dekker & Koot, 2003; Einfeld et al., 2006; McCarthy & Boyd, 2002) does not match the prevalence rates of mental illness in this population (Cooper et al., 2007; Einfeld et al., 2011; Einfeld & Tongue, 1996; McCarthy & Boyd, 2002). Additionally, when an individual with an intellectual disability presents for mental health services, their disability may not be the source of the pathology they are seeking to treat and instead may be focused more on the mental-health related concerns that all mental health professionals should be versed to treat as part of their training.

Limitations for Current Mental Health Services

In Marshall and colleagues' 2024 content analysis investigating keywords found in six counseling-related academic journal articles between the years 2016-2020, nothing related to persons with disabilities appeared as a top keyword in any of the journals reviewed. While the literature remains limited when it comes to investigating the attitudes and self-efficacy levels of clinical mental health counselors providing therapy services to individuals with intellectual disabilities in the United States, prior studies investigating health accessibility as it relates to services for people with intellectual disabilities have identified a lack of specialized services and

ineffective service collaboration as deficits in services for this population (Buckles et al., 2013). Whittle et al.'s (2018) research identified barriers for access to mental health care for individuals with intellectual disabilities: limited and scarce resources, logistical and geographical issues, organizational barriers, silo-ing of service sectors, competing service models, failure of interagency communication, inconsistent eligibility criteria, transition, unclear referral pathways, difficulty identifying need, lack of help-seeking, diagnostic overshadowing, misidentification of mental disorders, clinical knowledge deficits, severity of intellectual disability, and social determinants. Another potential barrier to the provision of counseling services to individuals with intellectual disabilities is the discovery that support staff working with individuals with intellectual disability report experiencing considerable amounts of stress (Hatton et al., 1999) and that as a result, coping and social support are impacted when exploring the experiences of these staff members (Devereux et al., 2009).

Application of Ethical Codes and Standards

2024 Council for Accreditation of Counseling and Related Educational Programs Standards

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) incorporates diversity and inclusion as part of their teaching practices in preparation programs as noted in their 2024 standards in section 2 standard B.1., which states, "The program objectives reflect current knowledge and projected needs concerning counseling practice in a diverse, multicultural, and global society with marginalized populations." Additionally, section 3 of CACREP's 2024 standards outlines foundational counseling curriculum requirements for the content area of courses that relate to the treatment of traditionally marginalized populations, such as individuals with intellectual disability, through the following standards by stating, "Counselor

education programs must document where and in what manner each of the numbered standards listed below is covered in the curriculum:

> "…the role and process of the professional counselor advocating on behalf of and with individuals receiving counseling services to address systemic, institutional, architectural, attitudinal, disability, and social barriers that impede access, equity, and success" as it relates to professional counseling orientation and ethical practice (section 3.A.4.);
>
> "…the effects of historical events, multigenerational trauma, and current issues on diverse cultural groups in the U.S. and globally… the effects of stereotypes, overt and covert discrimination, racism, power, oppression, privilege, marginalization, microaggressions, and violence on counselors and clients… disproportional effects of poverty, income disparities, and health disparities toward people with marginalized identities…principles of independence, inclusion, choice and self-empowerment, and access to services within and outside the counseling relationship…. And strategies for identifying and eliminating barriers, prejudices, and processes of intentional and unintentional oppression and discrimination" as it relates to social and cultural identities and experiences (section 3.B.4, 5, 7, 8, and 9);
>
> "…models of psychosocial adjustment and adaptation to illness and disability" as it relates to lifespan development (section 3.C.8);
>
> "…strategies for improving access to educational and occupational opportunities for people from marginalized groups" as it relates to career development (section3.D.11);
>
> "…. theories and models of counseling, including relevance to clients from diverse cultural backgrounds… culturally sustaining and responsive strategies for establishing and maintaining counseling relationships across service delivery modalities… strategies

> for adapting and accommodating the counseling process to client culture, context, abilities, and preferences … developmentally relevant and culturally sustaining counseling treatment or intervention plans" as it relates to counseling practice and relationships (section 3.E.1, 7, 11, and 13).

Counselor educators who adhere to CACREP's teaching standards are called to help facilitate growth in the areas of multicultural sensitivity and social advocacy as listed above. The CACREP standards used to guide accredited programs across the country tend to be more descriptive than prescriptive, offering little to no guidance to counselor education programs on how to incorporate their standards into coursework, or what courses should be taught. Adams et al. (2018) suggest that attention should be directed towards the areas in which action can be taken to create change rather than focusing on feelings of hopelessness. One method for addressing this change is integrating social justice issues in counseling courses that do not solely focus on multiculturalism and/or diversity as a topic. However, others suggest that a single multicultural course design that addresses the multicultural competencies may be a more effective approach to increasing the level of competence and openness in interacting with diverse populations (Celinska & Adams, 2016).

American Counseling Association Code of Ethics (2014)

Similarly, the ACA Code of Ethics (2014) notes the importance of advocacy and cultural competency in multiple sections, including Section A.2.c, Developmental and Cultural Sensitivity; A.4.b., Personal Values; C.2.a., Boundaries of Competence; and C.2.f., Continuing Education. Section A.2.c. asks counselors to utilize language that is appropriate for developmental level and cultural competence when engaging in practice, and to adjust practices as necessary to fit these needs. Section A.4.b. asks counselors to be aware of and avoid imposing their own values, attitudes, beliefs, or behaviors onto others while respecting diversity and

seeking training in areas they are not competent in. While Section C.2.a. asks counselors to practice only within their areas of competence, this does not mean counselors are exempt from working with diverse populations based on race, ethnicity, religion, sexual orientation, gender identity, or ability/disability status. Section C.2.f. asks counselors to recognize the need for continued education by embracing counseling humility and maintaining awareness of current issues within the field. With both the combined service needs identified for this historically marginalized population, as well as the values instilled into the counseling profession by ACA and CACREP, it is important to explore the ways in which counselors perceive their scope to provide services to individuals with intellectual disabilities.

Solutions Proposed by Literature

Teaching Practices to Increase Knowledge

Following Whittle et al.'s systematic analysis of literature on the subject in 2018, the following were identified as enablers for access to mental health care for individuals with intellectual disabilities: Innovative models of service delivery, clear referral pathways, established protocols, single point of access, interagency collaboration, education on the subject, capacity building, and up-skilling and training service providers. This impacts the field of counselor education as it includes a call to continue to help fill the current gap in increasing education on the subject of working with this population. Additionally, Walton et al.'s 2021 scoping review found that an increase in mental health related staff training in working with this population could benefit this population as it relates to increasing timely services and appropriate treatment.

In looking at what persons with intellectual disabilities view as important in their mental health care professionals, Weise et al. (2018) identified several critical areas. Participants

reported that they believe mental health professionals should be adaptable, able to communicate (on a developmentally appropriate level and without rushed time constraints), and work with a person's support network to reach identified goals. The findings also suggest the importance of a mental health clinician's ability to build rapport and trust with this population by demonstrating respect and suggest that people with intellectual disability could present as valuable educators and peer workers in teaching these attributes.

While no two clients may present the same way in neuro-typically developing populations, the same is true regarding those with intellectual disabilities and will still need to be met with the same, person-centered applications. To begin to implement educational practices that help counselors-in-training feel more prepared to work with this population, it is important to first take inventory to identify what counselors-in-training currently perceive to be working in preparing them to work with this population, if anything at all, as well as how prior exposure to this population might impact their confidence in working with this population.

Current Recommendations for Teaching Practices from the Literature

In Kelley et al.'s 2023 systematic review of the literature investigating empirically reviewed training on mental health care for direct support professionals serving individuals with intellectual disability, the authors discovered only fifteen articles. While the training programs noted were associated with some positive outcomes for those direct support professionals and/or individuals with intellectual disability, there were large limitations to those studies, including small sample sizes and lack of replication of training to further explore efficacy, highlighting this area as a largely understudied area of practice (Kelley et al., 2023). The most used frameworks guiding training programs for direct support professionals in Kelley et al.'s 2023 systematic review of the literature included a review of the biopsychosocial model and implementation of

cognitive behavioral therapy-based conceptualization and interventions, including third-wave cognitive therapy approaches such as dialectical behavioral therapy.

Hay and colleagues (2023) conducted a systematic review of the literature investigating interventions to improve the attitude, knowledge, and confidence of healthcare professionals, including primarily medical doctors and nurses, in treating patients with intellectual disability post-1980 that were published in English. In their study, all ten articles found included interventions using a theoretical component that consisted of reading materials, seminars, and/or didactic lectures, with 30% of the articles and interventions reviewed including some form of an experiential portion. Four of the ten articles and interventions utilized interactive components such as group discussions, workshop-style activities, or exercises, while two of the ten articles and interventions utilized an immersive component such as site visits or home visits, including contact with families or individuals with intellectual disability. Of the articles and interventions reviewed, 40% reported effectiveness in changing perceived confidence and attitudes, along with 60% reported achieving improvement in healthcare professionals' knowledge or skills based on Kirkpatrick classification scoring (Hay et al., 2023). Those four articles noted to have included interactive components as part of the intervention were the same four articles included in the 40% noted above reporting effectiveness in changing perceived confidence listed above (Hay et al., 2023).

Method

Prior studies have identified a need for greater quantity and quality of services for individuals with intellectual disability (Cooper et al., 2007; Einfeld et al., 2011; Einfeld & Tongue, 1996; Krahn et al., 2006; McCarthy & Boyd, 2002; Sheehan et al., 2015; Weiss & Lunsky, 2010). This study addresses a gap in the literature by asking counselors-in-training

what they perceive to be helpful in preparing to work with this population, as well as the context around their personal experiences with this population. This study explores counselors'-in-training attitudes towards counseling people with intellectual disability and perception of preparedness in counseling people with intellectual disability. To understand counselors'-in-training perception of preparedness, a semi-structured interview approach rooted in hermeneutic phenomenology was selected, as each individual counselor-in-training enters their counseling programs with unique experiences and backgrounds that have the ability to influence the phenomenon being investigated by this study: their perspectives and perception of preparedness to provide mental health services to individuals with intellectual disability (Ramsook, 2018; Fuster, 2019). Specifically, the data collected from the semi-structured interview process in this study aims to explore the experiences of counselors-in-training by addressing the following: (1) How would participants describe the training their programs have implemented related to working with individuals with intellectual disability? (2) What, if anything, do participants perceive to be helpful in preparing to work with this population of individuals with intellectual disability in the counseling field?

Procedures

Participant Selection

Participants for this study included masters-level, CACREP-accredited clinical mental health counseling students at various universities across the United States. Participants were adults ages 18 and older, students who were enrolled in their master's level program at the time of the interview process, attended part-time or full-time, and may or may not have experienced prior exposure or contact with a person with an intellectual disability to participate.

To ensure participants were a good fit for the study, they were asked to complete a brief demographics questionnaire via a Qualtrics survey (Appendix E), which was reviewed by the Principal Investigator (PI). The Qualtrics survey began with an information letter about the study and asked participants if they agreed and consented prior to moving forward with completing demographic information for the study. This demographics questionnaire found in Appendix E aided in ensuring they met the participant criteria listed above. When it was determined they were a good fit, the PI reached out to the participants using the contact information provided in the survey. At the end of the survey, participants had the option to select their own pseudonym for the study or opt to have one assigned to them by the PI. Questions were added during the semi-structured interview process as part of the hermeneutic circle to better understand phenomena occurring for participants (Gadamer, 1975). Such questions included asking participants to define how an intellectual disability is diagnosed using DSM-5 TR criteria to reduce any misunderstanding during the interview process, and asking participants if there was anything they would like to add to the data at the end of the interview after answering the questions listed in the interview protocol. Each participant was asked to complete an individual, one-on-one interview, which is the method of data collection recommended when using a hermeneutic phenomenological approach to assist the researcher with identifying each individual's interpretation of their experiences (Fuster, 2019; Ramsook, 2018). Using the departmental grant funding awarded, which totaled $500, each participant was given a $50 e-gift card to Amazon.com upon the completion of their demographic questionnaire and their one-hour interview.

Participant Recruitment

Participants for the study were recruited through purposive sampling. Purposive sampling was chosen following recommendations by Fuster (2019) and Ramsook (2018), outlining the process for hermeneutic phenomenological approaches to ensure participants meet the thick description requested to investigate specific phenomena for the study. Recruitment included using a counseling listserv through Cesnet-L. In addition, emails, including recruitment requests, were sent to program coordinators of CACREP-accredited clinical mental health counseling programs at academic institutions across the United States.

Data Collection

Upon approval from the institution's Institutional Review Board (IRB), the primary investigator (PI) conducted one-on-one semi-structured interviews via secure password-protected Zoom meetings. A total of twelve questions and sub-questions were created with the goal of eliciting the experiences of counselors-in-training preparing to work with individuals with intellectual disability. The semi-structured interviews were thought to last approximately 45 to 60 minutes but tended to last 20 to 40 minutes, with the average interview time of 30 minutes. The process of creating the semi-structured interview protocol followed guidance from hermeneutic phenomenological approaches, including questions that allowed for thick description to be included in answers as well as background about participants' unique lived experiences (Fuster, 2019; Ramsook, 2018). The questions were peer-reviewed by counselors familiar with CACREP's program standards to ensure the language used is developmentally appropriate for counselors-in-training who are in the beginning stages of their counselor education programs or their practicum and internship portions in the later stages of their programs. Additionally, questions were examined by peers to reduce bias by ensuring they are

not leading. These semi-structured interview questions can be viewed in Manuscript Appendix A.

Data Analysis

Once interviews concluded, the researcher saved recorded audio from the interviews to a secure, password-protected Box.com account under the participant's pseudonym. The researcher then utilized the software program NVivo to transcribe and code themes occurring within the interviews to identify larger phenomena that may be present in the data. The researcher ensured close attention to including thick description in coding procedures, as thick description adds to the context of individuals' experiences related to their meaning-making from a hermeneutic lens (Ramsook, 2018).

Data was coded inductively, allowing themes to emerge from the lived experiences of counselors-in-training (Creswell, 2014; Fuster, 2019; Ramsook, 2018). The first stage of analysis included identifying significant statements related to research questions posted in the study, followed by the second stage of organizing these statements into groups of similar themes through repetition and shared experiences (Creswell, 2014). Once the researcher categorized these themes with supporting quotes from the interviews, the researcher shared the findings with the peer auditor and members for member-checking to commence to ensure the lived experiences of participants were accurately reflected in the themes identified in the research (Creswell, 2014).

Reflexivity Statement

I, the researcher, approached this study as an able-bodied, white female while acknowledging my own privileges as such. I also take into consideration potential biases I hold as someone who is the sibling of an individual with a physical disability, as a counseling

clinician working with individuals with various disabilities, and the impact my experiences have had working at the post-secondary level in inclusive higher education for over six years, causing me to be very aware of where gaps currently exist in my community's mental health care for individuals with disabilities. I recognize my perspective is not the only perspective in working with this population, and as an able-bodied individual, I cannot speak on behalf of the intellectual disability community to state what is or is not desired of counselors providing them services. Also, having been exposed to individuals with disabilities throughout my lifetime, I cannot speak from my own experience on what individuals who have not been exposed to this population may need to feel comfortable and confident in working and interacting with this population.

Findings

For the data collection process, ten masters-level counselors in training attending CACREP accredited programs completed interviews about their experiences preparing to provide counseling to future clients. Interview questions were narrowed down to discuss participants' experiences preparing to work with individuals with disabilities, and more specifically, intellectual disability. These participants joined their interviews virtually via the Zoom platform, while physically located across the United States. Participant demographics can be found in Manuscript Table 1. From the data collected during the interviews, four themes emerged: (1) Diagnostic confusion, (2) Advocacy for access, (3) Diffusion of responsibility, and (4) Desire for further training. Coding used to determine these four themes can be viewed in Manuscript Table 2.

Manuscript Table 1: Participant Demographics

Pseudonym	Age	Gender	Race	Disability Identity	Program Setting	Year in Program	Internship Site Placement	Prior Contact with Individuals with ID	Provision of Services to Individuals with ID
Eleanor	22	Woman	White	No	Hybrid	2	CMH	Yes	Yes
Janet	24	Woman	White	No	In person	3	PP & CMH	Yes	No
Tahini	24	Woman	White	No	Hybrid	3	CMH	No	Unsure
Loreli	43	Non-binary	White	Yes	Hybrid	3	PP & CMH	Yes	No
Rory	26	Woman	White	No	Online	2	PP	No	Unsure
Emily	24	Woman	Black	No	Hybrid	3	PP	Yes	Yes
Kate	24	Woman	White	No	Online	2	UCC	Yes	Unsure
Anne	46	Woman	White	No	Hybrid	3	ES & PP	Yes	Yes
Nick	23	Man	White	No	Hybrid	2	UCC	Yes	No

Jess	24	Woman	Native American	No	Online	2	UCC	Yes	Yes

Note. Under "Internship Site Placement," CMH stands for Community Mental Health, PP stands for Private Practice, UCC stands for University Counseling Center, and ES stands for Elementary School.

Manuscript Table 2: Coding Results

Theme Derived	Code	Definition	Sample Quote
Diagnostic Confusion	Correct Dx	Used when participants correctly identified DSM-5-TR criteria for an ID diagnosis	“It's anyone that has like, adaptive behavior difficulty, like in living independently or their employment, usually with IQ being below the norm. It can be mild, moderate, severe.”
Diagnostic Confusion	Incorrect Dx	Used when participants incorrectly identified/were unable to identify DSM-5-TR criteria for an ID diagnosis	"ID is things that are affecting your brain, like your cognitive ability... so like having autism for example. That can be considered an intellectual disability rather than being paralyzed.”
Advocacy for Access	Positive Outlook on ID	Used when participants made favorable statements regarding individuals with ID	“They have innate worth and offer so much to relationships and just the world."
Advocacy for Access	Belief in Access	Used when participants made statements affirming the need for accessible mental health services for individuals with ID	“If someone has ID and a dog bit them and they’re [experiencing] trauma, I don’t believe that there’s any reason why an ID would counter indicate [effectiveness of] EMDR… as long as they are able to do the regulation skills and tolerate the processing.”
Diffusion of Responsibility	Barriers	Used when participants identified barriers for individuals with ID to access mental health care	“I think overall the biggest challenge is the stigma surrounding people with ID. There is a lot of infantilization of them.”

Diffusion of Responsibility	Personal Perception: Positive	Used when participants reported a positive perception of their confidence and/or preparedness to provide services to individuals with ID	"So, for me, because of my background, I think it's important, I feel very inclusive. I want to try and create those opportunities."
Diffusion of Responsibility	Personal Perception: Negative	Used when participants reported a negative perception of their confidence and/or preparedness to provide services to individuals with ID	"I don't think it's fair to the client for me to provide services, because on a scale of one to ten on how confident I feel, my confidence level would be like a four right now because of the lack of trainings and specific teaching on it."
Desire for Further Training	Lack of Interventions	Used when participants mentioned areas they perceived as lacking from their academic programs to prepare them to work with individuals with ID	"I think the only time ID was covered in my program was in the assessment class, and they basically told us how Autism is diagnosed and that it is usually other specialists that do it."
Desire for Further Training	Desired Interventions	Used when participants mentioned interventions they believe could have been helpful to prepare them to work with individuals with ID	"Because it isn't really something we can do role plays on, it would help to see someone with ID in like videos or to read about actual experiences in a book."

Note. Intellectual disability is referred to as ID; Diagnosis is referred to as Dx; Treatment is referred to as Tx.

Diagnostic Confusion

The first theme that emerged from the data exposed what could be contributing to feelings of hesitancy and inadequacy when it comes to providing services to individuals with intellectual disability: Confusion on what an intellectual disability actually is. During the interviews, seven of the ten participants were unable to correctly answer the question "How is an intellectual disability defined in the DSM-5-TR (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition)?"

Majority of participants were able to differentiate an intellectual disability from a physical disability. For example, Janet stated an intellectual disability is "things that are affecting your brain, like your cognitive ability... so like having autism for example. That can be considered an intellectual disability rather than being paralyzed." While Janet was correct that an intellectual disability impacts cognitive function, not all individuals on the autism spectrum qualify as having an intellectual disability; although, the two diagnoses can co-occur. Rory described an intellectual disability as "ADHD (Attention-Deficit/Hyperactivity Disorder), where someone really can't focus on things." The interviewer then clarified that while ADHD can co-occur with an intellectual disability, not all individuals with ADHD have an intellectual disability. Kate, Nick, and Tahini also described an intellectual disability as diagnoses that fall under the category of learning disabilities, such as dyslexia and ADHD, as well as autism spectrum disorder which is considered a developmental disability.

Advocacy for Access

A theme of advocacy for access to mental health services for this population was present throughout participant interviews, covering contributing factors to access such as discrimination, stigma, and consideration of collateral information to aid in treatment planning for services.

While some participants felt they lacked competence to provide services themselves to individuals with intellectual disability at the time of their interviews, each of the ten participants shared positive remarks affirming their belief that individuals with intellectual disability should somehow have access to mental health services. Loreli stated, “If someone has intellectual disability and a dog bit them and they’re [experiencing] trauma, I don’t believe that there’s any reason why an intellectual disability would counter indicate [effectiveness of] EMDR… as long as they are able to do the regulation skills and tolerate the processing.”

When discussing future plans for work as a counselor, the interviewer asked interviewees about their likelihood to provide services to individuals with intellectual disability in their desired counseling setting. Tahini expressed, “I would hope to work at a practice that would not discriminate in any way.” Janet stated, “I would not in any way be like, ‘Oh I really don’t want to see clients that have a disability.’”

When identifying considerations for services for individuals with intellectual disability during the interview process, Rory defended the population of individuals with intellectual disability against stigma that may exist in the clinician community by stating, “[People with disabilities] may be pathologized… not fitting into nice, neat boxes and [others] may see that as a problem when it’s just a difference in how we experience the world.” Jess stated, “I think overall the biggest challenge is the stigma surrounding people with intellectual disabilities. There is a lot of infantilization of them.” Anne and Nick provided statements of high regard for those with intellectual disability, stating respectively, “[People with intellectual disability] have innate worth and offer so much to relationships and just the world,” and, “[People with intellectual disability] have such kind hearts… it is shocking to see that sometimes people with higher cognitive functioning are not able to be kind.”

Additional considerations for providing individuals with intellectual disabilities counseling included the importance of including their support system in the planning of services. Nick shared a desire to gain information from parents, employers, and/or teachers of the individual with an intellectual disability to better understand presenting concerns. When discussing what she would like to know further before providing mental health services to an individual with intellectual disability, Emily stated,

> I would want to know what their family system and history look like as well as other relationships in general. How do they feel [about their disability] on a society level and visual level, and all of those layers? What are they doing to support themselves now, and do they have accommodations or modifications? … I feel like that all puts the puzzle pieces together when you are sourcing for referrals or supports and stuff.

Similarly, Kate expressed a desire to know how much the individual believes their disability affects them in their day-to-day life to identify next steps in services. Loreli reiterates the importance of collaboration in treatment planning, stating "if they say their goal is to become independent, I would love to work with someone else like a social worker on that in supporting independence skills and knowing what types of folks do that, then have them sign a release of information."

Diffusion of Responsibility

Throughout the ten interviews conducted, participants considered whose responsibility it is to provide counselors in training with information needed to serve the population of individuals with intellectual disability: Was it solely the responsibility of their university counseling programs, or are they called to independently seek training as a result of their code of ethics? Janet considered whether or not referral would be appropriate if an individual with an

intellectual disability sought mental health services through her, stating "Where does it come in, the piece with me needing to refer? Because in [our program] we talk so much about how important it is, that willingness to see clients from diverse backgrounds but we also can only provide services within our scope." Loreli shared, "as long as intellectual disability is considered a 'special population,' [providing mental health services] is going to be considered a niche thing, you know?" Emily reinforces this idea through her response,

> I feel like a misconception about working with individuals with intellectual disability is that it has to be this separate thing… their disability may not be their presenting concern. It's like I get where you are trying to encourage people to become knowledgeable about specific populations, but at the same time their disability may not be related to what they want to work on.

Potential Barriers to Services

As the interviewer and interviewees explored considerations for providing mental health services, participants pointed out potential barriers to provide services and the need for clinicians to mitigate these roadblocks to accessing services, which may contribute to difficulty in taking responsibility to provide services. Eleanor identified that many individuals with intellectual disability rely on health plans that fall under Medicaid and Medicare through previously funded federal services for individuals qualifying for disability services, which clinicians would need to accept to alleviate possible financial burden for clients with intellectual disability.

Further identifying barriers to communication in the counseling room, Anne reports concerns about needing to apply counseling theories on an appropriate developmental level due to the deficit in intellectual functioning for this population, stating "[Some counseling theories]

don't translate well for a lot of people. We even see this when counseling younger people." Nick echoes this sentiment, stating,

> I think I'd have to do some self-work and research on [the client]'s specific situation because I'm aware of how unique people's needs are, understanding the developmental levels and what might be appropriate. So, like, I'd look into, do we need to do an expressive arts or play modality, or are we ready for talk therapy? … I think there may be barriers in communication. There might be things that are very clear in my head that I want to communicate, but things that may not come across as intended.

Perception of Competency and Preparedness

When addressing personal feelings about competency and preparedness to provide services, participants fell into one of two camps: those who felt confident expressed how their prior experiences with individuals with disabilities made them feel prepared, while others with little to no exposure expressed a sense of nervousness. Anne reports, "If you don't already have some kind of proximity to people [with disabilities], certain things just may not register with you." Janet stated that as a result of having a family member with a disability, she tries to be aware of her tone and enunciation in a developmentally appropriate way when talking with an individual who has an intellectual disability. Additionally, she states "When using sarcasm, for example, or looking for social cues, I have to be aware that that can be harder to read for certain people. Sometimes as clinicians we need to adjust based on our clients." Kate says her exposure to individuals with disabilities in her personal life allowed her to "have less judgement towards people because you never really know what someone is going through."

Eleanor reports that when interacting with clients with disabilities, she felt like "there was more pressure, like it made me more nervous and question what I was doing. I don't feel

prepared myself to provide services to [individuals with intellectual disability].” Jess stated, “I think it depends on what resources I have available and the severity of the intellectual disability if I could provide services or not.” Loreli stated, “If I had [a client with an intellectual disability] I would be nervous because I would worry whether or not I was practicing within my scope… if I’m a bad person for not providing services. I would have to investigate and get support.” Rory stated, “I don’t think it’s fair to the client for me to provide services, because on a scale of one to ten on how confident I feel, my confidence level would be like a four right now because of the lack of trainings and specific teaching on it.”

Desire for Further Training

Lack of Interventions

The fourth theme identified in this study covers what participants felt were missing from their training when it came to increasing preparedness and confidence in working with individuals with intellectual disability, as well as what they would have desired to increase their sense of preparedness and confidence. While some participants shared instances in which their program provided a class lecture or seminar on considerations for counseling individuals with disabilities in general, only two of the ten participants report experiencing a lecture on counseling individuals with intellectual disability specifically. Even within these lectures, zero of ten participants report any material on counseling individuals with intellectual disability being presented over the course of the full class period or longer. Tahini reports, “Even though I took a class covering diverse populations, it was much more focused on diversity of ethnicity.” Anne said, “I think the only time intellectual disability was covered in my program was in the assessment class, and they basically told us how Autism is diagnosed and that it is usually other

specialists that do it." Eleanor stated, "When disability was mentioned, it was more interwoven in other classes, but never the main subject." Loreli said,

> When we talked about intellectual disability, it was covered for like five minutes in our diagnosis class, but that was it. We never talked about what special training was needed to work with [individuals with intellectual disability]... If we were going to talk about what disabilities were covered the most, and we ranked them, I think intellectual disability would be ranked the lowest.

Emily shared:

> A lot of conversation about not only people with disabilities but what their different stages of life are like are missed because it seems like disability was offered more as an elective focus rather than being embedded in the natural course of the degree plan. I feel like it should be a topic covered for everyone, regardless of your track.

Desired Interventions

During the interview process, participants shared the desire for the following interventions to be implemented based on what they deem as helpful to grow in confidence and preparedness to provide counseling services to individuals with intellectual disability: (1) Watching documentaries featuring people with disabilities (specifically intellectual disability), (2) Reading text or articles about best practices for providing counseling services to this population, (3) Introducing disability identity in case studies and conceptualization practiced in classes, (4) Broaching ableism and privilege as it relates to disability and ability identity for counselors, (5) Placing students at practicum and internship sites in which they are exposed to working with people with intellectual disability, and (6) Providing students with supervisors with experience working with individuals with different types of disability (including intellectual

disability). Eleanor shared, “Because it isn’t really something we can do role plays on, it would help to see someone with [an intellectual disability] in like videos or to read about actual experiences in a book.” Jess echoes the desire to learn from lived experiences, sharing “Instructors could share videos, articles... anything like that.” Tahini also shared a desire for verbal presentation, videos, articles, or hearing verbally from classmates’ experiences to learn more about working with individuals with intellectual disability, or any disability in general. Tahini said,

> I just think you could dedicate like a whole class in every topic to what that aspect of counseling would look like with a person with an intellectual disability. Like, show videos of what it looks like to diagnose a person with an intellectual disability, just working with a person with an intellectual disability.

Loreli shared, “If we are going to train people to work with this population, then you need to, I guess, like expose them to the population for real... you have to actually work with a person to know what their struggles are. We didn’t do a lot of videos in my school.” Kate reiterates the importance of the application piece for training, sharing “I’m not a learning by lecture kind of person, I want to actually be able to practice it.”

Janet shared, “I really liked in one of our classes doing an inventory checklist of things that, like, you don’t even realize could be considered a disability. That was a really good conversation.” Anne also touched on the importance of this reflection for counselors in training by stating, “I think it is important to ask counselors like, ‘What is your schema when it comes to working with this population?’”

Discussion

The findings of this research study aimed to address the roots of the lack of quality mental health services for individuals with intellectual disability discussed in earlier chapters of this dissertation by asking those who are in training to provide these services how they perceive their preparation from their training programs, as well as their own thoughts related to providing services to this population. In order to answer the research questions posed in this study, the interviewer conducted semi structured interviews grounded from a social constructivist lens with ten participants who were completing their practicum and/or internship portion of their masters level counselor education program. Through the completed inductive coding process, four themes emerged to better understand the counselors experiences of the in training during their time in their programs as it relates to applying counseling skills to working with individuals with intellectual disability. The four themes that emerged are: (1) Diagnostic confusion, (2) Advocacy for access, (3) Diffusion of responsibility, and (4) Desire for further training. This chapter will discuss those findings, implications for the field of counselor education, limitations of the study, as well as recommendations for future research on this topic.

Current literature demonstrates a gap in understanding how to improve the quantity and quality of mental health services provided to individuals with intellectual disability (Man et al., 2016; Weise & Troller, 2017). This research aimed to address this gap by asking those presently preparing to enter the workforce as counselors what they perceived as helpful and/or unhelpful when it comes to applying their skills in the counseling room to potential clients diagnosed with an intellectual disability. The findings within this study can be applied to counselor education through better informing counselor educators and the CACREP program governing body on how to implement teaching practices and content that may increase trainees' preparedness and confidence to provide counseling services to individuals with intellectual disability to address the

gap in quantity and quality for these services in the United States (Cooper et al., 2007; Einfeld et al., 2011; Einfeld & Tonge, 1996; McCarthy & Boyd, 2002; Walton et al., 2022). Participants' answers overall revealed a belief across all ten interviews that this population deserves access to quality mental health care, even though there is still a need for discussion on who is responsible for preparing counselors to provide these quality services, and how to do so within training programs.

Diagnostic Confusion

The confusion demonstrated in interviews of the diagnostic criteria for an intellectual disability can be considered a contributing factor for a lack of confidence in practitioners, as this lack of clarity makes it more difficult to identify how an intellectual disability actually impacts the day-to-day experiences of those diagnosed. Additionally, confusion about these symptoms may further contribute to inaccurate stigma around the diagnosis or cause assumptions that overlook needs of those diagnosed with an intellectual disability (such as clinicians not identifying the deficits in adaptive behavior functioning in those they are treating).

This speaks to a deficit in trainee preparedness, despite CACREP requiring a diagnostic course be implemented in counselors' masters-level training. This confusion is additionally depicted through responses in their demographics survey, as three of the ten participants stated they were unsure if they had treated an individual with an intellectual disability at their internship site. It is worth noting that the three participants who did correctly define an intellectual disability according to DSM-5-TR criteria noted in their demographics survey responses that they had prior exposure and contact with persons with an intellectual disability in their family, through work experience, or through knowing an acquaintance with an intellectual disability.

Advocacy for Access

Although some participants report a current lack of confidence and/or preparedness to work with those with an intellectual disability, all ten participants expressed the desire for mental health services to be accessible for this population. Discussion related to advocacy for access included identifying potential barriers to services which was also identified in the literature reviewed prior to this study, such as: 1) Lack of financial means to pay out of pocket for services, leaving many within this community relying on federally funded insurance programs such as Medicaid and Medicare, and 2) Barriers in communication, such as lack of training on implementing developmentally appropriate language, or how and whether to include the client's support system in treatment planning to set realistic and person-centered goals for therapy. While participants expressed the belief that these services should be provided, and these barriers should be mitigated for services, considerations on who should be responsible for addressing these leads us into the next theme: Diffusion of responsibility.

Diffusion of Responsibility

While sharing about their thoughts on individuals' access to services, participants considered whether their programs were to blame for a lack of perceived preparation to provide counseling services to individuals with intellectual disability, or if it was their own responsibility to seek out training as it relates to the American Counseling Association Code of Ethics (2014). Participants also mentioned considering if it was "cruel," "mean," or "wrong" that this population may not considered their "niche" to learn about when prioritizing continuing education outside of their training programs. Ultimately, despite their differing personal thoughts and feelings on seeking further training to work with this population themselves after their participation in these interviews, all participants were able to identify suggestions on what their

programs could implement in the future to help prepare counselors to work with this population based on what they perceive to have been helpful during their training experiences.

Desire for Further Training

During the interview process, participants were able to identify six recommendations collectively for counseling programs to implement to better prepare counselors in training to provide services to individuals with intellectual disability. These recommendations included: (1) Watching documentaries featuring people with disabilities (specifically intellectual disability), (2) Reading text or articles about best practices for providing counseling services to this population, (3) Introducing disability identity in case studies and conceptualization practiced in classes, (4) Broaching ableism and privilege as it relates to disability and ability identity for counselors, (5) Placing students at practicum and internship sites in which they are exposed to working with people with intellectual disability, and (6) Providing students with supervisors with experience working with individuals with different types of disability (including intellectual disability). These suggestions are supported by Hay and colleagues' 2023 systematic review of literature which identified interventions such as increased reading materials, implementation of seminars and didactic lectures, group discussions, workshops, and immersive learning components.

Limitations

Limitations for this study include the small participant size, potential impact of interviewer's biases and life experiences, and low diversity in the sample pool as it relates to race, ability/disability identity, and gender identity. While this study focused on the experiences of ten counselors in training, this does not mean their experiences expressed through the themes that emerged accurately represent all counselors in training. However, Tracy's text (2010) states

that transferability of findings can be achieved when it comes to qualitative research. With this in mind, it is the author's hope that exploring the experiences of these ten participants can help aid future discussions and research on this topic as it relates to improving access to services for individuals with intellectual disability at the source of counselors' training experiences. Despite methods implemented to utilize triangulation and trustworthiness, there is always the possibility present that the life experiences of the researcher could have impacted findings in some way, as noted in the author's reflexivity statement. Additionally, there is the possibility of social desirability that could have impacted participants' responses to interview questions, affecting themes derived from the data; although the effort to maintain anonymity of participants was made to reduce the chance of this occurring. Finally, because the sample pool involved in this study included eight women, one man, and one non-binary participant; over 80% of the participant pool identifying as White; and 90% identifying as members outside of the disability community, one should note that a more diverse participant pool could result in different emerging themes.

Recommendations for Future Research

This study focused on the experiences of counselors in training as it relates to preparation they may have received in their master's level programs to counsel individuals with intellectual disability. As noted in the limitations section, including a participant pool from more diverse backgrounds may better educate the field on experiences and desires as it relates to the training processes discussed in this study. Studies conducted in the future might also want to include the perspectives and experiences of counselor educators as it relates to CACREP standards and infusing intersectional considerations in class content, including developmental considerations and disability identity applied for individuals with an intellectual disability. Future research

should also seek out the thoughts of individuals with intellectual disability on what they perceive as helpful to increase their access to quality mental health services to include their perspectives in the conversation. It may also be beneficial to include participants who are currently practicing licensed and counseling in the mental health field in future research to gain perspectives from those with more experience. It may also be useful to seek out participants with intellectual disability to be a part of creating video case studies for use in counselor training programs, followed by a study to test the effectiveness of these visual and audio samples for counselors in training to increase perception of preparedness and confidence to counsel this population. Finally, while this study utilizes a qualitative approach to discuss participant experiences, it may be worth utilizing quantitative measures to further explore perceptions of preparedness, confidence, and self-efficacy in providing services to individuals with intellectual disability, both before and after implementing some of the recommendations noted in this dissertation to discover what works and what does not in instructing counselors in training to provide these services.

Implications for Practice and Counselor Education

As supported by previous literature (Hay et al., 2023; Kelley et al., 2023), in order to better prepare counselors to feel more competent and confident in providing mental health services to individuals with intellectual disability, it is recommended that counselor educators work to infuse more intersectional-focused teaching strategies in the classroom that apply considerations for this population to routine theories and skills taught in counseling courses. In this study, participants specifically reported a desire for increased teaching interventions that include (a) Watching documentaries featuring people with disabilities (specifically intellectual disability), (b) Reading text or articles about best practices for providing counseling services to

this population, (c) Introducing disability identity in case studies and conceptualization practiced in classes, (d) Broaching ableism and privilege as it relates to disability and ability identity for counselors, (e) Placing students at practicum and internship sites in which they are exposed to working with people with intellectual disability, and (f) Providing students with supervisors with experience working with individuals with different types of disability (including intellectual disability) to increase their confidence and competence levels when providing services to individuals with intellectual disability. By infusing these techniques in classes already established in counseling programs through CACREP recommendations, this would not ask programs to adopt additional courses to students' already packed schedules but rather allow for psychoeducation and considerations related to serving this population to be discussed in class sessions that already occur throughout a typical semester. As a result of these infused inclusive teaching practices, it is the author's hope that quality and quantity of services for this population could increase due to a rise in counselors' confidence and competence levels exiting their masters-level counselor training programs. This speaks to future research that can be conducted as well that focuses on measuring the efficacy of each teaching intervention mentioned by this study's participants, as the literature in this area is quite limited specifically relating to knowledge on serving individuals with intellectual disability.

Conclusion

This research study was conducted to better understand what counselors in training perceive to be helpful in preparing to provide services to individuals with intellectual disability. Ten counselors enrolled in the second or third year of their masters level training programs, who are participating in the practicum and/or internship phases of their education, completed semi-structured interviews that resulted in the identification of the following four themes: (1)

Diagnostic confusion, (2) Advocacy for access, (3) Diffusion of responsibility, and (4) Desire for further training. Through sharing their experiences and perceptions, these ten participants have contributed to the literature by helping readers better understand what those preparing to enter the workforce may need to improve quality and quantity of mental health services provided to those diagnosed with intellectual disability.

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Manuscript Appendix A:

Pre-Summer Focus Group Meeting Interview Protocol

Semi-Structured Questions

1. I see in your screening paperwork you completed prior to this interview, you stated your previous experience with individuals with intellectual disabilities and other disabilities included ____. Can you tell me more about these experiences and how they may have influenced your thoughts/attitudes towards individuals with ID?
2. If a client with an intellectual disability presented to you today for mental health services, how would you feel about providing these services?
3. What might you perceive as a challenge when working with individuals with intellectual disability?
4. If a client with an intellectual disability presented to you today for mental health services, what do you think would be important to consider for their services?
5. How likely do you think you are to work with a client with a co-occurring intellectual disability at your desired place of practice in the future?
6. During your time in your masters-level CACREP mental health counseling program, have there been any classes/workshops/seminars in which discussed working with clients with disability?
7. What about working specifically with clients with intellectual disability?
8. What methods did your program use specifically to discuss applications related to disability? (if clarification is needed, applications might have included case studies, verbal or presentation lecture material, use of media such as videos or articles, etc.)
9. What about intellectual disability specifically?

10. In what ways do you think such approaches were helpful and/or unhelpful in developing awareness, understanding, and/or skills working with this population?

11. Is there anything you believe your program could further implement to help increase your **confidence** in working with individuals with intellectual disabilities?

12. Is there anything you believe your program could further implement to help increase your **preparedness** in working with individuals with intellectual disabilities?

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Appendix A: Information Letter

INFORMATION LETTER

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS AN IRB APPROVAL STAMP WITH CURRENT DATES HAS BEEN APPLIED TO THIS DOCUMENT.)

Title of research study: Investigating Counselors in Training Attitudes and Perceptions on Counseling Clients with Intellectual Disability
Investigator: ***Claire Carriere Hebert, M.Ed., LPC, NCC, BC-TMH; supervised by Jinhee Park, Ph.D.***
Sponsor: ***Auburn University SERC Seed Grant***

You are invited to participate in a research study to explore the experiences of clinical mental health counselors-in-training from CACREP accredited programs as they prepare to potentially provide counseling services to individuals with intellectual disability to gain better understanding of prior exposure to individuals with intellectual disabilities, how/if they feel they are prepared by their training programs to work with this population, and what they perceive to be helpful in preparing to work with this population. The study is being conducted by Claire Carriere Hebert, M.Ed., LPC, NCC, BC-TMH who is the Principal Investigator while under the direction of Jinhee Park, Ph.D., Research Supervisor in the Auburn University Department of Special Education, Rehabilitation, and Counseling (SERC). You are selected as a possible participant because you are a counseling student enrolled in a masters-level, CACREP-accredited counseling program, and you are a graduate student aged 18 years or older.

What will be involved if you participate? If you decide to participate in this research study, you will be asked to complete a brief demographic survey and participate in a semi-structured interview. The time commitment will be approximately one hour. During the interview, you will be able to answer with as much or as little information as you like regarding your experiences. The researcher will analyze findings to gather themes from your experiences, and you will be contacted to review the findings.

Are there any risks or discomforts? Due to interviews being collected for this qualitative study, there is a risk of breach of anonymity. The researcher will be vigilant in order to protect participant anonymity throughout the study. Participants will be asked to select a pseudonym, or will be assigned one, in order to connect collected data and corresponding reports of research

findings. All interview audio will be transcribed by the Principal Investigator and the interview recordings will be destroyed after transcription and data collection is complete. All data will be kept in a secure file on a password-protected computer until they are deleted. Findings obtained through individuals' participation may be presented at a professional conference and published in a professional journal, but the researcher will not include participant names or any other identifying information in order to protect your privacy.

Are there any benefits to yourself or others? There are no immediate or direct benefits for you taking the research survey. However, your participation in the current study may help obtain data that provides insight about current counselor in training (CIT)s' attitudes and perceptions towards providing counseling services for individuals with intellectual disability. This will contribute to the professional counseling literature and provide considerations for counselor educators and supervisors to consider while preparing future counselors for the counseling profession. We cannot promise you that you will receive any or all of the benefits described.

Will you receive compensation for participating? Participants who meet criteria to participate in the study and are able to participate fully throughout the interview process will be eligible to receive a $50 e-giftcard to Amazon.com

Are there any costs? If you decide to participate, you will not incur any costs for participating in this study. Auburn University has not provided for any payment if you are harmed as a result of participating in this study.

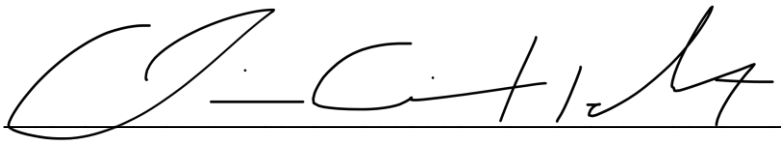
If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw, your data can be withdrawn as long as it is identifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University and/or the Department of Special Education, Rehabilitation, and Counseling.

Any data obtained in connection with this study will remain anonymous. Participants will be asked to select a pseudonym, or will be assigned one, in order to connect collected data and corresponding reports of research findings. All interview audio will be transcribed by the Principal Investigator and the interview recordings will be destroyed after transcription and data collection is complete. All data will be kept in a secure file on a password-protected computer until they are deleted. Findings obtained through individuals' participation may be presented at a professional conference and published in a professional journal, but the researcher will not include participant names or any other identifying information in order to protect your privacy.

If you have questions about this study, please ask them now or contact Claire Carriere Hebert via email at cac0215@auburn.edu, or Dr. Jinhee Park at 334-844-7620 or by email at jzp0095@auburn.edu. Also, please keep a copy of this document or save a copy on your computer for your information.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334) 844-5966 or e-mail at IRBadmin@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.



9/25/24

Investigator's signature Date

Claire Carriere Hebert, M.Ed., LPC, NCC, BC-TMH

Investigator's Name

Co-Investigator's signature Date

Co-Investigator's Name

Appendix B: Recruitment Request Email

Good morning,

My name is Claire Hebert, and I am a Counselor Education doctoral candidate in the Department of Special Education, Rehabilitation, and Counseling at Auburn University under the supervision of Dr. Jinhee Park. I am reaching out to you today regarding data collection for my dissertation study titled: *Exploring Clinical Mental Health Counselors-in-Training Experiences Preparing to Counsel Clients with Intellectual Disability* (Auburn University IRB Protocol #STUDY00000325).

I am asking for your assistance in distributing information regarding this study and the research survey link to your students who might meet eligibility criteria: (1) graduate students enrolled in your Clinical Mental Health Counseling program/course, and (2) ages 18 years or older. **Each participant who meets criteria to participate in the study, is selected, and is able to participate fully throughout the interview process will receive one $50 e-giftcard to Amazon.com.**

The purpose of this study is to explore the experiences of clinical mental health counselors-in-training as they prepare to potentially provide counseling services to individuals with intellectual disability to gain better understanding of prior exposure to individuals with intellectual disabilities, how/if they feel they are prepared by their training programs to work with this population, and what they perceive to be helpful in preparing to work with this population.

In this study, participants will be asked to complete a brief demographic survey and a semi-structured interview that will be audio recorded. All interviews will be conducted via Zoom or telephone. The total time commitment for participants will be approximately one hour. Participation in this study is completely voluntary, and participants may withdraw from this study at any time.

Any data obtained in connection with this study will remain anonymous to protect participants' privacy. Participants will be asked to select a pseudonym, or will be assigned one, in order to connect collected data and corresponding reports of research findings. All interview audio will be transcribed by the Principal Investigator and the interview recordings will be destroyed after transcription and data collection is complete. All data will be kept in a secure file on a password-protected computer until they are deleted. Findings obtained through individuals' participation may be presented at a professional conference and published in a professional journal, but the researcher will not include participant names or any other identifying information in order to protect participant privacy.

Please forward this email to your students so that those who are interested may participate in this study by following the information link below (link is all lowercase):
aub.ie/screeningid

Participants can see the attached information letter, which provides detailed information about the purpose of this study, the voluntary nature of participation, anonymity incentives, and potential harm. This information will also be presented when students follow the information link.

If you or your students have any questions about this research, please do feel free to reach out. I appreciate your support in this endeavor!

Best,

Principal Investigator: Claire Carriere Hebert, M.Ed., LPC, NCC, BC-TMH
Auburn University Supervising Faculty: Jinhee Park, Ph.D., CRC, Auburn University

The Auburn University Institutional Review Board approved this document for use on January 8, 2025. Protocol #STUDY00000325

Appendix C: Graphic for Distribution with Email

Appendix D: Qualtrics Survey including Demographic Questions and Information Letter

Dissertation Demographics Screening Questions

Note: This survey has been created and would be distributed via Qualtrics online.

Start of Block: Consent

Q1 Please read and review the information letter below before proceeding. You are encouraged to screenshot this letter to keep for your records should you wish. [Insert information letter here once approved by IRB]

Q2 I have read the above and consent to participate in this survey.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I have read the above and consent to participate in this survey. = No

End of Block: Consent

Start of Block: Contact and Pseudonym

Q5 Should you met criteria to participate in this study, what is a good email address for us to use to contact you for an interview?

_____

Q6 If you would like to create your own pseudonym to be used in the study to protect your identity, please write it here; otherwise leave blank and a pseudonym will be assigned to you by the principal investigator:

_____

End of Block: Contact and Pseudonym

Start of Block: Demographics ID Studies

Q3 Please answer the following demographic questions to the best of your ability and as honestly as possible. If you qualify for this study, you will be contacted by the primary researcher, Claire Hebert (cac0215@auburn.edu) to schedule an interview.

Q1 What is your age in years? (please type using numbers only)

_____

Skip To: End of Survey If Condition: What is your age in years (... Is Less Than 18. Skip To: End of Survey.

Q2 Are you currently enrolled in a masters-level CACREP program for mental health counseling?

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If Are you currently enrolled in a masters-level CACREP program for mental health counseling? = No

Q12 Please select your gender below:

- ○ Male (1)
- ○ Female (2)
- ○ Non-binary / gender non-confirming (3)
- ○ Prefer not to answer (4)
- ○ Prefer to self describe: (5) _____

Q14 How would you describe yourself? (choose all that apply)

- [ ] White (1)
- [ ] Black or African American (2)
- [ ] American Indian or Alaska Native (3)
- [ ] Asian (4)
- [ ] Native Hawaiian or Pacific Islander (5)
- [ ] Other (6) _____
- [ ] Prefer not to answer (7)

Q3 What format does your program take place in?

- ○ In-person (1)
- ○ Online, synchronus (2)
- ○ Online, asynchronus (3)
- ○ Hybrid (in-person and online elements) (4)

Q4 What year are you in your studies for your program? (please type using numbers only)

_____

Q5 Are you a full time or part time student in your current program?

- Full-time (1)
- Part-time (2)

Q9 Are you currently providing counseling services through the practicum and/or internship portion of your program?

- Yes (1)
- No (2)

Display This Question:

If Are you currently providing counseling services through the practicum and/or internship portion o... = Yes

Q10 What type of setting are you currently placed in for ptacticum/internship experiences? (e.g., private practice, community mental health, hospital or other inpatient setting, school setting, etc; please list below)

_____

Display This Question:

If Are you currently providing counseling services through the practicum and/or internship portion o... = Yes

Q27 Are you currently providing services to individuals diagnosed with an intellectual disability?

- Yes (1)
- No (2)
- Unsure (3)

Q15 For the following question, the term disability is defined by the United States Center for Disease Control and Prevention as: "any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and

interact with the world around them (participation restrictions)." My experience with disability includes the following (select all that apply):

- ☐ I have a disability. (1)
- ☐ I have a medical condition (not a disability). (2)
- ☐ I do not have a disability or a medical condition. (3)
- ☐ A member of my immediate family or close friend has a disability. (4)
- ☐ A member of my extended family, co-worker, or acquaintance has a disability. (5)
- ☐ Disability was the focus of all or most of my academic training. (6)
- ☐ Disability was addressed in classes, seminars, or workshops I attended. (7)
- ☐ I have recent work experience involving disability (within the past 5 years). (8)
- ☐ I have past work experience involving disability (5 or more years ago). (9)
- ☐ Other (10) _____
- ☐ None (11)
- ☐ Prefer not to say (12)

Display This Question:

If For the following question, the term disability is defined by the United States Center for Diseas... = I have a disability.

Q16 If you have been diagnosed with a disability, which of the following have been diagnosed? (Mark all that apply)

- [ ] A sensory impairment (e.g., vision or hearing) (1)
- [ ] A cognitive impairment (e.g., intellectual disability, traumatic brain injury) (2)
- [ ] A mobility impairment (e.g., spinal cord injury) (3)
- [ ] A learning disability (e.g., ADHD, dyslexia) (4)
- [ ] A mental health disorder (e.g., major depression, schizophrenia) (5)
- [ ] A chronic illness (e.g., diabetes, autoimmune disorder) (6)
- [ ] A disability or impairment not listed above (please specify) (7)

_____

- [ ] Prefer not to say (8)

Q29 For the following question, the term intellectual disability is defined by the Oxford Dictionary as "a disability that affects the acquisition of knowledge and skills, in particular any of various neuro-developmental conditions affecting intellectual processes, educational attainment, and the acquisition of skills needed for independent living and social functioning." The DSM 5-TR defines intellectual disability using the following criteria: 1. Deficits in intellectual functioning (reasoning, problem solving, planning, abstract thinking, judgement, academic learning, experiential learning; usually measured y IQ tests scoring at or below 70). 2. Deficits or impairments in adaptive functioning (communication, social skills, personal independence at

home or in community settings, school/work functioning). My experience with individuals with intellectual disability or other disabilities, includes the following (select all that apply):

- [ ] A member of my immediate family or close friend has an intellectual disability (1)
- [ ] A member of my immediate family or close friend has a disability that is not considered an intellectual disability (their disability is physical/mobility, learning, sensory, mental health, chronic illness related) (2)
- [ ] A member of my extended family, co-worker, or acquaintance has an intellectual disability (3)
- [ ] A member of my extended family, co-worker, or acquaintance has a disability that is not considered an intellectual disability (their disability is physical/mobility, learning, sensory, mental health, chronic illness related) (4)
- [ ] Working with individuals with intellectual disability has been a part of the focus of all or most of my academic training (5)
- [ ] Working with individuals with any type of disability has been a part of the focus of all or most of my academic training (6)
- [ ] Working with individuals with intellectual disability was/is addressed in my program's classes, seminars, or workshops. (7)
- [ ] Working with individuals with any type of disability was/is addressed in my program's classes, seminars, or workshops. (8)
- [ ] I have recent experience working with individuals with intellectual disabilities (within the last 5 years) (9)
- [ ] I have recent experience working with individuals with other forms of disability that are not intellectual disability (their disability is physical/mobility, learning, sensory, mental health, chronic illness related; within the last 5 years) (10)
- [ ] I have past experience working with individuals with intellectual disabilities (5 or more years ago) (11)
- [ ] I have past experience working with individuals with other forms of disability that are not intellectual disability (their disability is physical/mobility, learning, sensory, mental health, chronic illness related; 5 or more years ago) (12)

☐ Other (Please list): (13) _____

☐ None (14)

☐ Prefer not to say (15)

Q28 Thank you for your responses! If selected to complete an interview for this study, what does your general availability look like for the Spring 2025 semester?

_____

_____

_____

_____

_____

End of Block: Demographics ID Studies

Appendix E: Interview Protocol

Interview Protocol

Introduction (verbal):

Hello, my name is Claire, and I am Counselor Education doctoral student in the Department of Special Education, Rehabilitation, and Counseling at Auburn University. I want to thank you for taking the time to meet with me today to talk about your experiences related to prior exposure to individuals with disabilities, including intellectual disabilities, and experiences in your program related to working with individuals with intellectual disabilities.

Your participation is completely voluntary, and you have the right to withdraw and stop the interview at any time without penalty. Any information we collect today will be recorded, but to protect your privacy the recording will remain anonymousand be stored on a password protected computer. Once the interview has been transcribed, this recording will be destroyed. This interview will be semi-structured and last approximately 45 minutes to an hour. I will ask you a series of open-ended questions, that you can answer with as much or as little information as you feel comfortable sharing regarding your experiences. I hope that this interview feels more conversational, and there is no right or wrong way to answer any of these questions as everyone's experiences are unique to their work. If you have any questions or need clarification at any point, please let me know.

Are there any questions I can answer before we get started?

Main and Sub Questions:

1. I see in your screening paperwork you completed prior to this interview, you stated your previous experience with individuals with intellectual disabilities and other disabilities included ____. Can you tell me more about these experiences and how they may have influenced your thoughts/attitudes towards individuals with ID?

2. If a client with an intellectual disability presented to you today for mental health services, how would you feel about providing these services?

3. What might you perceive as a challenge when working with individuals with intellectual disability?

4. If a client with an intellectual disability presented to you today for mental health services, what do you think would be important to consider for their services?

5. How likely do you think you are to work with a client with a co-occurring intellectual disability at your desired place of practice in the future?

6. During your time in your masters-level CACREP mental health counseling program, have there been any classes/workshops/seminars in which discussed working with clients with disability?

7. What about working specifically with clients with intellectual disability?

8. What methods did your program use specifically to discuss applications related to disability?
(if clarification is needed, applications might have included case studies, verbal or presentation lecture material, use of media such as videos or articles, etc.)

9. What about intellectual disability specifically?

10. In what ways do you think such approaches were helpful and/or unhelpful in developing awareness, understanding, and/or skills working with this population?

11. Is there anything you believe your program could further implement to help increase your **confidence** in working with individuals with intellectual disabilities?

12. Is there anything you believe your program could further implement to help increase your **preparedness** in working with individuals with intellectual disabilities?

Debrief

Thank you so much for your participation in this interview and sharing your experiences with this work. To end our time today, I would like to give you an idea of what comes next in this process. I will be reviewing and transcribing our interview to analyze themes of your experiences and common themes amongst all participants. I will contact you at the completion of the analysis to give you an opportunity to review my findings and make sure I have captured your experience correctly. Findings gathered through your participation may be presented at one or more professional conferences and published in a professional journal. Your name and any identifying information will be excluded to protect your privacy. If you know of any other counselors-in-training that meet criteria for this study and may be interested in participating, please feel free to provide them with my contact information: cac0215@auburn.edu.

Do you have any final questions before we end today?

Thank you again!