5-20-2011

Professional Counselors' Perceptions of Knowledge, Barriers, Support and Action of Professional Advocacy

Michelle M. De La Paz
University of New Orleans

Professional Counselors' Perceptions of Knowledge, Barriers, Support and Action of Professional Advocacy

A Dissertation

Submitted to the Graduate Faculty of the
University of New Orleans
in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy
in
Counselor Education

by

Michelle M. de la Paz

B.A., University of New Orleans, 1992
M.Ed., University of New Orleans, 1998

May 2011

DEDICATION

With great honor, I dedicate my dissertation to my loving parents, Walter and Norma Smith, who have loved, nurtured, protected, and pushed me to achieve my goals.

You are the reason I have the “fire in my belly” to effect change in my personal and professional life, and continue to strive to assist others in reaching their full potential.

ACKNOWLEDGEMENTS

To my parents, Norma and Walter Smith, for their unconditional love and support throughout my entire life. Mom and Dad, you modeled and stressed the importance of family, education, and hard work. I hope to make you proud through my contributions of scholarship and service.

To my husband who has been sensitive, strong and supportive throughout this journey. You have shown your love through action as the exceptional cook, curious carpenter, neat gardener, and imperfect housekeeper. You are best as the loving father to Carsten.

To my son, Carsten, I love to see life through your curious eyes. I have made this journey to model the values of family, education and hard work.

To my son, Christopher, I am so proud of what you have accomplished and am confident that you will continue to grow. If you had not been a respectful, compassionate, and conscientious young man, I would never have been able to begin my journey as a counselor.

To my father-in-law, Dada, for your love and support for your son, grandson and me on this journey. You have taken me into your family so graciously. I completed the "Never-ending-story" in you name.

To Dr. Paradise, my Methodologist, Chair, and Teacher, with your sensitive, goodhearted nature, you have modeled professionalism, flexibility and truth. You created a safe learning environment through your honest and timely feedback. I thank you for gently helping me set limits in my life so that I could accomplish this work.

To Dr. Herlihy, committee member and mentor, you model justice in your work, scholarship and service. You brought clarity to my thought process and my writing. I was able to get unstuck the day you recommended that I apply a little Reality Therapy to my stuckness.

To Dr. Christine Ebrahim, friend, colleague and committee member, you have modeled professionalism, resiliency and excellence. I thank you for helping me through the rough spots. The lunches, phone calls and emails helped me put things into perspective.

TABLE OF CONTENTS

LISTS OF TABLES

ABSTRACT

Leaders in the counseling field are encouraging practitioners to develop a social justice perspective to counseling to ensure fair and equitable treatment of clients and stress the importance of advocating on behalf of these individuals (Lee, 2007; Lee & Waltz, 1998; Lewis, Arnold, House, & Toporek, 2003; Lewis & Bradley, 2000). The counseling profession, because it is a relatively young field struggling with its own identity (Chi Sigma Iota, 2005; Eriksen, 1999; Gale & Austin, 2003; Myers & Sweeney, 2004) could also benefit from advocacy. A two-pronged approach of professional advocacy, which is the process of advocating for both clients and the profession is the most effective and comprehensive method. The results of this study were intended to bring greater insight into professional counselors' willingness and ability to advocate on behalf of the profession by identifying their perceptions of activities, knowledge, skills, qualities, importance, need, barriers and support for professional advocacy, and by exploring the relationship between counseling professionals' attitudes toward professional counselor advocacy and their perceived level of conducting professional advocacy activities. Results indicated that professional counselors believe that they participate in professional advocacy activities and that they have the knowledge, skills, and qualities to conduct those professional advocacy activities. They report gaining most knowledge of professional advocacy from publications, then from modeling, then conferences and workshops, then from their master's or doctoral program, and last from websites. They endorsed the importance and need to conduct professional advocacy most due to needing to improve the public and professional image of counselors. Participants indicated the top three barriers to advocating are: not enough time, roadblocks caused by other professionals, and insufficient knowledge of professional advocacy strategies; however generally find support to advocate in colleagues, counselor

educators, supervisors and professional associations. Knowledge, skill, qualities, importance/need, barriers and support produced positive relationships when correlated to professional advocacy activities meaning that they will be more involved in professional counselor advocacy activities if they endorse these ideas. Additionally, several barriers produced significant, negative relationships with advocacy activities indicating that if they perceive barriers, they are less likely to be involved in those advocacy activities.

Keywords: Professional counselor advocacy; professional advocacy; advocacy; professional identity

CHAPTER I

INTRODUCTION

Counseling is a relatively new field struggling with its own identity and the ability to provide clients with needed services (Chi Sigma Iota, 2005; Eriksen, 1999; Gale & Austin, 2003; Myers & Sweeney, 2004). Recently, the profession fought unsuccessfully to become Medicare providers due to the need to cut costs to the Senate-passed health insurance reform bill (ACA, 2010). In 2008, the credentials, preparation and training of licensed mental health counselors were scrutinized by the *Institute of Medicine* (IOM) to determine whether counselors could practice independently under TRICARE, the health care benefits program for The *Department of Defense* (IOM, 2010). Currently, National Certified School Counselors, along with other specialized employees and teachers, are faced with the possibility of losing earned stipends in some public school districts due to state budget cuts (W. Rock, personal communication, April 22, 2010). Professional counselors also regularly express concerns about the lack of employment opportunities within state and federal agencies due merely to their credentials (ACA, 2006).

In the current climate of federal, state and local budget cuts where clients and professional counselors are affected, professional counselors are pressed to advocate for themselves and the clients they serve. Advocacy, broadly defined, is a systematic process of arguing, pleading or representing an issue that may not be heard by those who make decisions on behalf of consumer populations (Lee, 2007; Patrick, 2007). Consumer populations can be characterized as individuals, or groups of individuals, who have a disability or mental illness or who are considered to be a disenfranchised or oppressed group such as women, gay and lesbian individuals, and the elderly. The definition can be expanded to include the counseling profession (Patrick, 2007) because it is a relatively young field struggling with its own identity (Chi Sigma

Iota, 2005; Eriksen, 1999; Gale & Austin, 2003; Myers & Sweeney, 2004). Client oppression and the need to strengthen the profession of counseling are two equally important issues. In light of this fact, some leaders emphasize advocating for both client and for the profession (Myers & Sweeney, 2004; Meyers, Sweeney & White, 2002; Patrick, 2007). This two-pronged approach to professional advocacy is the most effective and comprehensive approach to advocacy as it allows both the profession and its clients to reach their fullest potential.

Defining Advocacy Principles

Advocacy is an element of the much broader concept, social justice. Social justice is defined in the literature by Lee (2007) as:

> promoting access and equity to ensure full participation of all people in the life of a society, particularly for those who have been systematically excluded on the basis of race or ethnicity, gender, age, physical or mental disability, education, sexual orientation, socioeconomic status, or other characteristics of background or group membership. (p. xiv)

Social justice within the counseling profession includes the elements of empowerment, advocacy, and agent of social change (Lee, 2007). Lee suggested that counselors can work effectively toward social justice initiatives by maintaining an awareness of individual and systemic issues while maintaining a nonjudgmental approach to clients. He further stated that clinicians should be cognizant of client viewpoints within the context of their lives, recognize environmental influences on client development, and intercede to challenge systemic barriers.

Empowerment has been defined in the mental health professional literature as altering the balance of power for marginalized clients at several systemic levels (i.e., interpersonal, community, and societal) and concurrently influencing both the individual and the community

(Gale & Austin, 2003). Empowerment is a form of social justice that has its origins in social work, community psychology, feminist theory, multicultural counseling, and education (McWhirter, 1997). As the major goal of social work intervention, Pinderhughes (1983) stated that clinicians must understand a client's power dynamic operating within the systemic levels (individual, familial, societal and cultural) to effectively empower clients. She defined power as "the capacity to influence the forces which affect one's life space for one's own benefit" (p. 332). Furthermore, empowerment is the developed ability and capacity to cope constructively with entities that undermine and/or hinder coping, goal achievement or reasonable control over individual destiny (Pinderhughes, 1983). In the counseling field, empowerment is a complex process involving counselor self-reflection, action, awareness of environmental power and dynamics, development of skills to enhance communities, a foundation for social action, and client and counselor both looking beyond individual counseling (Lee, 2007).

The professional literature uses various definitions and terms to explain advocacy. Lee identified advocacy as the "process or act of arguing or pleading for a cause or proposal either of one's own or on behalf of someone else" (1998, p. xvi). Advocacy also has been described narrowly in the literature as an "action taken by a counseling professional to facilitate the removal of external and institutional barriers to clients' well-being" (Toporek, 2000, p. 6). Further, advocacy follows a systemic perspective in which counselors have knowledge of principles to assist with changing systems and partner with clients who lack knowledge and skill.

Conceptual Framework

Social justice and advocacy can be traced to the philosophical beliefs of the political philosopher and theorist, John Rawls. His chief work, *A Theory of Justice* (1971) is a commentary on the social contract tradition of John Locke, Jean Jacques Rousseau, and

Immanuel Kant. The term "social contract" refers to a broad class of political theories established to explain an actual or theoretical agreement among members of an organized community in which its constituents give up their natural freedoms and the inherent rights, duties and limits of its members in exchange for personal safety (Barker, Locke, Hume, Rousseau, & Hopkins, 1960; Hobbes & Gaskin, 1998; Rawls, 1971). Rawls (1971) introduced two major principles of social contract: 1) each person has the inherent rights and liberties in comparison to like liberties of others, and 2) inequalities within the distribution of wealth and power are just only if they are reasonably expected to improve the lives of those least well off. Rawls described these liberties to include political liberty or the right to vote, freedom of speech and assembly, liberty of conscious or freedom of thought, freedom of the person and the right to hold property, and the freedom from arbitrary arrest and seizure. He further elaborated on the definition of inequalities such as disparities in the distribution of income and wealth and institutional biases. Institutional biases are prejudice, which comes from any institution, be it a business, family or other group, and can be represented by differences in authority, responsibility or chains in command making it difficult to have true equality. Rawls defended his stance by balancing the claims of liberty and equality. His philosophical writing created much discussion on the topic of justice and continues to warrant discourse (Boucher & Kelly, 1994).

Jane Addams, another pioneer of social justice and proponent of advocacy, is known for her community-based initiatives. As a social activist, Addams founded Chicago's Hull House which helped establish the settlement movement in the United States. The Hull House was an effort to "provide a center for a high social life; to institute and maintain educational and philanthropic enterprises and to investigate and improve the conditions in the industrial districts of Chicago" (Addams, 1910, p. 112). Jane Addams employed many forms of advocacy within

her lifetime. She empowered individuals and disenfranchised groups through her service, leadership and modeling. She advocated for individuals, communities and the whole of the United States by giving talks, speeches, and lectures. She wrote and published on a variety of topics in an effort to promote her philanthropic ideals. Addams also helped institute and participated in many professional organizations using her leadership skills to ultimately further her cause.

Addams and Rawls were pioneers who increased the philosophical understanding and appreciation of social justice principles. Rawls debated theoretical concepts of justice and inequality. Addams served her community and country by advocating for the rights of the oppressed. The discourse and action of these historical figures are precursors to modern day efforts in advocacy.

The counseling profession is increasingly becoming aware of oppression and the negative impact that social inequities have on client mental health (Toporek, 2000). In response to this phenomenon, Loretta Bradley announced a call to action during her 1999 Presidency of the American Counseling Association (ACA). Lewis, Arnold, House and Toporek, taskforce members of the Counselors for Social Justice (CSJ), an ACA division, developed the *Advocacy Competency Domains* in 2002. These competencies were then endorsed by the ACA Governing Council at the 2003 National Conference as a means to define counselors' various roles and responsibilities as advocates (Lewis et al., 2003). Understanding these competencies assists counselors in developing ways in which they can address identified inequities.

The competency domains are explained using a matrix of two continuums and outline the comprehensive range of advocacy efforts prescribed by the task force. One continuum represents the micro-level and widens to include the macro-level of involvement. The micro/macro level

continuum outlines with whom the counselor is involved: client/student, school/community, and public arena. In other words, the continuum begins with the student/client and expands to include the group, school/community or general public. The "acting" continuum addresses the level of involvement and includes: acting with (empowerment, collaboration and information) to acting on behalf (advocacy). This continuum explains the counselor acting with or acting on behalf of the client; which, plainly stated, is the professional counselor assisting individuals or groups in advocating for themselves to the counselor actually advocating for the individual or group. Client empowerment, also known as self-advocacy, uses system change and empowerment strategies in direct counseling.

Client advocacy is characterized by taking action on behalf of a client when external forces that impede an individual's development are identified (Lewis et al., 2003). Professional counselors can conduct community collaboration using interpersonal relations, communication, training and research to respond. Systems advocacy is a form of advocacy that involves collaborating with stakeholders at the school or community level to address issues and systemic factors that are barriers to client development. Public information level outlines competencies that are paramount to informing the public about the environmental factors in human development and involves recognizing the impact of oppression, identifying environmental factors and preparing and ethically communicating informational multi-media materials to the public. The final domain, social/political advocacy, involves social and political advocacy by "influencing public policy in a large public arena" (Lewis et al., 2003, p. 2). The two continuums shape the advocacy competency domains and assist the profession in conceptualizing advocacy involvement at various levels of the educational setting or client within the community or agency system.

Defining Professional Counselor Advocacy

Professional advocacy, a predominant mode of advocacy can be defined as a goal-oriented, multi-level process aimed at creating change by using personal and professional skills to promote, empower, support, and/or protect the growth and development of the professional, the profession and the consumers it serves. This process is developed by counselors and the profession itself having a strong professional identity and through advocacy strategies such as consumer education, professional education, legislative and community collaboration, and positive communication of individual counselors and the profession.

Much of the literature published includes professional advocacy as significant to overall advocacy efforts. Chi Sigma Iota, the counseling honor society, endorses advocacy of the profession noting that the right to serve a specific client population may be limited if counselors do not advocate on behalf of the profession (Chi Sigma Iota, 1998, Advocacy section, para.1). Although some in the field believe that advocating for the profession diminishes client resources and can be seen as self-serving (McClure & Russo, 1996; Toporek, 2000) others believe that advocacy is multifaceted and must involve both advocacy for clients and advocacy for the profession.

Historically, these two types of advocating, client advocacy and professional advocacy have been seen as mutually exclusive (Myers, Sweeney & White, 2002; Patrick, 2007). The contemporary view of advocating is a hybrid of both client and professional advocacy. Myers and Sweeney have argued that "advocacy of the profession has the potential to place counselors in positions where they can advocate effectively for the causes of their clients" (2004, p. 466). Further emphasis is made that all counselors have both the opportunity and responsibility to

advocate for both their clients and their profession (Myers, Sweeney & White, 2002). The literature also supports using these competencies both for the profession and to increase the availability of mental health services to consumers (D'Andrea & Daniels, 2000; Goodman & Waters, 2000; Patrick, 2007; Stone, 2003; Weissberg, Kumpfer & Seligman, 2003). Advocacy of the counseling profession is important to the unique philosophy of professional counseling and its deserving clients.

Chi Sigma Iota (CSI), the counseling honor society, instituted a new advocacy initiative and its executive team decided to make advocacy for counselors a "long-term, sustained commitment," (CSI, 2007) that would be "broadly based and inclusive as the profession itself." The counselor advocacy leadership conferences held in 1998 spawned six advocacy themes which were developed to address professional counselor advocacy. These themes included: a) counselor education, b) intra-professional relations, c) marketplace recognition, d) inter-professional relations, e) research, and f) prevention/wellness. The counselor education theme was developed to "ensure that all counselor education students graduate with a clear identity and sense of pride as professional counselors" (CSI, 2007, Theme A). Intra-professional relations are important to professional advocacy and involve the development and implementation of a "unified, collaborative advocacy plan for the advancement of counselors and those whom they serve" (CSI, Theme B). Marketplace recognition was developed to address the need for counselors to receive suitable compensation for their services in all settings and have the freedom to provide services within their scope of practice. Inter-professional relations are accomplished by collaborating with other organizations, groups and disciplines on issues of shared importance (CSI, 2007). Research is an effective means to advocate using scientific research to further the counseling profession and the services counselors provide. True to the

professional identity of counselors, prevention and wellness is established by encouraging client wellness; incorporating wellness into their philosophical orientation, practices, research and advocacy for client welfare; and by identifying counselor needs and training and to retraining counselors from a wellness/prevention model.

Key Studies on Advocacy within the Counseling Profession

Several studies have been conducted to conceptualize advocacy (Eriksen, 1999; Field & Baker, 2004; Myers & Sweeney, 2004; White & Semivan, 2006). The studies define advocacy and collectively educate the counseling profession on the skills, values, beliefs and the actual process of advocacy for clients and the profession. The researchers delved into the perceived reasons and motivations for professional counselor advocacy, and they noted several barriers to advocating.

White and Semivan (2006) conducted a qualitative research study involving 24 participants aimed to operationally define advocacy while identifying differences between advocating for the counseling profession and advocating for the client. Participants were asked to generate lists of the most important components of advocacy, reasons why it is important for counselors to learn advocacy skills, and ways in which they have advocated successfully. The participants ranged in age from 20 to over 60 years old with the majority of participants ranging from 30 to 59 years of age. Almost 66% of the participants were female and nearly 92% held two or more leadership positions. Participants in the study reported that the techniques, strategies, basic concepts and overall skills are the same whether advocating for the client or the profession; however, the study generated a few differences between advocating for the profession versus for the client. The differences include the focus, goals and scope of advocating. The researchers recognized the top five components of advocacy to include knowledge/skill level (of needs,

environments, legislation, values and personal biases), interest and passion, collaboration/systemic intervention (for client, colleagues and organization), action/implement change, and research (including fact finding and gathering data). Based on results, professional counselor advocacy is used to protect and promote the profession, develop the counselor role and professional identity, and for the knowledge and use of skills in leadership, clinical and organizational settings. The research further identified several actions that were successful in advocating: political legislative action; active involvement in professional organizations; research/publishing; and community service/promote knowledge of the field.

In the quest to understand advocacy within the school counseling setting, Field and Baker (2004) conducted a qualitative study. This study was in response to two initiatives: the National School Counselor Training Initiative developed by the Education Trust which stresses the importance of advocating for the academic success of students (House & Hayes, 2002) and the American School Counselor Association's (ASCA) position that professional school counselors should advocate as members of the educational team (ASCA, 1997). Participants were nine female, high-school school counselors who participated in two focus group interviews. Six counselors identified themselves as European American and three self-identified as African American. The mean age and years of work experience were 45.3 and 14.2 respectively. All five of the counselors from the first focus group were at the same large high school; however, the second focus group was comprised of four counselors from different, smaller high schools within the same county. The focus group participants recognized advocacy strategies and environmental factors affecting these efforts. Participants reportedly gained knowledge through formal training (counselor education programs, professional conferences, workshops), modeling by colleagues with strong advocacy skills, personality traits (altruism, helping professional), and experiences.

Field and Baker's research identified fundamental counseling skills that can be translated into advocacy. Participants identified environmental barriers such as a vague job description and unclear expectations, lack of communication regarding students, and feeling devalued. Counselor participants recognized fellow counselors, balance and professional boundaries as environmental strengths.

An earlier qualitative study was conducted by Eriksen (1999) to gain a scientific understanding of professional advocacy within the counseling field. The study was conducted using participant-observation, key informant interviewing, and document analysis and consisted of 28 interviews of leaders of the counseling profession who were actively involved in advocacy. Fifty percent of the professionals were female with two of the participants were from an ethnic minority group. Seventy-five percent were licensed as counselors and 68% had doctoral degrees. Over 75% were over forty years old and 54% had advocated for the profession for 11 or more years. Eriksen's research on professional counselor advocacy indicated that counselors believed that they can translate their skills, values and personalities that make them effective counselors into appropriate advocacy efforts. A clear sense of professional identity also emerged as an essential element of professional advocacy efforts. Eriksen's qualitative research indicated several barriers to the advocacy process, including a lack of a clear professional identity and internal conflicts within the subspecialties of the counseling field.

The literature reflects only one quantitative study concerning professional advocacy which was conducted by Myers and Sweeney (2004). Myers and Sweeney mailed 180 surveys to leaders in the field. Leaders in state (n = 71), regional and national professional and credentialing counseling associations responded to the survey. Respondents (51%) reported having doctoral degrees and one in five reported being counselor educators. More than two thirds (69%) had

been in the field for 16 or more years, and over 41% had been counselors for more than 20 years. With an average of 21 years in the field, the respondents offered a wealth of information; however respondents with the years of experience and level of knowledge did not represent the perceptions of a majority of counselors, especially those who are not in leadership roles. Respondents to the Myers and Sweeney (2004) survey reported on the types and success of advocacy activities implemented. The leaders gave valuable input on their perception of the advocacy needs of professional counselors. Additionally, Myers and Sweeney (2004) asked leaders to rate key obstacles to advocacy efforts. The results of Myers and Sweeney's national survey indicated that there are a variety of ongoing advocacy initiatives. The study identified a specific need for resources and inter-professional collaboration. Participants agreed on the importance of advocacy for the future of the profession, and 87% of respondents indicated that advocacy efforts need to "improve the public and professional image of counselors" (p. 468).

Importance of the Study

The recent issues regarding budget cuts and the instability of personal income due to the lack of opportunities for professional counselors have been discussed passionately for the past several years within the professional counselor literature. In a study by Myers and Sweeney (2004), most leaders agreed that the profession needs to "improve the public and professional image of counselors" (p. 468). In 2000, Fall, Levitov, Jennings and Eberts (2000) completed an empirical study, which examined the public's "confidence levels" across five vignettes of varying severity of mental health problems. Fall et al. explored professional identity from the perspective of the client-consumer, finding that participants knew *less* about the counseling profession as opposed to the other professions studied. The literature also documents the disjointed nature of subspecialties and training which has contributed to the inability of the

profession and its members to communicate the uniqueness of the profession (Gale & Austin, 2003).

Professional counselors also continue to have a strained relationship with psychologists which began in 1970 when professional counselors became a distinct profession after gaining licensure and accreditation (Goodyear, 2000). Although there is a shared identity between counseling and psychology, as reflected in the memberships of both associations, professional counselors promoting licensure, scope of practice and other legislation inclusive of professional counselors are met with continued opposition by the psychology boards (Gale & Austin, 2003). McDaniels, one of the professionals interviewed by Gale and Austin, warned that professional counselors must create intra-professional relations and work together to advocate because "there are people who would deny [professional counselors] the opportunity to work in ways, and with groups, that are best reached through counseling" (Gale & Austin, p.206). Professionals emphasized that professional counselors must be willing to undertake new roles and to work collaboratively both with each other and with professionals from other helping professions. Briddick added that the counseling profession must have knowledge of competing professions and whether what professional counselors do is effective, similar to or different from other professions (Briddick, 1997).

The existing research defines professional advocacy and assists the profession in related concepts; however it does not provide information on average professional counselors in the field. Eriksen (1999) added to the knowledge of professional advocacy within the counseling field using qualitative research techniques including 28 interviews of leaders of the counseling profession who were actively involved in advocacy. Most participants were licensed counselors, over forty years old, held doctoral degrees and reported having advocated for the profession for

11 or more years. Field and Baker's study (2004) offered rich information about the definition, barriers and optimal conditions for advocacy; however, this study does not represent the views of non-school counseling professionals. The sample population of White and Semivan's study was predominantly professionals seasoned in their careers and involved in their professional associations (2006). Although this information adds to the knowledge of advocacy, this sample does not represent the average counseling professional. These studies were qualitative in nature; therefore, the results of the study are not generalizable to the counselor population. Myers and Sweeney (2004) conducted the only quantitative study. They only surveyed leaders in the field therefore, their results are not indicative of the average licensed professional counselor in the field ranging from the novice to the seasoned professional. Expanding the research by using quantitative methods could yield valuable information about the general population of counselors and increase the profession's knowledge of professional advocacy.

Purpose of Study

The purpose of this study was to identify the perceptions of professional counselor advocacy held by counselors of different backgrounds. The literature has suggested a number of factors that influence the attitudes of professionals towards professional counselor advocacy initiatives (Eriksen, 1999; Field & Baker, 2003; Myers & Sweeney, 2003; Patrick, 2007; White & Semivan, 2006), including knowledge of professional advocacy principles, skills and traits, actual advocacy activities utilized, perceived barriers to professional advocacy, and perceived support to advocate. The results of this study provide insight into professional counselors' willingness and ability to advocate on behalf of the profession by identifying the attitudes counseling professionals have regarding their knowledge of professional advocacy (and where they gained this knowledge), skills and qualities endorsed; advocacy activities practiced;

opinions on the importance and need to advocate; barriers encountered; and support gained from various entities. By exploring the relationship between counseling professionals' attitudes toward professional counselor advocacy and their perceived level of conducting professional counselor advocacy activities, the results of the study provide insight into professional counselors' willingness and ability to advocate on behalf of the profession.

Research Questions

This study explored several general research questions in order to understand how numerous factors relate to whether counselors advocate for themselves and their profession. The questions were:

- To what degree do professional counselors perceive they are knowledgeable of professional advocacy?
- Where do professional counselors gain their knowledge of professional counselor advocacy?
- To what degree do professional counselors believe that they have the skills to participate in professional advocacy efforts?
- To what degree do professional counselors believe that they have the qualities (interest/passion, commitment, resilience/persistence, toughness/force, life-long learner attitude and self-confidence) to participate in professional advocacy efforts?
- To what degree do professional counselors believe that they participate in professional advocacy efforts?
- To what degree do professional counselors believe that it is important and that there is a need to participate in professional counselor advocacy efforts?

- To what degree do professional counselors believe there are barriers to participating in professional counselor advocacy?
- What do professional counselors identify as barriers to participating in professional counselor advocacy efforts?
- To what degree do professional counselors feel they receive support from counselor educators, supervisors, associations, and colleagues in participate in professional advocacy efforts?
- Is there a correlation between the level professional counselors' perceive they are knowledgeable of professional advocacy and their involvement in professional advocacy activities?
- Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perceived level of skill to conduct professional advocacy?
- Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perception of their professional advocacy qualities?
- Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perception of the importance or need to advocate?
- Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perception of the barriers to advocating?
- Is there a correlation between professional counselors' level of participating in professional advocacy efforts and the perceived level of support participants receive from counselor educators, supervisors, associations and colleagues?

Assumptions of the study

The researcher made basic assumptions regarding the research for this study. The first assumption was that the *Professional Counselor Advocacy Inventory* (PCAI) created by the researcher for this exploratory study is valid and accurately measures counselors' perceptions as they pertain to professional advocacy. In addition, it is assumed that the participants who complete the PCAI are licensed professional counselors who will willingly and honestly answer the inventory questions.

Summary

This chapter introduced and defined professional counselor advocacy and the need for the counseling profession to advocate. In addition, it provided a conceptual framework and the importance of the study including research questions and assumptions of the study. Future chapters provide a review of the literature, research methodology, results and discussion regarding this topic.

CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of this chapter is to examine literature and research related to professional counselor advocacy and the perceptions of counselors regarding their knowledge of advocacy principles, skills and qualities, advocacy activities, barriers, and support. This chapter is organized into eight sections that build a conceptual framework for examining professional advocacy. In the first section, the origins of advocacy and social justice are examined. Then, the history of advocacy within the counseling profession is summarized. Sections three and four discuss client and then professional advocacy using the advocacy competencies, themes and professional advocacy plans. Research regarding client and professional advocacy is reviewed. The last sections summarize the professional advocacy components, barriers and supports identified in the literature.

Leaders in the counseling field are encouraging practitioners to develop a social justice perspective to counseling to ensure fair and equitable treatment of clients (Lee, 2007; Lee & Waltz, 1998; Lewis, Arnold, House & Toporek, 2003; Toporek, 2000). The counseling literature stresses the importance of advocating on the behalf of these individuals (Lee, 2007; Lee & Waltz, 1998; Lewis, Arnold, House, & Toporek, 2003; Lewis & Bradley, 2000). Advocacy, broadly defined, is a systematic process of arguing, pleading or representing an issue that may not be heard by those who make decisions on behalf of consumer populations (Lee, 2007; Patrick, 2007). Consumer populations can be characterized as individuals, or groups of individuals, who have a disability or mental illness or who are considered to be a disenfranchised or oppressed group such as women, gay and lesbian individuals, and the elderly. The definition can be expanded to include the counseling profession (Patrick, 2007) because it is a relatively

young field struggling with its own identity (Chi Sigma Iota, 2005; Eriksen, 1999; Gale & Austin, 2003; Myers & Sweeney, 2004). Client oppression and the need to strengthen the profession of counseling are two equally important issues. In light of this fact, some leaders emphasize advocating for both client and for the profession (Myers & Sweeney, 2004; Meyers, Sweeney & White, 2002; Patrick, 2007). This two-pronged approach to professional advocacy is the most effective and comprehensive approach to advocacy as it allows both the profession and its clients to reach their fullest potential.

Advocacy is an element of the much broader concept, social justice. Social justice is defined in the literature by Lee (2007) as:

> promoting access and equity to ensure full participation of all people in the life of a society, particularly for those who have been systematically excluded on the basis of race or ethnicity, gender, age, physical or mental disability, education, sexual orientation, socioeconomic status, or other characteristics of background or group membership (p. xiv).

Social justice within the counseling profession includes the elements of empowerment, advocacy, and agent of social change (Lee, 2007). Lee suggested that counselors can work effectively toward social justice initiatives by maintaining an awareness of individual and systemic issues while maintaining a nonjudgmental approach to clients. He further stated that clinicians should be cognizant of client viewpoints within the context of their lives, recognize environmental influences on client development, and intercede to challenge systemic barriers.

Empowerment has been defined in the mental health professional literature as altering the balance of power for marginalized clients at several systemic levels (i.e., interpersonal, community, and societal) and concurrently influencing both the individual and the community

(Gale & Austin, 2003). Empowerment is a form of social justice that has its origins in social work, community psychology, feminist theory, multicultural counseling, and education (McWhirter, 1997). As the major goal of social work intervention, Pinderhughes (1983) stated that clinicians must understand a client's power dynamic operating within the systemic levels (individual, familial, societal and cultural) to effectively empower clients. She defined power as "the capacity to influence the forces which affect one's life space for one's own benefit" (p. 332). Furthermore, empowerment is the developed ability and capacity to cope constructively with entities that undermine and/or hinder coping, goal achievement or reasonable control over individual destiny (Pinderhughes, 1983). In the counseling field, empowerment is a complex process involving counselor self-reflection, action, awareness of environmental power and dynamics, development of skills to enhance communities, a foundation for social action, and client and counselor both looking beyond individual counseling (Lee, 2007).

The professional literature uses various definitions and terms to explain advocacy. Lee identified advocacy as the "process or act of arguing or pleading for a cause or proposal either of one's own or on behalf of someone else" (1998 p. xvi). Advocacy also has been described narrowly in the literature as an "action taken by a counseling professional to facilitate the removal of external and institutional barriers to clients' well-being" (Toporek, 2000, p. 6). Further, advocacy follows a systemic perspective in which counselors have knowledge of principles to assist with changing systems and partner with clients who lack knowledge and skill.

Social Justice Roots

Social justice can be traced to the philosophical beliefs of political philosopher and theorist, John Rawls. His chief work, *A Theory of Justice* (1971) is a commentary on the social contract tradition of John Locke, Jean Jacques Rousseau, and Immanuel Kant. The term "social

contract" refers to a broad class of political theories established to explain an actual or theoretical agreement among members of an organized community in which its constituents give up their natural freedoms and the inherent rights, duties and limits of its members in exchange for personal safety (Barker, Locke, Hume, Rousseau, & Hopkins, 1960; Hobbes & Gaskin, 1998; Rawls, 1971). Rawls (1971) introduced two major principles of social contract: 1) each person has inherent rights and liberties in comparison to like liberties of others, and 2) inequalities within the distribution of wealth and power are just only if they are reasonably expected to improve the lives of those least well off. Rawls described these liberties to include political liberty or the right to vote, freedom of speech and assembly, liberty of conscious or freedom of thought, freedom of the person and the right to hold property, and the freedom from arbitrary arrest and seizure. He further elaborated on the definition of inequalities such as disparities in the distribution of income and wealth and institutional biases. Institutional biases are prejudice which comes from any institution, be it a business, family or other group, and can be represented by differences in authority, responsibility or chains in command, making it difficult to have true equality. Rawls defends his stance by balancing the claims of liberty and equality. His philosophical writing created much discussion on the topic of justice and continues to warrant discourse (Boucher & Kelly, 1994).

Jane Addams, another pioneer of social justice and proponent of advocacy is known for her community-based initiatives. The National Association of Social Workers (NASW) celebrates Addams as a leader of the 19th and 20th century progressive movement and as the first American female recipient of the Nobel Peace Prize in 1931 (NASW, 2008). NASW touts Addams' achievements in the area of social justice and strives to embody the ideals held by

Addams, which can be found in the NASW's current mission to reinvest in community advancement initiatives (NASW, 2008).

As a social activist, Addams founded Chicago's Hull House which helped establish the settlement movement in the United States. The Hull House was an effort to "provide a center for a high social life; to institute and maintain educational and philanthropic enterprises and to investigate and improve the conditions in the industrial districts of Chicago" (Addams, 1910, p. 112). Within the first year of the house, Addams and a friend, Ellen Starr, actively assisted the poor within the industrial districts of Chicago by caring for children, nursing the infirm, and providing an outlet for troubled people to express their concerns. The dynamic team advocated for the poor by giving speeches and convincing young women from elite families to assist in their cause to improve the conditions of the community (The Nobel Foundation, 1931). Addams spent a great deal of time traveling to express her views and she became the first president of the National Federation of Settlements. Addams also advocated to educate her community and created opportunities to advance the cause of peace during World War I.

Jane Addams employed many forms of advocacy within her lifetime; these techniques will be discussed later in this chapter. She empowered individuals and disenfranchised groups through her service, leadership and modeling. She advocated for individuals, communities and the whole of the United States by giving talks, speeches, and lectures. She wrote and published on a variety of topics in an effort to promote her philanthropic ideals. Addams also helped institute and participated in many professional organizations using her leadership skills to ultimately further her cause.

Addams and Rawls were pioneers who increased the philosophical understanding and appreciation of social justice principles. Rawls debated theoretical concepts of justice and

inequality. Addams served her community and country by advocating for the rights of the oppressed. The discourse and action of these historical figures are precursors to modern day efforts in advocacy.

History of Advocacy in the Field of Counseling

According to Kiselica and Robinson (2001), a social justice perspective, including advocacy initiatives, has been infused into the counseling profession from its beginnings. Frank Parsons and Clifford Beers were pioneers and advocated for their clients' vocational and occupational needs, and humane treatment for those diagnosed with mental illness (Kiselica & Robinson, 2001; McWhirter, 1997). Many other counseling professionals also have made significant contributions to the field of social justice. Social justice oriented publications emerged in the 1970s and seemed to be in response to the civil rights movement (Takaki, 1993), the women's movement (Adams et al., 2000), and gay and lesbian movements (Adams et al., 2000; Jennings, 1994). These movements made it increasingly difficult to ignore the larger, social, political and economic context affecting human development at the time.

In the 1980s and 1990s, literature continued to discuss advocacy principles as a plea to address the needs of clients (Conye, 1983; Eldride, 1983; Katz, 1985; Lee & Waltz, 1998; McWhirter, 1991; Wren, 1983). Katz (1985) published "The Sociopolitical Nature of Counseling," one of the most powerful articles of the time, in *The Counseling Psychologist*. She called for the profession to engage in self-examination. Katz (1985) observed that the profession of counseling psychology was unaware that the inherent set of values and norms that inform the profession creates a judgmental atmosphere and limits effectiveness. She explored how counseling theory, research and practice were founded by the values and norms of the White culture and argued that the traditional, Western counseling perspectives disregarded

environmental factors and cultural experiences. Furthermore, she provided an overview of the evolution of psychological history and how the dominant culture's value and belief system had shaped counseling practice. She further demonstrated that the sociopolitical nature of the profession demanded that the field of counseling psychology be transformed to meet the needs of the client population.

Katz prescribed many approaches to address the profession's lack of attention to social justice principles within the counseling profession. She proposed that the profession should recognize the impact of the social/political climate, the impact of counselor values on counseling, and that all forms of oppression affect the growth and development of minorities and the dominant, White culture. Professionals were encouraged to make explicit their values; redesign theory to include cultural and political impact; identify appropriate strategies, theories or models based on the population; and diagnose from an environmental view as well as intra-psychic perspective. She recommended that the profession expand services to include remedial/preventative mechanisms and flexible delivery of services to address social issues. Increasing the number of minority counseling professionals and developing licensing and accrediting procedures to create cultural competence in the counseling field were also suggested.

Another publication, edited by Courtland Lee and Gary Waltz, which discusses advocacy and social justice principles, is *Social action: A mandate for counselors* (1998). The authors argued for the need for counselors to provide counseling from a social justice perspective, to empower clients within disenfranchised groups or to assist clients by actively advocating for the causes of both individuals and groups from these disenfranchised groups. In one of the most recent books regarding social justice, *Counseling for Social Justice*, Lee (2007) and contributing authors challenged educational inequities, identified socioeconomic

disadvantages of sexism and ageism, advocated for equal access for those with disabilities, and promoted healthy male development and racial/ethnic equality. The authors also focused on professional issues related to social justice including international issues, ethics, fair access and use of assessments, conducting research, and counselor training in social justice.

Advocating for Clients

Advocacy Competencies and the Counseling Professional's Role

The counseling profession is increasingly becoming aware of oppression and the negative impact that social inequities have on client mental health (Toporek, 2000). In response to this phenomenon, Loretta Bradley announced a call to action during her 1999 Presidency of the American Counseling Association (ACA). Lewis, Arnold, House and Toporek, taskforce members of the Counselors for Social Justice (CSJ), an ACA division, developed the *Advocacy Competency Domains* in 2002. These competencies were then endorsed by the ACA Governing Council at the 2003 National Conference as a means to define counselors' various roles and responsibilities as advocates (Lewis et al., 2003). Understanding these competencies assists counselors in developing ways in which they can address identified inequities.

The competency domains are explained using a matrix of two continuums and outline the comprehensive range of advocacy efforts prescribed by the task force. One continuum represents the micro-level and widens to include the macro-level of involvement. The micro/macro level continuum outlines with whom the counselor is involved: client/student, school/community, and public arena. In other words, the continuum begins with the client or student and expands to include the group, school/community or general public. The "acting" continuum addresses the level of involvement and includes: acting with (empowerment, collaboration and information) to acting on behalf (advocacy). This continuum explains the counselor acting with or acting on

behalf of the client, which, plainly stated is the counselor assisting individuals or groups in advocating for themselves to the counselor actually advocating for the individual or group. These two continuums shape the advocacy competency domains and assist the profession in conceptualizing advocacy involvement at various levels of the educational setting or client within the community or agency system. A more specific explanation of the levels is defined in the following section.

Client/student empowerment level. This type of advocacy, also known as self-advocacy, uses system change and empowerment strategies in direct counseling. According to the developed continuum, counselors who are advocacy-oriented are more in tune to the impact of social, political, economic and cultural factors on human development. In order to lay the groundwork for self-advocacy, Lewis et al. (2003) suggest that counselors help clients "understand their own lives in context" (p.1). Direct interventions of this competency include: identifying strengths, resources, factors within the client context, client responses to a systemic or internalized oppression, and external barriers that affect development. Training students in self-advocacy skills and assisting clients in developing and carrying out action plans are additional interventions. Counselors can facilitate client empowerment through awareness of sociopolitical forces and barriers to client well being within the counseling setting (Enns, 1993; Toporek, 2000) and provide teaching, guiding and support for clients to seek mental health services (Patrick, 2007).

Client/student advocacy level. Counselors take action on behalf of a student or client when they become conscious of external forces that impede an individual's development (Lewis et al., 2003). Environmental interventions include accessing needed resources, obtaining relevant services and education, and identifying barriers to the well-being of individuals and vulnerable

groups. Developing plans, identifying allies, and implementing the plan to address barriers would fall within this level of intervention.

Community collaboration level. Lewis et al. (2003) suggest that counselors can use interpersonal relations, communication, training and research to respond when they recognize recurrent themes within the environment. The proposed competencies are to identify the factors within the community, inform appropriate groups of common concerns, and to develop alliances by using counseling skills such as effective communication, the ability to identify strengths and resources, and assessing the effect of counselor interactions within the community.

Systems advocacy level. This form of advocacy involves collaborating with stakeholders at the school or community level to address issues and systemic factors that are barriers to client development. In addition to providing and interpreting data, the competencies dictate that counselor advocates must analyze the source of political influence, develop a plan, address resistance, and assess the outcome of the advocacy.

Public information level. Another domain on the continuum outlines competencies that are paramount to informing the public about the environmental factors in human development. This domain involves recognizing the impact of oppression and other obstacles, identifying environmental factors, preparing multi-media materials that provide a clear explanation of environmental factors, ethically and appropriately communicating information for the population, disseminating information to the media while identifying other professionals involved in disseminating information, and assessing the influence of the public information.

Social/Political Advocacy level. The final domain involves social and political advocacy by "influencing public policy in a large public arena" (Lewis et al., 2003, p. 2). According to Lewis et al. counselors must distinguish problems best suited for this form of action, identify

appropriate avenues, seek and join allies, support existing alliances for change, and with allies prepare data, lobby legislators and policy makers and maintain open dialogue with communities and clients to ensure advocacy is consistent with original goals.

Advocating for the Profession

Professional Advocacy Defined

The advocacy competencies explained in the previous section were intended to guide the professional in advocating for individuals within the community or school setting and do not focus on advocacy for the profession of counseling. Professional advocacy is a predominant mode of advocacy and has been well defined by White and Semivan (2006) as:

> The collective goal-oriented multi-level actions proactively aimed at advancement of individuals inclusive of prevention, access and provision of needed services and the related professional/political activities that legitimize the professional actions and intentions of professionals that are used to influence public views of the field of counseling (p. 2).

Much of the published literature includes professional advocacy as significant to overall advocacy efforts. Chi Sigma Iota, the counseling honor society endorses advocacy for the profession, noting that the right to serve a specific client population may be limited if counselors do not advocate on behalf of the profession (Chi Sigma Iota, 1998, Advocacy section, para.1). Although some in the field believe that advocating for the profession diminishes client resources and can be seen as self-serving (McClure & Russo, 1996; Toporek, 2000) others believe that advocacy is multifaceted and must involve both advocacy of client and advocacy for the profession.

Historically, these two types of advocating, client advocacy and professional advocacy have been seen as mutually exclusive (Myers, Sweeney & White, 2002; Patrick, 2007). The contemporary view of advocating is a hybrid of both client and professional advocacy. Myers and Sweeney have argued that "advocacy of the profession has the potential to place counselors in positions where they can advocate effectively for the causes of their clients" (2004, p. 466). Further emphasis is made that all counselors have both the opportunity and responsibility to advocate for both their clients and their profession (Myers, Sweeney & White, 2004). The literature also supports using these competencies for both the profession and to increase the availability of mental health services to consumers (D'Andrea & Daniels, 2000; Goodman & Waters, 2000; Patrick, 2007; Stone, 2003; Weissberg, Kumpfer & Seligman, 2003). Advocacy of the counseling profession is important to the unique philosophy of professional counseling and its deserving clients.

Advocacy Themes

Chi Sigma Iota (CSI), the counseling honor society, instituted a new advocacy initiative and its executive team decided to make advocacy for counselors a "long-term, sustained commitment," (CSI, 2007) that would be "broadly based and inclusive as the profession itself." The counselor advocacy leadership conferences held in 1998 spawned six advocacy themes which were developed to address professional counselor advocacy. These themes included: a) counselor education, b) intra-professional relations, c) marketplace recognition, d) inter-professional relations, e) research, and f) prevention/wellness.

Theme A: Counselor Education. This theme is "to ensure that all counselor education students graduate with a clear identity and sense of pride as professional counselors" (CSI, 2007). Leadership developed eight objectives to achieve this goal. Several objectives suggest

that educators in counselor education programs identify themselves as professional counselors and will be credentialed accordingly at state and national levels. Educators are to be members of state and national associations and will be involved in and encourage their students to be involved in these associations. The leadership requires students to identify themselves as professional counselors, become members of the state counseling association, ACA and its divisions, develop a respect for and knowledge of counseling specialties and as graduates be eligible for professional counselor credentials at both the state and national level (NCC, LPC) upon completion of supervised post-graduate clinical experience. Counselor education programs are encouraged to adopt CACREP accreditation standards and within their curriculum teach advocacy for clients and the profession.

Theme B: Intra-professional relations. The leaders address the need for the counseling profession, with all of its specialties, to intermingle and collaborate with one another. Intra-professional relations, as stressed in this theme, are important to professional advocacy and involve the development and implementation of a "unified, collaborative advocacy plan for the advancement of counselors and those whom they serve" (CSI, 2007). Professional counseling associations are encouraged by leaders to establish a professional identity that is then expressed to the public; proactively collaborate on advocacy assignments through research, grants, legislation and connected activities; and maintain a cohesive front in seeking counselor-related legislation at all levels of government (CSI, 2007, Theme B).

Theme C: Marketplace Recognition. The leaders addressed the need for professional counselors to receive suitable compensation for their services in all settings and have the freedom to provide services within their scope of practice (CSI, 2007, Theme C). One objective

was developed to identify professional counselors as competent service providers. Another objective was created to stress that professional counselors have access to employment and/or compensation across settings for services these counselors are qualified to perform. Counselors should also be recognized in the media and elsewhere as providing valuable service to clients, families, organizations, and the general public as a part of marketplace recognition (CSI, 2007, Theme C).

Theme D: Inter-professional Relations. The goal set forth by the leaders is to achieve advocacy goals for both the profession and clients by collaborating with other organizations, groups and disciplines on issues of shared importance. (CSI, 2007 Theme D) The objectives include: 1) identify state and national entities to develop relationships, open communication, share information and to form possible alliances; 2) initiate and cultivate a relationship with these organizations to modify and/or address developing or changing concerns or situations; 3) establish a strategy to address initiatives by other groups or organizations that could potentially omit, limit or block the employment or practice of professional counselors; and 4) sustain counselor advocacy initiatives by establishing and maintaining resources and personnel (CSI, 2007, Theme D).

Theme E: Research. Based on the themes, it is effective to advocate using scientific research to further the counseling profession and the services counselors provide (CSI, 2007, Theme E). Researchers can demonstrate effectiveness of counseling through outcome research, assessing outcomes of counselor preparation, assessing public awareness of counseling, determining sources of funding research, and encouraging the use of research. CSI encourages research by offering grants, awards, and other incentives.

Theme F: Prevention and Wellness. True to the professional identity of counselors, the Theme F was established to "promote optimum human development across the life span through prevention and wellness" (CSI, 2007, Theme F). CSI identifies three objectives for counselors to maintain a prevention and wellness perspective. Counselors are encouraged to focus on client wellness by incorporating wellness into their philosophical orientation, practices, research and advocacy practices; by identifying counselor needs and training related to wellness and prevention; and to retraining counselors from a wellness/prevention model.

Planning for Professional Advocacy

The literature describes core elements of the advocacy process and chronologically accounts the beginnings of advocacy and social justice initiatives (Kiselica & Robinson, 2001); however, the literature falls short of providing a comprehensive system to effectively *plan* for advocacy from a dual perspective for both client and profession (Patrick, 2007). Patrick introduced such an advocacy model and outlines this method through activities that are intrinsic to advocating for the client population while promoting the profession through professional advocacy initiatives. Patrick encouraged counselors to employ these initiatives throughout their careers through community leadership, consumer education, professional education, legislation promotion, professional association involvement, publishing, public policy involvement, and advocacy training. Her thorough plan offers counselors opportunities to promote professional agendas of the counseling profession while counselors and the profession are already acting from their role as helping professionals. The following is a summary of the advocacy strategies that Patrick and others in the field found effective in advocating for both client and profession.

Community Leadership. Patrick viewed community leadership as a component of the professional role in which counselors add a powerful expertise, embody the advocacy role and

are viewed as decision makers by the community. She promoted direct collaboration by initiating legislative agendas and forming coalitions (2007). Counselors can advocate from the dual perspective by establishing advisory boards in educational settings (Weist, 2003), and by providing outreach to empower clients to self-advocate (March, 1999; Myers & Gill, 2004; Wallack, Doorfman, Jernigan, & Themba, 1993). Indirect collaboration such as counselors in practice within the community (Eriksen, 1999) also promotes the counseling profession through media contact and public forums. These initiatives assist the client and community while promoting the profession.

Consumer education. Counseling professionals can serve as experts to the community by providing information to the community on mental health issues and engage in media advocacy on behalf of clients and the profession (Patrick, 2007). This exposure provides accurate dissemination of information to the public through websites. Each counseling profession maintains a website (i.e.: apa.org, counseling.org, socialworkers.org) that provides information to consumers and its professional members about mental health and well being. Other outreach efforts include psycho-education to schools, mental health agencies, and other counselor professionals; community forums on subjects ranging from child abuse prevention to domestic violence; and professionals as experts on topical radio programs on parenting, medical conditions and life span (CSI, 2009; Patrick, 2007). The consumer education in all formats has a dual purpose: to educate the public and for individuals to be "exposed to the role of the counselor professional and the value of this role to their well-being or potential well-being" (Patrick, 2007 p. 194).

Professional education. Counselors can obtain education on advocacy through advocacy competencies and themes, CACREP standards, courses specific to the topic, and throughout the

curriculum in counselor education programs (CACREP, 2007; Capella, 2007; CSI, 2007; Lewis et al., 2003; Osborne et al., 1998). Additional knowledge can be obtained from various websites for the mental health professions (apa.org, counseling.org, nasw.org). The American Psychological Association (APA) website informs professionals and the public that the association "represents the largest most visible national presence advocating for psychology at the federal level" (APA, Government Relations). According to the site, APA collaborates with legislators and federal agencies while these entities create regulations and legislation relevant to psychologists. APA reportedly seeks to educate Congress about the field and its relevance to federal policy, advocate for increased funding and support for research and behavioral and mental health services, strengthen the voice of the psychology field at the regulatory level, advance opportunities for education and training of psychologists, and combine expertise within the field for the welfare of the country. The website informs both the public and professionals that the organization advocates for education, public interest and science, and for the purpose of government relations.

The American Counseling Association (ACA) website, www.counseling.org, offers similar educational opportunities. Under the resource section of the website, counselors can find downloadable documents such as the *Definition of Professional Counseling, Public Awareness Ideas and strategies for Professional Counselors*, and the advocacy competencies previously mentioned. The website provides information on legislative updates and information on current issues such as spending bills for education and other agencies, counselor recognition within the Veterans Affairs (VA) system and Medicare (ACA, n.d., Public Policy). Another section within public policy offers information and research on how to communicate with Congress including statistics on the most effective means of advocating to the legislature. The *Call to Action* link is

connected to capwiz.com and assists individuals in finding their local, state and federal legislators, relevant issues and alerts, elections and candidates, and a media guide of national media organizations, local newspapers, television stations, and radio. ACA provides resources and reports such as the effectiveness and need for professional counselors, and statistics on the number of mental health professionals and supervision requirements. Counselors also can access additional links and a government relations list-serve.

NASW also dedicates a segment of their website to educating professionals and consumers and coordinates advocacy efforts. Sections contain information on grassroots advocacy, legislative advocacy, congressional testimony, letters and comments, education for professionals and the public on legislative issues of concern to NASW, updates and advocacy materials on governmental relations issues, and political action for candidate election (NASW, 2009a).

Legislative Promotion. Professional counselor advocacy can be enacted by professional associations or by organizations promoting a specific mental health agenda (Patrick, 2007). Psychologists promote professional interests through a wide range of advocacy activities while focusing on consumers' services, the healthcare marketplace and policy makers (Martin, 2000). NASW recently created initiatives to increase the welfare of general society while promoting the profession of social work. One extensive movement is the Social Work Reinvestment Initiative (NASW, 2009b) which is a collaborative effort to strengthen the profession of social work and the communities it serves. The initiative, comprised of leading social work organizations and other stakeholders, is committed to securing federal and state investments related to recruitment, training, retention and research for the profession of social work. The Dorothy I. Height and Whitney M. Young, Jr. Social Work Reinvestment Act is a part of that federal initiative. The act

was developed to address the challenges to the social work profession such as dangerous working conditions, significant educational debt, and comparatively inadequate compensation. This legislation was proposed in an effort to "create the foundation for a professional workforce to meet the ever-increasing demand for the essential services that social workers provide" (NASW, 2009b, p.1). In 2004, the American Counseling Association's Public Policy Agenda mission was to "increase support for professional counselors and their clients in all appropriate Federal and State laws, regulations and legislation" (ACA, 2005). An advocacy strategy was then built around this idea and was the impetus to advocate for the policies and positions related to the cause. Current issues such as spending bills for education and other agencies and counselor recognition within the Veterans Affairs (VA) system and Medicare, are examples of such policies (ACA, 2009, Public Policy). Patrick identified that legislative advocacy may focus on support of legislation that ultimately results in enacting laws that regulate the title and practice of counseling at the state level (2007).

Advocacy Training. A portion of research in the field has been dedicated to understanding and implementing professional advocacy (CSI, 2007; Eriksen 1999; Field & Baker, 2004; Myers & Sweeney, 2004; Patrick, 2007; White & Semivan, 2007) Counselors armed with advocacy skills gained through professional counselor associations, other professions, or advocacy groups can more effectively represent the goals of the profession while influencing policy and swaying decision makers (2007). Counselors can enhance communication through media advocacy efforts and creating influential dialogue and messages to legislators or other entities (Patrick, 2007).

Counselor advocates have increasingly utilized media advocacy, the persuasive use of such mediums as print, television, radio and internet to deliver a message, proposal or cause to

strengthen the profession (Brawley, 1997; Eriksen, 1997; Kiselica & Robinson, 2001; Myers, Sweeney & White, 2002; Wallack, Dorfman, Jernigan & Themba, 1993; Wallack, Woodruff, Dorfman & Diaz, 1999). The various mental health professions (ACA, APA, and NASW) have utilized internet, YouTube, Twitter, newspaper, television, and radio to get messages out about consumers and/or their profession. NASW, particularly, has capitalized on technology by using YouTube, video streams of the NASW lobbyist educating professionals and consumers on their recent Initiative (NASW, 2009b). SocialWorkersSpeak.org, an interactive site developed by NASW, was developed to improve public understanding of the strengths and expertise of the social work profession and to critically analyze and therefore improve the way social issues are covered and portrayed in the news media and entertainment industries.

Professional Association Involvement. The literature recognizes involvement in professional associations to be an effective means of advocacy (CSI, 2009; Eriksen, 1997; Lewis et al., 2003; Patrick, 2007; White & Semivan, 2006). The professional association has the capacity to institute change within the profession or community through several avenues. The associations and their leaders highlight causes and issues from a state, regional, national and global level. This phenomenon can be seen in the 2007 Association for Counselor Educators and Supervisors, (ACES) Conference, *Vanguards for Change: ACES and Social Justice* where this theme sparked counselor supervisors and educators to research, present and dialogue about social justice and advocacy concepts. Patrick (2007) recommended that professionals can participate in professional activities in regional or state associations through presentations, research, publishing, specialized projects for consumer needs, interest groups, serving on advocacy-based committees, using media appearances to represent the profession or a cause promoted by the association, volunteering at events, and participating in list serves requesting a "call to action."

Publishing. Publishing is considered a distinctive form of counselor and professional advocacy and comes in journal articles, books, newsletters, other print materials and web-based formats. Literature helps define the purpose of advocacy and lends itself as a process and activity that is generative to the profession (Leahy, Chan & Saunders, 2003; Myers & Gill, 2004; Tanenbaum, 2005). Publishing provides detailed information about the nature and importance of advocacy, and educates readers on advocacy models and the possible impact of advocacy within the counseling professions (Patrick, 2007). As an integral part of research, an investigator must first fact find, gather data, evaluate and then publish research findings for the profession and for overall consumption (Eriksen, 1999; White & Semivan, 2006). This literature guides and prepares practitioners on advocacy and areas of needed improvement, directly informs the activities of the advocate (Eriksen, 1997; Kiselica & Robinson, 2001; Lee, 1998; Lorion, Iscoe, DeLeon, & VandenBos, 1996; Myers & Gill, 2004; Myers; Sweeney & White, 2002; Patrick, 2007), encourages dissemination of manuals to guide advocacy planning and action (Eriksen 1997; Lewis & Bradley, 2000; Teasdale, 1998; Wallack, Dorfman, Jernigan & Themba, 1993) and informs and drives interest in advocacy as an effective tool for counseling professions (Patrick, 2007).

Public Policy Involvement. The counseling profession has used public policy measures to address mental health care, licensure legislation, and social issues (Abramson, Steele & Abramson, 2003; Karlin & Duffy, 2004). Patrick (2007) identified knowledge about the needs of consumers, historic efforts of the advocate and strong research skills as necessary for this specific form of advocacy. These position statements must be backed by goal-supported research and reflect the strategic plan of the association (Kiselica & Robinson, 2001; Myers, Sweeney & White, 2002; Wallack, Dorfman, and Jernigan & Themba, 1993). Coalition builders at the

community level can promote the mission of the profession while building relationships to address consumer issues important to human service professionals. As noted by Patrick (2007), the counselor advocate can act on behalf of the consumer's needs to bring about social change and directly impact the quality of life of these consumers or the advocate can work in a professional advocacy role, working toward improving the profession, thereby also impacting the services that clients ultimately receive.

Research Studies on Advocacy within the Counseling Profession

Several studies have been conducted to conceptualize advocacy (Eriksen, 1999; Field & Baker, 2004; Myers & Sweeney, 2004; White & Semivan, 2006). The studies define advocacy and collectively educate the counseling profession on the skills, values, beliefs and the actual process of advocacy for clients and the profession. The studies delved into the perceived reasons and motivations for professional counselor advocacy, as well as, noted several barriers to advocating.

White and Semivan (2006) conducted a qualitative research study involving 24 participants aimed to operationally define advocacy while identifying differences between advocating for the counseling profession and advocating for the client. Participants were asked to generate lists of the most important components of advocacy, reasons why it is important for counselors to learn advocacy skills, and ways in which they have advocated successfully. The participants ranged in age from 20 years to over 60 years old with the majority of participants ranging from 30 to 59 years of age. Almost 66% of the participants were female and nearly 92% held two or more leadership positions. Based on the results of their study, White and Semivan defined advocacy as "a process that seeks to create change by using personal and professional

skills to promote, empower, support, and/or protect the growth and development of an organization or person" (p. 2). They further define professional advocacy as:

> The collective goal-oriented multi-level actions proactively aimed at advancement of individuals inclusive of prevention, access and provision of needed services and the related professional/political activities that legitimize the professional actions and intentions of professionals that are used to influence public views of the field of counseling (p. 2).

Participants in the study reported that the techniques, strategies, basic concepts and overall skills are the same whether advocating for the client or the profession; however, the study generated a few differences between advocating for the profession versus for the client. The differences include the focus, goals and scope of advocating. The researchers recognized the top five components of advocacy to include knowledge/skill level (of needs, environments, legislation, values and personal biases), interest and passion, collaboration/systemic intervention (for client, colleagues and organization), action/implement change, and research (including fact finding and gathering data). Participants reported the focus and goal of client advocacy is to protect and assist clients and to change policy and make systemic interventions. Based on results, professional counselor advocacy is used to protect and promote the profession, develop the counselor role and professional identity, and for the knowledge and use of skills in leadership, clinical and organizational settings. The research further identified several actions that were successful in advocating: political legislative action; active involvement in professional organizations; research/publishing; and community service/promote knowledge of the field.

The researchers offered several ways in which counselors can advocate for clients, for self, for the profession, and for agency. Based on their research, White and Semivan

recommended that clinicians advocate for clients through services such as psycho-education groups, skills training programs, support groups, and direct support to clients. The researchers recommended following a social justice perspective by respecting clients' culture and world view, assisting clients around barriers, and extending and changing availability to meet needs of various populations. Suggestions for advocating for self include educating oneself about the issues effecting counseling and clients, joining professional associations and utilizing the ACA website to write letters to legislators, writing media organizations that misrepresent mental illness and mental health counselors, and taking action against public advertisements that misuse the word counselor.

Advocating for the profession, as stated by White and Semivan, incorporates creating brochures that describe a counselor's identity and skills, a website explaining the role of a professional counselor and speaking about mental health organizations at venues such as YMCA/YWCAs, libraries, community service centers and churches to reduce the stigma around mental illness. Advocating for the agency involves teaching colleagues how to advocate for self and clients, support colleagues in advocacy efforts, share conference information with colleagues and start a list serve to inform work colleagues of legislation that affects counselors and clients.

The sample for White and Semivan's study was predominantly professionals seasoned in their careers and involved in their professional associations. Nearly 92% of the individuals held two or more leadership positions and fell within 30-59 years of age. Although this information adds to the knowledge of advocacy, this sample does not represent the average counseling professional. Expanding the research by using quantitative research could gain valuable information about the general population of counselors and increase the profession's knowledge of professional advocacy.

In the quest to understand advocacy within the school counseling setting, Field and Baker (2004) conducted a qualitative study. This study was in response to two initiatives: the National School Counselor Training Initiative developed by the Education Trust which stresses the importance of advocating for the academic success of students (House & Hayes, 2002), and the American School Counselor Association's (ASCA) position that professional school counselors should advocate as members of the educational team (ASCA, 1997). Participants were nine female, high-school school counselors who participated in two focus group interviews. Six counselors identified themselves as European American and three self-identified as African American. The mean age and years of work experience were 45.3 and 14.2 respectively. All five of the counselors from the first focus group were at the same large high school; however, the second focus group was comprised of four counselors from different, smaller high schools within the same county. The researchers sought to define advocacy and what it meant to the participant counselors. In addition, the researchers sought to identify 1) the most important advocacy behaviors performed by school counselors, 2) ways in which they learned to be advocates, 3) how the environment strengthens or inhibits the ability to advocate and 4) evidence that the participants value advocacy in practice. Three main themes emerged from the focus groups: counselors extending themselves beyond regular counseling duties; performing specific behaviors such as supporting, writing letters, simplifying processes, and communicating with decision makers on behalf of students; and focusing on the student on a case level, or individual client level of intervention. The participants defined advocacy as focusing on the individual, supporting counseling colleagues, having an ethical belief system or philosophy, and advocating for the profession. One counselor stated, "We have to be advocates of our profession because nobody else in the whole school understands our position and or what it is we are supposed to

do…it is a daily struggle, from my perspective, not to be dumped upon" (Field & Baker, 2004, p. 59). Counselor participants reported consistency, support from administrators, and positive feedback from students, parents, and community agencies as evidence of the value of advocacy in practice.

The focus group participants recognized advocacy strategies and environmental factors affecting these efforts. Participants reportedly gained knowledge through formal training (counselor education programs, professional conferences, workshops), modeling by colleagues with strong advocacy skills, personality traits (altruism, helping professional), and experiences. Field and Baker's research identified fundamental counseling skills that can be translated into advocacy such as understanding and embracing differences, maintaining emotional independence, flexibility, acceptance, realistic expectations and humor. Although not themes, participants identified humor and speaking for students as ways to advocate. Field and Baker (2004) also noted that counselors may have difficulty identifying advocacy behaviors without adequate training in those behaviors. Participants identified environmental barriers such as a vague job description and unclear expectations, lack of communication regarding students, and feeling devalued. Counselor participants recognized fellow counselors, balance and professional boundaries as environmental strengths.

Field and Baker's study offered rich information about the definition, barriers and optimal conditions for advocacy; however, the study does not represent the views of non-school counseling professionals. In addition, the study was qualitative in nature; therefore the results of the study are not generalizable to the counselor population. A quantitative study would elicit more comprehensive results from a broader base of counselors provided that the research is conducted using appropriate sampling techniques.

An earlier qualitative study was conducted by Eriksen (1999) to gain a scientific understanding of professional advocacy within the counseling field. The study was conducted using participant-observation, key informant interviewing, and document analysis and consisted of 28 interviews of leaders of the counseling profession who were actively involved in advocacy. Fifty percent of the professionals were female and two of the participants were from an ethnic minority group. Seventy-five percent were licensed as counselors and 68% had doctoral degrees. Sixty-four percent identified themselves as mental health counselors, while the rest of the participants were from other specialties. Forty-six percent were practicing counselors, 32% administrators, 29% counselor educators, and 7% researchers. Over 75% were over forty years old and 54% had advocated for the profession for 11 or more years. Fifty-four percent had advocated at the national level, 36% advocated at the state level, and 10% had advocated in both arenas.

Eriksen sought to answer the following research questions: a) What are the essential elements of counselor advocacy? b) What do counselor advocates believe works best in advancing the profession? c) What do counselor advocates do when advocating? d) What factors influence the choice of advocacy strategies? e) Who do counselor advocates consider to be the main targets of their advocacy? f) What are the obstacles to advocacy and how can they be overcome? Eriksen's research on professional counselor advocacy indicated that counselors believed that they can translate their skills, values and personalities that make them effective counselors into appropriate advocacy efforts. The research elicited four skills/values from the counseling profession that are also essential elements of advocating. These values include inclusiveness towards specialties and other mental health specialties, education on what counselors do, good communication and listening skills (asking questions, info gathering, and

clarifying) and relationship building. Other elements identified were leadership, organizational strength and unity, long-term planning, perseverance and consumer focus. A clear sense of professional identity also emerged as an essential element of professional advocacy efforts. The types of personalities that make effective counselor advocates are described as energetic, forceful, enthusiastic, upbeat, intelligent, and having a confident attitude. However, she noted that just as many personalities were nearly the opposite and as introverts effected change through subtle, non-verbal communication (Erksen, 1999). These findings suggest that counselor advocates do not fit a specific mold and can fight for social justice principles modestly or through expressive means**.**

Eriksen's qualitative study also outlined key steps to the advocacy process and timeline. The steps include the development of a professional identity, problem identification, assessing resources, strategic planning, training members, and celebrating victories. The data suggested that group advocacy is comprised of a small, core group of diverse individuals that handles planning, networks for action, establishes a protocol for authority to make immediate decisions, creates a structure for disseminating information quickly and includes objectives for both internal and external group concerns.

Counselors indicated in Eriksen's study that the magnitude of the problem would indicate the level of motivation to act. The participants identified several situations that warranted action: (a) losing clients due to their inability to pay out of pocket and lack of insurance coverage for counselors, (b) inability to find work at schools or mental health agencies that do not hire counselors, and (c) concern for clients and students who are unable to access programs or services due to shortages of funds and providers.

Eriksen's qualitative research indicated several barriers to the advocacy process. Two major obstacles noted were the lack of a clear sense of professional identity and the internal conflicts within ACA. Conflicts "within groups" represented groups inside the counseling field. This conflict was reported to cause stress, tension, and distrust among ACA members. Noted factors included polarization, dominance by subgroups within ACA, underrepresentation of the interests of other groups within the organization. Additional obstacles identified were a general lack of unification within the ACA and a lack of focus on the future as an association. Inter-group conflict, as termed by Eriksen, is the conflict caused between the counseling profession and other professional groups which causes public uncertainty, loss of status with legislators, insurance companies and other funding sources, confusion over decision makers, and success by groups merely because of the most Political Action Committee (PAC) funds. Eriksen listed many obstacles to counselor professional advocacy such as counselors' unwillingness to take a stand for themselves or a belief, being complacent, apathetic, satisfied with the status quo, and lack of self esteem. Participants voiced a concern that they lacked resources such as sufficient funds, position and time to make an impact. Counselors indicated that individuals can self-advocate immediately; however, strategic planning is necessary to plan group advocacy efforts. Additional obstacles included the inability of leaders to motivate membership and the phenomenon that most work is done by only a few individuals.

The literature reflects only one quantitative study concerning professional advocacy which was conducted by Myers and Sweeney (2004). Seventy-one leaders in state, regional and national professional and credentialing counseling associations responded to the survey. The survey collected the respondents': a) demographic information, b) structure of the advocacy efforts of the organization, c) nature and success of these efforts, d) perception of current

advocacy needs of the profession, e) resources needed by the organization for advocacy efforts, f) existence of inter-professional alliances for advocacy and perception for need of such alliances, g) obstacles to effective advocacy, and h) perceptions of the importance of advocacy for the future of the counseling profession.

Myer and Sweeney mailed 180 surveys to leaders in the field who were state and division presidents and/or past presidents of the American Counseling Association (ACA), executive directors and past presidents of the various counseling boards and committees, and past and current chairs of ACA's public policy and legislation committees at the division, state branch and national levels. Thirty-nine percent of the sample population responded to the survey. Fifty-one percent of the respondents reported having doctoral degrees and one in five reported being counselor educators. More than two thirds (69%) had been in the field for 16 or more years, and over 41% had been counselors for more than 20 years. With an average of 21 years in the field, the respondents offered a wealth of information; however respondents with such years of experience and level of knowledge do not represent the perceptions of a majority of counselors, especially those who are not in leadership roles.

In addition, the survey commented on the structure of the organization and professional advocacy. More than half of the organizations have a statement concerning professional advocacy and of those, 31% stated that it was a part of their mission statement, 39% noted that it was a part of their strategic plan, almost two thirds reported having committees, half reported having a fee for professional advocacy, nearly one third reported having a lobbyist and one fourth reported paying a staff person to perform the task.

Respondents to the Myers and Sweeney (2004) survey reported on the types and success of advocacy activities implemented. Unpaid individuals were frequently utilized through

committees/volunteers (68%), coalitions with professional groups (59%), and government relations liaisons (55%). Media opportunities (e.g., radio, television) (48%), and written material such as literature and information (63%) and advocacy training packets (47%) were other categories frequently employed. Categories reported as least utilized include paid staff (31%), paid consultants (24%), and other (10%). The activities that received the highest reported success were used most often. It is important to note that government relations liaisons and advocacy literature/information were reported by the leaders to be the least needed resources needed by only 31% and 32%, respectively, even though they were reported as being used more frequently than some of the other advocacy resources.

The leaders gave valuable input on their perception of the advocacy needs of professional counselors. A significant number of respondents (87%) agreed that the profession needs to "improve the public and professional image of counselors" (p. 468). This response was followed by publicizing counseling and services counselors provide (75%). Equal numbers (69%) reported pursuing legislative action on behalf of jobs for professional counselors, ensuring equal access to employment with other professionals and parity of pay for counselors with other mental health professionals as important advocacy efforts. Well over half (59%) checked the need to develop a common definition/identity for professional counselors. Hiring paid staff was least checked (23%) suggesting that the majority of the participants believe that there is no need to hire professionals to advocate.

Additionally, Myers and Sweeney (2004) asked leaders to rate key obstacles to advocacy efforts. The obstacles generated were inadequate resources (58%), not enough money (51%), opposition by other providers (51%), lack of collaboration (47%), resistance of public policy makers (42%), lack of training in advocacy (41%), not enough time to deal with advocacy

(39%), lack of advocacy leadership (39%), lack of awareness of advocacy issues (35%), not a priority (28%), little interest in advocacy (27%), and not having a training packet in advocacy (18%). The researchers noted several participants provided written responses regarding obstacles to advocacy ranging from politics, lack of energy, lack of commitment, the belief that counselors are apathetic to concerns due to the demands of the profession, and that counselors are reluctant to self-advocate. Nearly 80% rated advocacy of the profession as most important on a 1-3 scale.

The results of Myers and Sweeney's national survey indicated that there are a variety of ongoing advocacy initiatives. The study identified a specific need for resources and inter-professional collaboration. Participants agreed on the importance of advocacy for the future of the profession, and 87% of respondents most frequently checked that advocacy efforts need to "improve the public and professional image of counselors" (p. 468).

Characteristics of Professional Advocacy

Professional Identity

Advocacy for clients and the profession is an integral part of professional identity and is noted in the counseling standards, journals and research (CSI, 2007; Eriksen, 1999; LaFleur, 2007; Myers & Sweeney, 2004). Counselor educators and supervisors are encouraged to guide and mentor novice counselors towards a strong professional identity (Myers et al., 2002; Remley & Herlihy, 2010). Leaders recognize that in order for the counseling profession and its constituents to develop a strong identity they need to have a strong knowledge and appreciation for the concepts of professional identity (Lafleur, 2007; Remley & Herlihy, 2010).

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) was developed more than 25 years ago to ensure that counseling students master knowledge and skill while developing a professional counselor identity (CACREP, 2009). The

CACREP 2009 Standards require counseling programs to include advocacy as a part of professional orientation and ethical practice, one of the eight core curricular areas. CACREP stipulates that curricula for this core area should include the role and processes of advocating for the profession as well as the processes of advocating in an effort to eradicate systemic barriers to access, equality and the overall achievement of clients.

Advocacy of the profession ironically strengthens professional identity and, in essence, allows it. Having the ability to articulate distinctions among mental health professionals enables recognition of the profession and allows for the profession to fight for its position in the marketplace (Pistole, 2002). Remley and Herlihy (2010) consider understanding and having a sense of pride in one's profession as essential to the development of a professional identity. They further assert that pride can be articulated by defending the profession against inaccurate statements about the profession or its members. In other words, having pride and a strong sense of professional identity assists the individual professional in advocating for self and the profession as a whole. This self-advocacy is indirectly related to advocating for clients who may not be able to utilize professional counselors' services due to such issues as politics, role clarification, and inability to access care from a professional who espouses the unique holistic, developmental, counseling perspective.

Advocacy Skills

Aside from the advocacy competencies and the advocacy themes, the review of the literature identifies many components of advocacy through dialogue, speculation and research in the field. Some of the skills used in advocacy are qualities inherent in counselor practice and already present in the individual (Eriksen 1997, 1999; Field & Baker, 2004; White & Semivan, 2006). Eriksen's (1999) qualitative research indicated that counseling skills and values such as

the educational approach and inclusive nature of the counseling profession are central to advocacy intervention. Relationship building, good communication and effective listening skills can be effective advocating skills with specialties within the counseling field, other mental health professions and others within the community. Field and Baker's (2004) research identified fundamental counseling skills that can be translated into advocacy such as understanding and embracing differences, maintaining emotional independence, flexibility, acceptance, realistic expectations and humor. Additional counseling skills germane to advocating are the abilities to be sensitive to clients, assess client needs, define goals, implement effective research-based interventions, and evaluate outcomes (Kiselica & Robinson, 2001; Kurpuis & Rozecki, 1992; Patrick, 2007)

Advocacy Qualities

Interest, passion, and personality are deemed important qualities in the advocacy process (Eriksen, 1999; Patrick, 2007; White & Semivan, 2007). Patrick (2007) listed passion and commitment, drive and persistence, toughness and resilience, life-long learner attitude, and self-confidence as important qualities of the counselor advocate. The types of personalities that make effective counselor advocates are described by Eriksen (1999) as energetic, forceful, enthusiastic, upbeat, intelligent, and confident attitude. However, Eriksen noted that just as many personalities were nearly the opposite and as introverts effected change through subtle, non-verbal communication (1999). Additional skill sets effective for advocacy include communication competencies such as public speaking or writing, time management and organizational skills, role balance and coalition building (Patrick, 2007) Eriksen outlined leadership skills, long-range planning, education and training, and consumer focus as essential to the process.

Importance and Need to Advocate for the Profession

The counseling profession has noted that professional advocacy is important to clients, the professionals themselves and to the actual profession. White and Semivan's (2006) study reported reasons to advocate such as to protect and promote the profession, protect and assist clients, change policy and make systemic interventions, develop the counselor role and professional identity, and to have the ability to use knowledge and skills in leadership, clinical and organizational environments. Counselors indicated in Eriksen's study (1999) that the magnitude of the problem would indicate the level of motivation to act. The participants identified several situations that warranted action: (a) losing clients due to their inability to pay out of pocket and lack of insurance coverage for counselors, (b) inability to find work at schools or mental health agencies that do not hire counselors, and (c) concern for clients and students who are unable to access programs or services due to shortages of funds and providers.

The counseling profession also has a barrier to advocacy within its own identity. In the Myers and Sweeney (2004) study, most leaders agreed that the profession needs to "improve the public and professional image of counselors" (p. 468) and nearly 80% rated advocacy of the profession as most important to the profession. The literature documents the disjointed nature of subspecialties and training which has contributed to the inability of the profession and its members to communicate the uniqueness of the profession (Gale & Austin, 2003).

In 2000, Fall, Levitov, Jennings and Eberts (2000) completed an empirical study, which examined the public's "confidence levels" across five vignettes of varying severity of mental health problems. Two graduate students over a six-month time frame conducted the study at an international airport, an interstate bus/train station, and a shopping center, all within the same southern city. The sample of 190 participants volunteered to complete the survey which included

a) demographic section, b) five case vignettes and c) the Knowledge of Mental Health Practitioners assessment. Fall et al. explored professional identity from the perspective of the client-consumer and found that doctoral-level counselors were preferred over masters-level counselors. Participants were less confident in the Licensed Professional Counselors' (LPC) ability to treat serious psychiatric disorders. The study produced additional findings that the participants knew less about the counseling profession as opposed to the other professions studied.

Professional counselors also continue to have a strained relationship with psychologists, which began in 1970 when professional counselors became a distinct profession after gaining licensure and accreditation (Goodyear, 2000). Although there is a shared identity between counseling and psychology, as reflected in the memberships of both associations, professional counselors promoting licensure, scope of practice and other legislation inclusive of professional counselors are met with continued opposition by the psychology boards (Gale & Austin, 2003). McDaniels, one of the professionals interviewed by Gale and Austin, warned that professional counselors must create intra-professional relations and work together to advocate because "there are people who would deny [professional counselors] the opportunity to work in ways, and with groups, that are best reached through counseling" (Gale & Austin, p. 206). Professionals emphasized that professional counselors must be willing to undertake new roles and to work collaboratively both with each other and with professions from other helping professionals. Briddick added that the counseling profession must have knowledge of competing professions and of whether what professional counselors do is effective, similar to or different from other professions (Briddick, 1997).

Barriers to Professional Counselor Advocacy

The professional counselor literature identifies many of the barriers to professional advocacy. Contributors to the *Journal of Counseling and Development* identified the lack of research within the association and inability of the membership to identify strengths to actively promote the profession impedes the development of the identity of professional counseling (Gale & Austin, 2003). The literature indicated that the profession and its members lack a clear sense of professional identity and focus on the future (Eriksen, 1999; Gale & Austin, 2003). These weaknesses in turn obstruct the advocacy process. Research identified inadequate resources, limited funding and lack of time as significant deterrents (Eriksen, 1999; Myers & Sweeney, 2004). Additional deficits of individual counselors identified in the research were lack of self-esteem, indifference, complacency and an unwillingness to take a stand for themselves or for their beliefs (Eriksen, 1999).

Participants in the Field and Baker (2004) qualitative study identified environmental barriers to advocacy such as a vague job description, unclear expectations, and feeling devalued. Studies noted problems with intra- and inter-professional relations including opposition by other providers and the lack of collaboration/communication within the profession. Research noted that the conflict between the counseling profession and other professional groups causes public uncertainty and loss of status with legislators, insurance companies and other funding sources, confusion over decision makers, and success by groups merely because of the most Political Action Committee (PAC) funds. Additional obstacles included the need for strategic planning, lack of advocacy leadership, inability of leaders to motivate membership and the phenomenon that most work is done by only a few individuals (Eriksen, 1999; Myers & Sweeney, 2004).

Although there are barriers to advocacy, the counseling profession must be compelled to advocate for the profession and in doing so assist their clients. White and Semivan's (2006) qualitative study was able to operationally define advocacy while identifying differences between advocating for the counseling profession and advocating for the client. The research suggested that the techniques, strategies, basic concepts and overall skills are the same whether advocating for the client or the profession. The researchers recognized the top five components of advocacy to include knowledge/skill level, interest and passion, collaboration/systemic intervention, action/implement change, and research. Participants reported the focus and goal of client advocacy is to protect and assist clients and to change policy and make systemic interventions. Based on results, professional counselor advocacy is used to protect and promote the profession, develop the counselor role and professional identity, and for the knowledge and use of skills in leadership, clinical and organizational settings. The research further identified several actions that were successful in advocating: political legislative action; active involvement in professional organizations; research/publishing; and community service/promote knowledge of the field. The sample population of White and Semivan's (2006) study was predominantly professionals who were seasoned in their careers and involved in their professional associations. Nearly 92% of the individuals held two or more leadership positions and were 30-59 years of age. Although this information adds to the knowledge of advocacy, this sample does not represent the average counseling professional. Expanding the research by using quantitative research could yield valuable information about the general population of counselors and increase the profession's knowledge of professional advocacy.

It is important to understand the evolution of the counseling field together with its social justice perspective. As argued by many leaders in the field, counselors must advocate and assist

clients in becoming empowered. The counseling profession can benefit from viewing issues from a systemic perspective and both individually and collectively address their own issues of oppression within the mental health field. As Myers, Sweeney, and White (2002) stated, advocacy has a dual role and includes advocacy for the client as well as the profession. Individuals cannot advocate for clients if they are unhappy in their position or are not given the chance to provide services that they are qualified to provide. The advocacy competencies can be extended to include the microcosmic system in which counselors find themselves. The very characteristics that support effective practice as counselors also support the potential to advocate effectively for others and for the profession. Counselor educators, supervisors, colleagues and individual counselors can assist and support counselors not only with how they will look at the client's world systemically, but their own professional experience and how it affects the counselor, the client and the profession.

CHAPTER THREE

METHODOLOGY

The methodology used in this study is described in this chapter. The chapter is organized in the following subsections: purpose of the study, research question, characteristics of sample, instrument development, expert panel, data collection plan, data analysis, and delimitations.

Purpose of Study

The purpose of this study was to identify the perceptions of professional counselor advocacy held by counselors of different backgrounds. The literature has suggested a number of factors that influence the attitudes of professionals towards professional counselor advocacy initiatives (Eriksen, 1999; Field & Baker, 2003; Myers & Sweeney, 2003; Patrick, 2007; White & Semivan, 2006) including knowledge of professional advocacy principles, skills and traits, actual advocacy activities utilized, perceived barriers to professional advocacy, and perceived support to advocate.

The results of this study provide insight into professional counselors' willingness and ability to advocate on behalf of the profession by identifying the attitudes counseling professionals have regarding their knowledge of professional advocacy (and where they gained this knowledge), skills and qualities endorsed; advocacy activities practiced; opinions on the importance and need to advocate; barriers encountered; and support gained from various entities. By exploring the relationship between counseling professionals' attitudes toward professional counselor advocacy and their perceived level of conducting professional counselor advocacy activities, the results of the study provide insight into professional counselors' willingness and ability to advocate on behalf of the profession.

Research Questions

This study explored several general research questions in order to understand how numerous factors relate to whether counselors advocate for themselves and their profession. The questions were:

- To what degree do professional counselors perceive they are knowledgeable of professional advocacy?
- Where do professional counselors gain their knowledge of professional counselor advocacy?
- To what degree do professional counselors believe that they have the skills to participate in professional advocacy efforts?
- To what degree do professional counselors believe that they have the qualities (interest/passion, commitment, resilience/persistence, toughness/force, life-long learner attitude and self-confidence) to participate in professional advocacy efforts?
- To what degree do professional counselors believe that they participate in professional advocacy efforts?
- To what degree do professional counselors believe that it is important and that there is a need to participate in professional counselor advocacy efforts?
- To what degree do professional counselors believe there are barriers to participating in professional counselor advocacy?
- What do professional counselors identify as barriers to participating in professional counselor advocacy efforts?

- To what degree do professional counselors feel they receive support from counselor educators, supervisors, associations, and colleagues in participate in professional advocacy efforts?
- Is there a correlation between the level at which professional counselors perceive they are knowledgeable of professional advocacy and their involvement in professional advocacy activities?
- Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perceived level of skill to conduct professional advocacy?
- Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perception of their professional advocacy qualities?
- Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perception of the importance or need to advocate?
- Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perception of the barriers to advocating?
- Is there a correlation between professional counselors' level of participating in professional advocacy efforts and the perceived level of support participants receive from counselor educators, supervisors, associations and colleagues?

Characteristics of the Sample

Participants for this study were drawn from the American Counseling Association (ACA) membership which has over 44,000 members; of that total, 21,200 members are professional

members. ACA provided a random sample of 3,000 professional members of ACA. Participants were contacted through a mass, electronic email message (see Appendix B) using the lists titled, *Professional Counselor Advocacy List* (PCAL) and *Professional Counselor Advocacy List* (PCAL2). These lists were compiled of working email addresses from the ACA *Directory*. Of the 3,000 email addresses provided, two addresses were undeliverable and were eliminated from the potential pool, yielding a sample of 2,998 of potential respondents. Surveys were returned by 452 participants representing a 15% return rate and of those returned, 390 of the surveys were fully completed. The data were analyzed using the participant responses.

The August 2010 ACA membership statistics reported 73% of its current membership is female. A significant number of respondents for this study were female (79.2%), thus making the sample similar to the gender characteristics of ACA members. Descriptive data for the participants' sex appear in Table 1.

Table 1
Frequency Distribution of Respondents by Sex

Sex	n	%
Female	309	79.2
Male	81	20.8
Total	390	100.0

Participants represented a variety of racial and ethnic backgrounds (see Table 2). Most of the respondents identified themselves as European American/White (84.1%). African American made up 6.9% (n = 27) of the respondents, Hispanic/Latino represented 3.1% and Asian American/Pacific Islander and Native American/Indian each represented 1% and Middle Eastern

represented 0.8% of the population sampled. Participants who selected the racial/ethnic category "other" represented 3.1% of the population and included self-identifiers of Asian Indian, Chicano, Tri-racial and Mestizo/Mixed.

Table 2
Frequency Distribution of Respondents by Race/Ethnicity

Race/Ethnicity	n	%
African American/Black	27	6.9
Asian American/Pacific Islander	4	1.0
European American/White	328	84.1
Hispanic/Latino	12	3.1
Middle Eastern	3	0.8
Native American/American Indian	4	1.0
Other	12	3.1
Total	390	100.0

Note. Participants who selected the racial/ethnic category "other" represented 3.1% of the population and included self-identifiers of Asian Indian, Chicano, Tri-racial and Mestizo/Mixed.

Respondents to the survey were also asked to identify whether they have any disability. Results are reported in Table 3. Almost 94% (n = 366) of respondents denied having any disability. Those respondents who reported having some sort of disability included 4.9% with an acquired disability (n = 19), 0.5% with a developmental disability from birth (n = 2), 0.5% with a psychological disability from birth (n = 2) and 0.3% with a physical disability from birth.

Table 3
Frequency Distribution of Respondents by Disability Status

Disability Status	n	%
Physical Disability from Birth	1	0.3
Psychological Disability from Birth	2	0.5
Developmental Disability	2	0.5
Acquired Disability	19	4.9
No Disability	366	93.8
Total	390	100.0

Participants were asked to disclose their age in years (see Table 4) for the purposes of comparing the study's sample population to the age of respondents from previous research on professional advocacy within the counseling profession. The respondents' age ranged from 23 years to 76 years old. The mean age was 48 years with a standard deviation of 11.86.

Table 4
Frequency Distribution of Respondents by Age

Age	N	%	Age	N	%
23	1	0.3	50	9	2.3
24	2	0.5	51	12	3.1
25	2	0.5	52	10	2.6
26	4	1.0	53	17	4.4
27	7	1.8	54	11	2.8
28	4	1.0	55	14	3.6
29	9	2.3	56	11	2.8
30	9	2.3	57	25	6.4
31	7	1.8	58	9	2.3
32	7	1.8	59	16	4.1
33	11	2.8	60	14	3.6
34	5	1.3	61	10	2.6

Table 4 (continued)

Frequency Distribution of Respondents by Age

Age	N	%	Age	n	%
35	7	1.8	62	11	2.8
36	5	1.3	63	12	3.1
37	10	2.6	64	3	0.8
38	7	1.8	65	5	1.3
39	7	1.8	66	10	2.6
40	13	3.3	67	1	0.3
41	2	0.5	68	0	0.0
42	6	1.5	69	2	0.5
43	5	1.3	70	1	0.3
44	9	2.3	71	0	0.0
45	9	2.3	72	0	0.0
46	8	2.1	73	1	0.3
47	7	1.8	74	1	0.3
48	12	3.1	75	1	0.3
49	8	2.1	76	1	0.3
Total				390	100.0

Participants were asked to report all current professional licenses. The results are reported in Table 5. Totals for the frequencies of responses exceed the total number of respondents due to the common practice of members of the counseling profession holding multiple licenses. licensed professional counselors (LPC) (n = 245) represented the highest number of responses with 62.8%. Licensed mental health counselors (LMHC) represented 12.8%, licensed rehabilitation counselors (LRC) represented 1.3% and licensed marriage and Family Therapists (LMFT) made up a total of 3.8% of the responses. Nearly 42.8% percent (n=165) of the respondents identified having certifications that were not listed. Respondents were able to list licenses within the "other category." Many of the respondents identified that they were not yet

licensed (n = 23) and they were working on a "counseling certification," "not fully licensed yet as mental health counselor," "not yet a licensed school counselor," "not licensed," "resident in counseling," "completing LPC hours," "working towards LPCC," "completing LPC hours, student," "[licensed mental health counselors] LMHC Board eligible," "associate licensed counselor." Twelve respondents reported being national board certified counselors including those who were reported to be working on their license and one who stated "to be grandfathered in as a licensee in 2011." Additional respondents reported that they were licensed professional counselors (LCPC) (n = 7), licensed alcohol and drug abuse counselors (LADAC) (n = 7), psychologist or psychology (n = 7); licensed clinical social worker (LCSW) (n = 3), and school counselors (n = 4). A few listed non-mental health professions such as law and teaching. A complete list of those licenses/certifications can be found in Appendix C.

Table 5
Frequency Distribution of Respondents by Licensure Attained

Licensure Status	n	%
Licensed Professional Counselor	238	62.8
Licensed Mental Health Counselor	46	12.8
Licensed Rehabilitation Counselor	4	1.3
Licensed Marriage and Family Therapist	14	3.8
Other	165	42.8
Total	467	123.5

Note. Since it is common for members of the counseling profession to hold multiple licensure or certifications, totals for the frequencies of respondents exceed the total number of respondents. Many respondents identified that they were not yet licensed (n = 23) Twelve respondents reported being National Board Certified Counselors, Licensed Clinical Professional Counselors (LCPC) (n = 7), Licensed Alcohol and Drug Abuse Counselors (LADAC) (n = 7), Psychologist or in Psychology (n = 7); Licensed Clinical Social Worker (LCSW) (n = 3), and school counselors (n = 4). A few participants listed non-mental health professions such as law and teaching. A complete list of those certifications can be found in Appendix C.

Participants were also asked to indicate their primary specialty. The results are presented in Table 6. Nearly 57% (n = 219) of the respondents identified mental health counseling as their specialty and 10. 8% indicated Counselor Education was their primary specialty. substance abuse counseling (n = 18), marriage and family counseling (n = 22), professional school counseling (n = 26), rehabilitation counseling (n = 5) and supervision (n = 1) represent smaller portions of the sample with 4.6%, 5.6%, 6.7%, 1.3% and 0.3%, respectively. Fifty-seven respondents chose the "Other" category making up the second largest specialty category with 14.6%. A complete list of specialties listed in the "Other" category can be found in Appendix C.

Table 6
Frequency Distribution of Respondents by Primary Specialty

Primary Specialty	n	%
Mental Health Counseling	219	56.2
Substance Abuse Counseling	18	4.6
Counselor Education	42	10.8
Marriage and Family Counseling	22	5.6
Professional School Counseling	26	6.7
Rehabilitation Counseling	5	1.3
Supervision	1	0.3
Other	57	14.6
Total	390	100.0

The study provided information regarding respondents' primary work setting. The frequencies for this are listed in Table 7. Options for this category included agency (federal, state, nonprofit, or private), college (counseling/advising or counselor education), private practice, supervision and other. Nearly one-third (n = 113) of respondents reported practicing in a private practice setting. Nonprofit agency held the second highest response rate with 17.9% (n = 70), college – counselor education (n = 54) third at 13.8%, and the "Other" category (n = 50)

fourth, with 12.8%. Several remaining categories, agency-private (n = 31), college – counseling and advising (n = 27), agency –state (n = 25), agency – federal (n = 10), and supervision (n = 4) together accounted for the remaining 24.8%.

Table 7
Frequency Distribution of Respondents by Primary Work Setting

Primary Setting	n	%
Agency- Federal	10	2.6
Agency - State	25	6.4
Agency – Nonprofit	70	17.9
Agency – Private	31	7.9
College - Counseling/Advising	27	6.9
College - Counselor Education	54	13.8
Private Practice	119	30.5
Supervision	4	1.0
Other	50	12.8
Total	390	100.0

Participants of the survey were asked to indicate in which state they currently reside. ACA is comprised of four regions: Midwest, North Atlantic, Southern and Western. ACA members automatically belong to one of these regions based on the state in which they reside. There are 13 states in the ACA Midwest Region: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, and Wisconsin. The North Atlantic Region includes 10 states: Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont. There are 14 states in the southern region: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia. The western region incorporates 13 states, plus the Philippines: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah,

Washington State, and Wyoming. ACA members who reside in any of these jurisdictions and belong to the ACA automatically belong to the ACA-Western Region. The results are presented in Table 8.

Table 8
Frequency Distribution of Respondents by State of Residence

State	n	%
Alabama	8	2
Alaska	2	1
Arizona	16	4
Arkansas	3	1
California	11	3
Colorado	11	3
Connecticut	4	1
Delaware	0	0
District of Columbia	2	1
Florida	13	3
Georgia	14	4
Hawaii	1	0
Idaho	3	1
Illinois	23	6
Indiana	7	2
Iowa	3	1
Kansas	2	1
Kentucky	3	1
Louisiana	11	3
Maine	0	0
Maryland	9	2
Massachusetts	6	2
Michigan	14	4
Minnesota	6	2
Mississippi	4	1

Table 8 (continued from page 67)

State	n	%
Missouri	14	4
Montana	3	1
Nebraska	7	2
Nevada	2	1
New Hampshire	0	0
New Jersey	11	3
New Mexico	7	2
New York	18	5
North Carolina	10	3
North Dakota	0	0
Ohio	18	5
Oklahoma	7	2
Oregon	1	0
Pennsylvania	14	4
Puerto Rico	0	0
Rhode Island	2	1
South Carolina	6	2
South Dakota	1	0
Tennessee	8	2
Texas	38	10
Utah	1	0
Vermont	0	0
Virginia	21	5
Washington	4	1
West Virginia	2	1
Wisconsin	9	2
Wyoming	3	1
I do not reside in the United States	5	1
Total	388	100

Participants were asked to provide the number of years in the field (see Table 9) for the purposes of comparing the study's sample population to the number of years of respondents from previous research on professional advocacy within the counseling profession. The participants' years of experience ranged from 1 year to 40 years of experience. The mean years of experience was 14.16 with a standard deviation of 10.49 indicating considerable variability in experience.

Table 9
Frequency Distribution of Respondents by years of experience in the counseling profession.

Years of Experience	n	%	Years of Experience	n	%	*M*	*SD*
1	16	4.1	21	7	1.8		
2	21	5.4	22	4	1.0		
3	19	4.9	23	1	0.3		
4	20	5.1	24	4	1.0		
5	31	7.9	25	17	4.4		
6	12	3.1	26	6	1.5		
7	11	2.8	27	2	0.5		
8	15	3.8	28	7	1.8		
9	6	1.5	29	3	0.8		
10	38	9.7	30	11	2.8		
11	11	2.8	31	2	0.5		
12	15	3.8	32	3	0.8		
13	9	2.3	33	4	1.0		
14	8	2.1	34	0	0.0		
15	16	4.1	35	7	1.8		
16	7	1.8	36	4	1.0		
17	5	1.3	37	6	1.5		
18	11	2.8	38	4	1.0		
19	4	1.0	39	5	1.3		
20	17	4.4	40	1	0.3		
			Total	390	100	14.16	10.49

The electronic message requesting participation was sent over a five-week time span. The first message was successfully sent to 1998 email addresses on the PCAL resulting in 220 started surveys and 156 completed surveys. The second message was sent to 1988 email addresses from the PCAL producing 116 surveys started and 78 completed. After consulting the dissertation chair, the investigator purchased an additional email list of 1000 unduplicated emails of professional members of ACA. This list, called *Professional Counselor Advocacy List 2* (PCAL2), was purchased in order to ensure a minimum required response rate. The PCAL2 was sent at Week 4 and produced 89 started surveys and 66 completed surveys. The final message was sent to both email panels, the PCAL and PCAL2 and resulted in an additional 121 started surveys and 78 completed surveys. The total responses of the survey totaled 390 completed surveys surpassing the minimum of 300. It was assumed that responses from each list were equal as they were each randomly generated.

Personal information was gathered on participants in order to provide descriptive statistics and to assist future researchers in developing studies in this area. Information on gender, race/ethnicity, disability status, age, degree, license, and state of residence were collected to identify the characteristics of the sample. Data were collected on primary work setting, primary specialty and number of years in the field and were expected to contribute to differences in the attitude ratings of the participants. Prior researchers (Eriksen, 1999; Field & Baker, 2003; Myers & Sweeney, 2003; White & Semivan, 2006) have focused on the meaning of professional advocacy and counselors' perceptions of their ability, identified barriers and means of support to advocate. Several factors such as age, years in the field, level of education and specialty were identified by researchers; however, the findings were not generalizable to the population of professional counselors. For instance, the quantitative research of Myers and Sweeney (2004)

was limited to leaders in the field which is an elite representation of professional counselors; and, the qualitative research findings are limited to the general concepts of advocacy and cannot be generalized to the entire population of counselors (Eriksen, 1999; Field & Baker, 2003; Myers & Sweeney, 2003; White & Semivan, 2006).

There is limited research examining the impact of many variables on the attitudes of professional counselors regarding professional advocacy. Currently, there is no research that examines where counselors gain knowledge of professional advocacy or that has examined the impact of work setting, specialty, level of perceived support and level of perceived barriers of professional advocacy on counselors' involvement in professional advocacy activities. There is limited research on perceived barriers to and support for professional advocacy (Eriksen, 1999; Myers & Sweeney, 2003). Additionally, there is only limited research on the impact that age, level of education, and years of experience have on the likelihood that practitioners will conduct advocacy activities (Eriksen, 1999; Field & Baker, 2003; Myers & Sweeney, 2003; White & Semivan, 2006).

Instrument Development

No previous study has examined counseling professionals' perceptions of their level of knowledge, ability, involvement in, support for, or barriers to conducting professional advocacy, nor is there an existing instrument appropriate to collect the data necessary for this study. A few studies, however, have touched upon the subject of advocacy of the counseling profession and are important to mention. In a qualitative research study involving 24 participants, White and Semivan (2006) conducted focus groups aimed to operationally define advocacy while identifying differences between advocating for the counseling profession and advocating for the

client. An earlier qualitative study was conducted by Eriksen (1999) to gain a scientific understanding of professional advocacy within the counseling field. The study was conducted using participant-observation, key informant interviewing, and document analysis and consisted of 28 interviews of leaders of the counseling profession who were actively involved in advocacy. In the quest to understand advocacy within the school counseling setting, Field and Baker (2004) conducted a qualitative study involving nine female, high-school counselors who participated in two focus group interviews.

One quantitative study by Myers and Sweeney (2004) added to knowledge obtained from the qualitative studies previously mentioned. The researchers mailed surveys to 180 leaders in the field who were state and division presidents and/or past presidents of American Counseling Association (ACA), executive directors and past presidents of the various counseling boards and committees, and past and current chairs of ACA's public policy and legislation committees at the division, state branch and national levels. The researchers identified successful advocacy strategies; advocacy needs, including the need to improve the public and professional image of counselors; and advocacy obstacles.

I created the *Professional Counselor Advocacy Inventory* (PCAI) (see Appendix A) for this study with the specific purpose of determining professional counselors' perceptions of their level of (a) knowledge and where they gained this knowledge, (b) skill, (c) qualities, (d) involvement, (e) importance and need (f) identified barriers, and (f) support related to professional counselor advocacy. The study also provided analysis of the relationship between counseling professionals' attitudes toward professional counselor advocacy and their perceived level of conducting professional counselor advocacy activities. The results of the study provided

insight into professional counselors' willingness and ability to advocate on behalf of the profession.

The instrument consisted of 73 items divided into seven sections. In Section I - Knowledge of Professional Advocacy, participants were asked to rate their personal knowledge of professional counselor advocacy and where they gained that knowledge. Item 1 asked participants to rate their knowledge of how to conduct professional advocacy using a 7-point Likert scale with anchored responses at each point. Possible responses range from strongly disagree (1), somewhat disagree (2), disagree (3), neither agree nor disagree (4), somewhat agree (5), agree (6) and strongly agree (7). Items 2-15 asked respondents to indicate where they received this knowledge. Items 2, 5, 8 and 11, and 14 asked respondents to first indicate either yes or no for each type of knowledge source (educational program, conference or workshop, publication, website, and modeling. After noting yes or no, the participants were asked to rate their level of agreement on questions 3, 6, 9, 12, and 15 on the same Likert scale developed for item 1 with the addition of a "Not Applicable" response indicating that the respondent did not use the identified source. For items 4, 7, 10, and 13, participants were invited to list additional sources where they gained knowledge of professional advocacy other than from ACA or Chi Sigma Iota.

Items 1-15 were derived from White and Semivan's (2004) study (see Table 10 for list of references) which identified knowledge/skill level as one of the main themes of advocacy and recognized that advocacy involves teaching colleagues how to advocate for self and clients and encouraged sharing conference information with colleagues (see Table 10 for all items and literature references). Field and Baker's (2004) study introduced formal training (counselor education programs, professional conferences, and workshops) and modeling by colleagues with

strong advocacy skills. Myers and Sweeney (2006) researched the use of advocacy-training packets to teach professional advocacy. These items were also derived from the CACREP 2009 *Standards* (CACREP, 2007), which includes curriculum that teaches the role and processes of advocating for the profession and for clients, the advocacy competencies which include teaching self-advocacy skills (Lewis et al., 2003), and advocacy themes identified by CSI, which encourages counseling programs to adopt the CACREP accreditation standards to teach advocacy for clients and the profession within the curriculum (CSI, 2007). Patrick (2007) encouraged learning and teaching professional advocacy skills through publishing in journals and through websites.

In Section II, Professional Skills and Qualities, participants were asked to respond to 14 opinion statements indicating whether they possess the skills and qualities to conduct professional advocacy using a 7-point Likert scale with anchored responses at each point. Possible responses range from strongly disagree (1), somewhat disagree (2), disagree (3), neither agree nor disagree (4), somewhat agree (5), agree (6) and strongly agree (7). These items were derived from the research of White and Semivan (2006) who identified interest and passion as one of the top five themes of advocacy; Eriksen (1999) who described general counseling skills in addition to confidence, tough/forceful, resilience/persistence, commitment and tough/forceful attributes; and Field and Baker (2004) who identified fundamental counseling skills that can be translated into advocacy. Public speaking, writing and life-long learner were also discussed in the literature as skills and qualities necessary to advocate (Patrick, 2007).

In Section III, Professional Advocacy Efforts, participants were asked to respond to 13 opinion statements concerning professional advocacy efforts indicating their level of agreement by using a 7-point Likert scale with anchored responses at each point. Possible responses range

from strongly disagree (1), somewhat disagree (2), disagree (3), neither agree nor disagree (4), somewhat agree (5), agree (6) and strongly agree (7). Items 30-42 stem from the research and literature regarding educating others about counselor preparation, the role as a counselor, similarities and differences to other professions. Remley and Herlihy (2010) discussed the importance of knowing how to explain the role of counselor and the differences from other professions as a part of professional identity. Eriksen (1999) and White and Semivan (2006) gained information from their qualitative studies elaborating on the concepts of educating others. Items 33 -34 relate to building alliances through inter- and intra-professional relations and were derived from Eriksen (1999) and White and Semivan's research that identified these issues qualitatively. These ideas were also discussed in the advocacy themes through inter- and intra-professional relations and through the competencies through self-advocacy and systems advocacy (CSI, 2007, Lewis, 2003). Item 35 is related to conducting community service projects and is noted by White and Semivan's (2006) research and Patrick (2007) as a valuable means to provide assistance to clients while promoting the profession. Item 36 relates to creating multi-media activities which was noted in the advocacy themes (CSI, 2007) as market place recognition and the public information level of the advocacy competencies (Lewis et. al, 2003), and from Patrick (2007) as consumer education. Item 37 relates to research and publishing and was derived from White and Semivan's research (2006) which identified research and publishing as a main theme, by the advocacy theme regarding research (2007) and by Patrick (2007), an avid proponent of research and publishing for professional education and promotion of the profession. Item 38 was derived from the CSI (2007) advocacy themes and touches on the need to educate, model and promote prevention and wellness. Items 39 and 40 were draw from the research of White and Semivan (2006) and Myers and Sweeney (2004) which suggested being

involved in associations, and from the advocacy competencies which recommend that students become members of professional associations for counselors. Item 41 was taken from Eriksen (1999), White and Semivan (2006) and Myers and Sweeney's (2004) research which all identified the importance of being involved on boards or committees as a way of advocating. The literature also stressed the importance of being on a board or committee, and is noted in Patrick's (2003) literature as professional association involvement and through the advocacy theme counselor education (CSI, 2007). Item 42, regarding participation in legislative activities, was an idea that originated from the advocacy competencies (Lewis et al., 2003) as political advocacy, by Patrick (2007) as legislative promotion and from Eriksen's (1999) research which noted legislative promotion as key to the professional advocacy process.

Section IV, Importance for and Need to Advocate, required responses to 5 opinion statements, items 44-48, indicating respondents' level of agreement by using a 7-point Likert scale with anchored responses at each point. Possible responses range from strongly disagree (1), somewhat disagree (2), disagree (3), neither agree nor disagree (4), somewhat agree (5), agree (6) and strongly agree (7). Item 43 was derived from the advocacy competencies (Lewis et. al, 2003). Item 44 relates to the need to improve the public and professional opinion of the profession and is derived from Myers and Sweeney's (2004) research which specifically asked participants to rate this idea and from Fall et al. (2000) in which the researchers found that participants knew less about the counseling profession as opposed to other professions studied. Item 45 and 46 were taken from Eriksen's (1999) research and the advocacy competencies which both identified employment and compensation as issues that warranted action. Item 47 was derived from the literature regarding social justice and the idea that individuals can be disenfranchised and need to advocate for themselves (Lee, 2007).

In Section V, Barriers to Professional Advocacy, participants were asked to respond to 12 opinion statements indicating participants' level of agreement by using a 7-point Likert scale with anchored responses at each point. Possible responses range from strongly disagree (1), somewhat disagree (2), disagree (3), neither agree nor disagree (4), somewhat agree (5), agree (6) and strongly agree (7). In Item 60, participants were also invited to add additional barriers for item 60 not mentioned in the opinion statements. Item 48 concerns the barrier of lack of knowledge of professional advocacy strategies which is covered by the same literature on which items 1-15 were built. Item 49 relates to the inability to explain counselor credentials, role or comparison to other professionals and is derived from Eriksen's (1999) research regarding barriers and the advocacy theme of counselor education (CSI, 2007). Item 50 is identified by the lack of collaboration on legislative activities initiated from Eriksen's (1999) research regarding the presence of internal conflict within ACA and specifically quantified by Myers and Sweeney (2004). Item 51 regarding roadblocks caused by other professionals was specifically identified by both Goodyear (2000) and Gale and Austin (2003) who discuss the issues counselors are faced with in the marketplace. Items 52, 53, 54, 55, 56, 57 and 58 were derived from Eriksen (1999) who identified many barriers such as counselors' satisfaction with the status quo, lack of sufficient funds, lack of position, lack of time, lack of leadership, lack of skill level, and fear of being seen as a "trouble maker." Myers and Sweeney (2004) were also referred to for items 54, 55, 56 and 57, and Field and Baker (2004) for item 57. Item 59 and 60 were added to the instrument for respondents to rate "other" barriers and list those specific barriers and were prompted by all of the aforementioned research regarding barriers to professional advocacy.

In Section VI, Support for Professional Advocacy, participants were asked to respond to 4 opinion statements concerning support of professional advocacy, indicating their level of

agreement by using a 7-point Likert scale with anchored responses at each point. Possible responses range from strongly disagree (1), somewhat disagree (2), disagree (3), neither agree nor disagree (4), somewhat agree (5), agree (6) and strongly agree (7). Items 61-64 were derived from the research of White and Semivan (2006) and Field and Baker (2004) who both discussed receiving support from colleagues in advocacy efforts. Their ideas were expanded to include other entities such as counselor educators, supervisors and associations.

Section VII, Demographic Information, was designed to collect information used to construct the independent variables for the study. These variables are: sex, race, disability status, age, degree attained, license, specialty, primary work setting, state in which they are licensed, and number of years in the field.

Table 10
Instrument Development - Professional Counselor Advocacy Inventory

Items	Literature Reference
Section I -Knowledge of Professional Advocacy	
1-15	Field & Baker (2004); CSI, (2007); Lewis et al. (2003); Myers & Sweeney, (2004); Patrick (2007); White & Semivan (2006)
Section II – Professional Advocacy Skills and Qualities	
16-23	Eriksen (1999); Field & Baker (2004); Lewis et al. (2003); Patrick (2007); White & Semivan, (2006)
24 – 29	Eriksen, (1999); Field & Baker (2004); Myers & Sweeney (2004); White & Semivan (2006)
Section III– Advocacy Efforts	

Table 10 (continued from page 78)

30 - 42	CSI (2007); Eriksen, (1999); Lewis et al (2003); Myers & Sweeney, (2004); Patrick (2007); Remely & Herlihy (2010); White & Semivan, (2006)
Section IV – Importance for and Need to Advocate	
43 – 47	CSI (2007); Eriksen (1999); Fall et al. (2000); Lee (2007); Myers & Sweeney (2004); White & Semivan (2006);
Items	Literature Reference
48 - 60	CSI (2007); Eriksen (1999); Field & Baker (2004; Gale & Austin (2003); Goodyear (2000); Lewis et al. (2003); Myers & Sweeney (2004);
Section VI– Support for Professional Advocacy	
61-64	Field & Baker (2004); Lewis et al. (2003); White & Semivan (2007)
Section VII– Demographic Information	
65 – 74	Participants' Demographic Information

Expert Panel

Two expert panels were used to review the original 43-item PCAI to ensure content validity. The first expert panel consisted of five female professional counselors. Four were Caucasian and one African American. All five panel members lived and worked in Louisiana. They each identified their primary specialty with two reporting mental health counseling, one professional school counseling, and two counselor education. Settings included one school, two private practices, one non-profit agency and one college. The highest degree earned for two of the panelists was a doctorate while the other three held master's degrees. Panel members all

identified themselves as being licensed professional counselors (LPC). Panel members' mean number of years in the counseling field was 11 years (range 4.5-23 years).

The first expert panel made suggestions regarding the PCAI ranging from increasing the ease of reading specific items to adding or changing questions. Two members suggested reducing the number of short answer questions to simplify the survey and data collection process. One member gave additional feedback on using a drop-down menu to assist potential participants in easily identifying specific skills, barriers and other professional advocacy variables while also clarifying the meaning of those items. Overall, the panel reported taking approximately 15 minutes to complete the survey.

After obtaining the feedback from the panel, the PCAI became a 64-item inventory, due in part to the addition of several items instead of using short-answer responses. Additionally, a Likert scale component was added to the inventory. The suggestions and new items were discussed with the dissertation chair and then implemented.

Due to the new length of the inventory and the nature of the changes, the inventory underwent review by an additional expert panel. The second panel consisted of four panel members. All four were Caucasian and lived and worked in Louisiana. Three were female and one male. The specialties reported included one individual in professional school counseling, one private practice, and two within the mental health field. Settings included one school, two private practice, and two state agencies. The highest degree earned for all panelists was the master's degree. All panel members identified themselves as being licensed professional counselors (LPC); one also identified himself as a licensed marriage and family therapist (LMFT). Panel members' mean number of years in the counseling field was 16 years (range 4-28 years).

The second panel provided some insight to the clarity and ease of the PCAI. One member suggested that the phrase "if yes, then rate each item below" be added to items 14-17. The item only had "Yes ____ No ____ if yes, then" after each type of source of knowledge. For instance, for educational program, the item read "Educational Program Yes ____ No ____ if yes, then." The member suggested that the phrase be changed to "Educational Program Yes ____ No ____ if yes then rate each item below" therefore ensuring that each item be completed as intended. All members reported the inventory was fairly simple to complete and of reasonable length. One panelist stated that the instrument was "easy to understand and follow and kept me interested. I did not have to think, 'What is she asking?' or 'What does she mean?'" The members reported taking anywhere from 9-15 minutes to complete the inventory with a mean of 13 minutes. All changes were reviewed by the dissertation chair and implemented.

Data Collection

Several steps were completed to ensure accurate and appropriate data collection. The University of New Orleans Committee for the Protection of Human Subjects in Research (IRB) reviewed and approved all procedures and protocols related to data collection (see Appendix B). The survey was sent out using Qualtrics™ (www.neworleans.qualtrics.com), an on-line survey and data collection service, after receiving approval from the committee. The data were then collected using the membership list provided by ACA.

The *Professional Counselor Advocacy Inventory (*PCAI) was developed for use as an on-line survey through Qualtrics.com creation tools. A secure electronic link was created through which participants could access the survey. Although the total population of potential participants is identifiable by means of their electronic mail addresses before data collection, the

PCAL did not contain questions that could reveal the identity of individual respondents. The data collection tool does not provide any mechanism for identifying participants.

ACA provided a randomly selected list of 3,000 professional members' names and email addresses. These email addresses were then entered into a generic electronic mailing list titled Professional Counselor Advocacy List (PCAL). The list had no identifying information and contained only electronic mail addresses provided by ACA. Potential participants for the inventory were contacted by a generic mass electronic message requesting participation. The electronic message included a brief description of the study, a statement regarding participant anonymity, and a consent form to participate in the study. The message provided directions for accessing the PCAI via a secure electronic link generated by Qualtrics.com. Thus, participation in the study was both completely anonymous and voluntary.

After the participants accessed the on-line version of the PCAI, they were asked to complete the survey including demographic information. Two generic electronic messages (see Appendix B) were sent via mass email to potential participants thanking those who had already participated and reminding those who had not. The electronic reminders were sent at weeks 3 and 5 of the study. The final generic mass message was sent to thank all participants, indicate that data collection had been completed and to notify participants of the opportunity to request the results of the study to be sent via email.

Data Analysis

Data analysis for this study included descriptive statistics, and Pearson product moment correlations to identify components of professional counselor advocacy and the perceived differences among professional counselors from varying backgrounds of the knowledge, skills, qualities, importance, activities, barriers, and support of professional advocacy.

Research Question 1

To what degree do professional counselors perceive they are knowledgeable of professional advocacy?

Data Analysis

Descriptive statistics were calculated on inventory responses to item 13.

Research Question 2

Where do professional counselors gain their knowledge of professional counselor advocacy?

Data Analysis

Descriptive statistics were calculated on inventory responses to items 14-18.

Research Question 3

To what degree do professional counselors believe that they have the skills to participate in professional advocacy efforts?

Data Analysis

Descriptive statistics were calculated on inventory responses to items 19-26.

Research Question 4

To what degree do professional counselors believe that they have the qualities (interest/passion, commitment, resilience/persistence, toughness/force, life-long learner attitude and self-confidence) to participate in professional advocacy efforts?

Data Analysis

Descriptive statistics were calculated on inventory responses to items 27-32.

Research Question 5

To what degree do professional counselors believe that they participate in professional advocacy efforts?

Data Analysis

Descriptive statistics were calculated on inventory responses to items 33-45.

Research Question 6

To what degree do professional counselors believe that it is important and that there is a need to participate in professional counselor advocacy efforts?

Data Analysis

Descriptive statistics were calculated on inventory responses to items 46-50.

Research Question 7

To what degree do professional counselors believe there are barriers to participating in professional counselor advocacy?

Analysis

Item 60 which elicited short-answer responses regarding barriers to professional counselor advocacy was analyzed by the grounded theory approach, which utilizes an open coding technique (see Cohen, Manion, & Morrison, 2007). The data were specifically analyzed by: 1) reading and re-reading open-ended responses from participants, 2) coding these data according to the emerging themes, 3) re-reading responses to organize sub-themes within the data until reaching saturation, and 4) counting the frequency of those themes.

Research Question 8

What do professional counselors identify as barriers to participating in professional counselor advocacy efforts?

Data Analysis

Descriptive statistics were calculated on inventory responses to items 51-60.

Research Question 9

To what degree do professional counselors feel they receive support from counselor educators, supervisors, associations, and colleagues in participate in professional advocacy efforts?

Data Analysis

Descriptive statistics were calculated on inventory responses to items 61-64.

Research Question 10

Is there a correlation between the level professional counselors perceive they are knowledgeable of professional advocacy and their involvement in professional advocacy activities?

Data Analysis

Pearson product moment correlations were used to answer this research question. A factor analysis was completed to assist in validating the instrument and to determine the psychometric properties of the instrument. Data were gathered from Item 1 and from items related to advocacy activities (factors 1-3 and Items 38-40) to answer this question. A conservative alpha level was used to determine significance ($p < .01$).

Research Question 11

Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perceived level of skill to conduct professional advocacy?

Data Analysis

Pearson product moment correlations were used to answer this research question. A factor analysis was completed to assist in validating the instrument and to determine the psychometric properties of the instrument. It was felt that the large number of items that seemed similar could be parsimoniously examined with less tests of significance by using a factor analysis with varimax rotation to group significant items into summed scores based on the identified factor structure. This procedure has been recommended by DiStefano, Zhu, & Mindrila (2009). A scree test (Costello & Osborne, 2005) was used to identify factors. Data were gathered from advocacy skills (Items 16-23) and from items related to advocacy activities (factors 1-3 and items 38-40) to answer this question. A conservative alpha level was used to determine significance (p <.01).

Research Question 12

Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perception of their professional advocacy qualities?

Data Analysis

Pearson product moment correlations were used to answer this research question. A factor analysis with varimax rotation was completed to assist in validating the instrument and to determine the psychometric properties of the instrument. The same procedures identified in research question 11 were used. Data were gathered from advocacy qualities (items 24-29) and from items related to advocacy activities (factors 1-3 and items 38-40) to answer this question. A conservative alpha level was used to determine the level of significance (p <.01).

Research Question 13

Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perception of the importance or need to advocate?

Data Analysis

Pearson product moment correlations were used to answer this research question. A factor analysis was completed to assist in validating the instrument and to determine the psychometric properties of the instrument. The same procedures for the factor analysis in research question 12 were used here. The perceptions of licensed professional counselors' professional advocacy efforts (factors 1-3 and items 38-40) were correlated to the importance and need to advocate (items 43-47) to answer this question. A conservative alpha level was used to determine the level of significance ($p < .01$).

Research Question 14

Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perception of the barriers to advocating?

Data Analysis

Pearson product moment correlations were used to answer this research question. A factor analysis, similar in procedure to research question 11, was completed to assist in validating the instrument and to determine the psychometric properties of the instrument. The perceptions of licensed professional counselors' professional advocacy efforts (factors 1-3 and items 38-40) were correlated to professional counselors' perception of barriers to advocating (items 51-60) to answer this question. A conservative alpha level was used to determine the level of significance ($p < .01$).

Research Question 15

Is there a correlation between professional counselors' level of participating in professional advocacy efforts and the perceived level of support participants receive from counselor educators, supervisors, associations and colleagues?

Data Analysis

Pearson product moment correlations were used to answer this research question. A factor analysis, similar to research question 11, was completed to assist in validating the instrument and to determine the psychometric properties of the instrument. The results of the perception of professional counselors' level of participating in professional advocacy efforts (factors 1-3 and items 38-40), were correlated to the results of perceived level of support participants receive from counselor educators, supervisors, associations and colleagues (items 61-64) to answer this question. A conservative alpha level was used to determine the level of significance. ($p < .01$).

CHAPTER FOUR

RESULTS

The purpose of this study was to identify the perceptions held by counselors of different backgrounds regarding professional counselor advocacy. The literature has suggested a number of factors that influence the attitudes of professionals towards professional counselor advocacy initiatives (e.g., Eriksen, 1999; Field & Baker, 2003; Myers & Sweeney, 2003; Patrick, 2007; White & Semivan, 2006), including knowledge of professional advocacy principles, skills and traits, actual advocacy activities utilized, perceived barriers to professional advocacy, and perceived support to advocate. By exploring the relationship between counseling professionals' attitudes toward professional counselor advocacy and their level of preparation, years in the field, licensure status, specialty, work setting, and need to advocate on a personal level, the results of the study may provide insight into professional counselors' willingness and ability to advocate on behalf of the profession.

Analysis of Research Questions

Research Questions

This study explored several general research questions in order to understand how numerous factors relate to whether counselors advocate for themselves and their profession. The questions were:

- To what degree do professional counselors perceive they are knowledgeable of professional advocacy?
- Where do professional counselors gain their knowledge of professional counselor advocacy?

- To what degree do professional counselors believe that they have the skills to participate in professional advocacy efforts?
- To what degree do professional counselors believe that they have the qualities (interest/passion, commitment, resilience/persistence, toughness/force, life-long learner attitude and self-confidence) to participate in professional advocacy efforts?
- To what degree do professional counselors believe that they participate in professional advocacy efforts?
- To what degree do professional counselors believe that it is important to participate in professional counselor advocacy efforts?
- What do professional counselors identify as barriers to participating in professional counselor advocacy efforts?
- To what degree do professional counselors believe there are barriers to participating in professional counselor advocacy?
- To what degree do professional counselors feel they receive support from counselor educators, supervisors, associations, and colleagues to participate in professional advocacy efforts?
- Is there a relationship between number of years of experience as a counselor and professional counselors' involvement in professional advocacy?
- Is there a difference among the specialties of professional counselors and their reported knowledge of professional advocacy?
- Is there a correlation between professional counselors' level of participating in professional advocacy efforts and their perception of the barriers to advocating?

- Is there a correlation between professional counselors' level of participating in professional advocacy efforts and the perceived level of support they receive from counselor educators, supervisors, associations and colleagues?

Instrumentation

I created the 73-item *Professional Counselor Advocacy Inventory* (PCAI) for this study with the specific purpose of determining professional counselors' perceptions of their level of: (a) knowledge and where they gained this knowledge, (b) skill, (c) qualities, (d) involvement, (e) importance and need (f) identified barriers, and (f) support related to professional counselor advocacy. In addition, differences among counselors' level of participation in professional counselor advocacy activities were calculated based on (a) number of years in counseling field, (b) primary work setting, (c) primary specialty, (d) perception of barriers, and (e) perceived level of support. The instrument is divided into seven sections: Knowledge of Professional Advocacy, Professional Advocacy Skills and Qualities, Advocacy Efforts, Importance for and Need to Advocate, Professional Advocacy, Barriers to Professional Advocacy, Support for Professional Advocacy and Demographic Information.

Research Question 1

Research Question 1 asked to what degree professional counselors perceive they are knowledgeable of professional advocacy. Descriptive survey statistics were calculated on inventory responses for PCAI item 1. The frequency for each item and statistical results for Research Question 1 are presented in Table 11. The results indicated that of the 390 participants, 305 (78.2%) agreed to some level that they know how to advocate for the profession. Of the respondents who agreed, nearly 43% of the respondents reported they strongly agree and almost 36% reported agreeing with the statement. Only 65 respondents (16.6%) reported that they

disagreed, ranging from strongly disagree to somewhat disagree, and 5.1% neither agreed nor disagreed with the concept. The mean of the distribution was 5.06 with a standard deviation of 1.48. The results indicated that a strong majority of individuals from the sample agreed that they know how to advocate and seem to more than somewhat agree.

Table 11
Frequency Distribution for Item 1 for Research Question 1

Item	n	%	*M*	*SD*
Knowledge of Professional Advocacy				
1. I know how to advocate for the profession.				
Strongly Disagree	15	3.8%		
Disagree	15	3.8%		
Somewhat Disagree	35	9.0%		
Neither Agree nor Disagree	20	5.1%		
Somewhat Agree	139	35.6%		
Agree	115	29.5%		
Strongly Agree	51	13.1%		
Total	390	100%	5.06	1.48

Research Question 2

Research Question 2 asked where professional counselors gained their knowledge of professional counselor advocacy. Descriptive survey statistics were calculated on inventory responses to items 2-3. The comparisons of the descriptive statistics and frequency for each item and statistical results for Research Question 2 are presented in Table 12. The results indicate that of the 390 participants, 207 (53%) indicated that they gained knowledge of professional advocacy from their master's or doctoral educational program and 183 (47%) reported not gaining knowledge of professional advocacy from a program.

Of the participants who agreed to have gained knowledge of professional advocacy from an educational program, 194 participants reportedly gained the knowledge from their master's program in counselor education and 44 participants indicated that they received knowledge from a master's program in a related field. Respondents who gained knowledge from a counselor education program indicated a 94% (n = 182) level of agreement, ranging from somewhat agree to strongly agree. The mean was 5.70 with a standard deviation of 1.21. The participants who indicated gaining knowledge from a master's program in a related field indicated a 75% (n = 33) level of agreement using that same scale. The mean for that group was 5.18 and the standard deviation was 1.90. A higher mean indicates a stronger agreement with the statement regarding professional advocacy beliefs; a lower mean indicates a stronger disagreement. Higher scores regarding gaining knowledge of professional advocacy from master's programs in both counseling and related fields indicated a high level of agreement.

Respondents also reported that they received knowledge of professional advocacy from a doctoral program; 62 reported receiving knowledge from a doctoral program in counselor education and 23 indicated obtaining information about professional advocacy from a doctoral program from a related field. The respondents who received knowledge from a doctoral program in counselor education agreed (ranging from somewhat agree to strongly agree) at a rate of 92% (n = 57) with a mean of 6.15 and standard deviation of 0.96. The respondents who indicated gaining knowledge from a doctoral program from a related field agreed on that same scale at a rate of 69.5% (n = 23) with a mean of 5.52 and a standard deviation of 1.41. A higher mean indicates a stronger agreement with the statement regarding professional advocacy beliefs; a lower mean indicates a stronger disagreement. Higher scores on this item regarding gaining

knowledge of professional advocacy from doctoral programs in both counseling and related fields indicated a high level of agreement.

Based on this study, master's students in general seem to have gained more knowledge from their program. Doctoral students indicated that they received more professional advocacy training from counselor education programs. The percentage of respondents who did not gain knowledge of professional advocacy is surprisingly high at 47%. In addition, those who reportedly gained knowledge, nearly 30%, reported not gaining much.

Table 12
Frequency Distribution for Item 2-3 for Research Question 2

Item	n	%	*M*	*SD*
Knowledge of Professional Advocacy				
2. I gained knowledge of professional advocacy from my masters or doctoral educational program.				
Yes	207	53.1		
No	183	46.9		
Total	390	100		
3. If yes, indicate the degree of knowledge gained from masters or doctoral educational program.				
Master's program in counseling				
Strongly Disagree	5	2.6		
Disagree	3	1.5		
Somewhat Disagree	1	0.5		
Neither Agree nor Disagree	3	1.5		
Somewhat Agree	60	30.9		
Agree	74	38.1		
Strongly Agree	48	24.7		
Total	194	100	5.70	1.21

Table 12 (continued from page 94)

Item	n	%	*M*	*SD*
Master's program in related field				
Strongly Disagree	4	9.1		
Disagree	3	6.8		
Somewhat Disagree	0	0.0		
Neither Agree nor Disagree	4	9.1		
Somewhat Agree	8	18.2		
Agree	13	29.5		
Strongly Agree	12	27.3		
Total	44	100	5.18	1.90
Doctoral program in counseling				
Strongly Disagree	0	0.0		
Disagree	0	0.0		
Somewhat Disagree	0	0.0		
Neither Agree nor Disagree	5	8.1		
Somewhat Agree	9	14.5		
Agree	20	32.3		
Strongly Agree	28	45.2		
Total	62	100.0	6.15	0.96
Doctoral program in related field				
Strongly Disagree	0	0.0		
Disagree	1	4.3		
Somewhat Disagree	0	0.0		
Neither Agree nor Disagree	6	26.1		
Somewhat Agree	2	8.7		
Agree	7	30.4		
Strongly Agree	7	30.4		
Total	23	100.0	5.52	1.41

Research Question 2 asked where professional counselors gained their knowledge of professional counselor advocacy. Descriptive survey statistics were calculated on inventory

responses to items 5-6. The comparisons of the descriptive statistics and frequencies for each item and statistical results for Research Question 2 are presented in Table 13. Respondents reported whether they gained knowledge of professional advocacy from association conferences and workshops sponsored by local, state, regional, and national American Counseling Association (ACA) and/or Chi Sigma Iota (CSI), an international counseling honor society.

A significant number of participants (64.1%) indicated that they gained knowledge of professional advocacy from ACA conferences and workshops. Of those respondents who gained knowledge from this source, 93.5% (n = 188) endorsed some level of agreement, ranging from somewhat agree to strongly agree. The mean of this group was 5.89 with a standard deviation of 1.14. A higher mean indicates a stronger agreement with the statement regarding professional advocacy beliefs; a lower mean indicate a stronger disagreement. Higher scores on knowledge gained from conferences and workshops indicated a high level of agreement. Nearly 65% of the participants gained knowledge of professional advocacy from ACA conferences and workshops and nearly all of those agreed to have received knowledge.

Participants indicated some level of agreement as to whether they gained knowledge from conferences or workshops from a regional association of ACA (i.e., Midwest, North Atlantic, Southern or Western) and of those 66.3% (n = 51) indicated some level of agreement, with a mean of 5.18 and a standard deviation of 1.90. ACA state associations had an 80.8% level of agreement with a mean of 5.38 and a standard deviation of 1.57; ACA divisions at 78.8% with a mean of 5.42 and a standard deviation of 1.65; and CSI at 69.5% with a mean of 4.83 and a standard deviation of 1.83. Participants also responded to an "other" category where 89% indicated some level of agreement with a mean of 5.62 and standard deviation of 1.22. A higher mean indicates a stronger agreement with the statement regarding professional advocacy beliefs;

a lower mean indicates a stronger disagreement. Higher scores on knowledge gained from conferences and workshops indicated a high level of agreement. Respondents appeared to have gained most from "other" conferences and workshops. This may be due to the fact that many of the responses that were generated were from their specialty areas, such as play therapy or substance abuse, or from non-counseling associations such as psychology or social work. ACA state and division conferences also had high percentages, but CSI and regional ACA conferences had the least.

Respondents were asked to list specific conference or workshop sources other than ACA or CSI where they gained knowledge of professional advocacy. Many of the responses represented ACA national, regional, state and local conferences and workshops; however, a number of the responses were unique. Respondents reported gaining knowledge of professional advocacy from associations on drug abuse, art therapy, Christianity, clinical pastoral supervision and psychotherapy, marriage and family, mental health, psychology (general, psychology of women, Black psychologists and psychologists for social responsibility) education, higher education and disability, adult intellectual disabilities, career development, school counseling, play therapy, licensure boards, social work, victim assistance, national boards, occupational health nursing, rehabilitation, on-line continuing education, yoga therapy, behavioral health, professional golf, advanced human behavior, eating disorders, equine assisted growth and learning (horse therapy), and choice theory. A full list of responses is provided in Appendix D.

Table 13
Frequency Distribution for Item 5-6 for Research Question 2

Item	n	%	*M*	*SD*
Knowledge of Professional Advocacy – Conferences/Workshops				
5. I gained knowledge of professional advocacy from association conference(s) or workshop(s)**.**				
Yes	250	64.1		
No	140	35.9		
Total	390	100.0		
6. If yes, degree of knowledge gained from professional advocacy from conference(s) or workshop(s)**.**				
ACA				
Strongly Disagree	3	1.5		
Disagree	4	2.0		
Somewhat Disagree	1	0.5		
Neither Agree nor Disagree	3	1.5.		
Somewhat Agree	41	20.6		
Agree	88	44.2		
Strongly Agree	59	28.7		
Total	199	100.0	5.89	1.14
Regional association of ACA (Midwest, North Atlantic, Southern or Western)				
Strongly Disagree	3	3.9		
Disagree	7	9.1		
Somewhat Disagree	1	1.3		
Neither Agree nor Disagree	15	19.5		
Somewhat Agree	20	26.0		
Agree	20	26.0		
Strongly Agree	11	14.3		
Total	77	100.0	4.90	1.59

Table 13 (continued from page 98)

Item	n	%	*M*	*SD*
State Association of ACA				
Strongly Disagree	6	4.6		
Disagree	6	4.6		
Somewhat Disagree	1	0.8		
Neither Agree nor Disagree	12	9.2		
Somewhat Agree	32	24.6		
Agree	40	30.8		
Strongly Agree	33	25.4		
Total	130	100.0	5.38	1.57
Division of ACA				
Strongly Disagree	6	5.1		
Disagree	5	4.3		
Somewhat Disagree	3	2.6		
Neither Agree nor Disagree	11	9.4		
Somewhat Agree	21	17.9		
Agree	37	31.6		
Strongly Agree	34	29.1		
Total	117	100.0	5.42	1.65
Chi Sigma Iota				
Strongly Disagree	6	8.3		
Disagree	6	8.3		
Somewhat Disagree	4	5.6		
Neither Agree nor Disagree	6	8.3		
Somewhat Agree	18	25.0		
Agree	20	27.8		
Strongly Agree	12	16.7		
Total	72	100.0	4.83	1.83

Table 13 (continued from page 99)

Item	n	%	*M*	*SD*
Other professional association (APA, NASW, etc.)				
Strongly Disagree	4	3.1		
Disagree	0	0.0		
Somewhat Disagree	2	01.6		
Neither Agree nor Disagree	8	6.3		
Somewhat Agree	29	22.7		
Agree	59	46.1		
Strongly Agree	26	20.3		
Total	128	100.0	5.65	1.22

Note. Sources for conferences and workshops included associations on drug abuse, art therapy, Christianity, clinical pastoral supervision and psychotherapy, marriage and family, mental health, psychology (general, psychology of women, black psychologists and psychologists for social responsibility) education, higher education and disability, adult intellectual disabilities, career development, school counseling, play therapy, licensure boards, social work, victim assistance, national boards, occupational health nursing, rehabilitation, on-line continuing education, yoga therapy, behavioral health, professional golf, advanced human behavior, eating disorders, equine assisted growth and learning (horse therapy), choice theory, and Union. A full list of responses is provided in Appendix D.

Research Question 2 also asked professional counselors to indicate whether they gained knowledge of professional advocacy from publications sponsored by local, state, regional, and national American Counseling Association (ACA) and/or Chi Sigma Iota (CSI) an international counseling honor society. Descriptive survey statistics were calculated on inventory responses to items 8-9. The comparisons of the descriptive statistics and frequencies for each item and statistical results for Research Question 2 are presented in Table 14. Most participants, 79.7% (n = 311), reported gaining knowledge of professional advocacy from publications.

Three hundred respondents reported gaining knowledge from ACA publications; 95.7 % of those respondents (n = 287) endorsed some level of agreement, ranging from somewhat agree to strongly agree. The mean of this group was 5.97 with a standard deviation of 0.98. Participants

(n = 85) agreed that they gained knowledge from publications from a regional association of ACA (i.e., Midwest, North Atlantic, Southern or Western) and of those 48.2 % (n = 41) indicated some level of agreement with a mean of 4.26 and a standard deviation of 1.82. Respondents (n = 142) indicated a 69.7% level of agreement that the received knowledge from ACA state associations with a mean of 5.02 and a standard deviation of 1.66. One hundred forty-two respondents received knowledge from ACA divisions at 71.8 % with a mean of 5.14 and a standard deviation of 1.64. Those who responded receiving knowledge from CSI (n = 83) responded favorably at 56.7 % with a mean of 4.53 and a standard deviation of 1.80. Participants (n = 138) also responded to the "other" type of publication category where 80.1% indicated some level of agreement with a mean of 5.46 and standard deviation of 1.43. A higher mean indicates a stronger agreement with the statement regarding professional advocacy beliefs; lower means indicate a stronger disagreement. Higher scores on knowledge gained from publications indicated a high level of agreement. ACA publications received the highest response rate with the highest level of agreement. Half the participants indicated that they gained knowledge from state and division publications with only approximately a 70% agreement rate. Participants gave the lowest agreement rating ranging from 48-57% to Regional and CSI sources.

Respondents were asked to list if they gained knowledge of professional advocacy from publications of professional association(s) other than ACA or CSI. Many of the responses represented ACA national, regional, state and local conferences and workshops; however, a number of the responses indicated specialties within the counseling, psychology and social work fields. The full list of responses is presented in Appendix D.

Table 14
Frequency Distribution for Item 8-9 for Research Question 2

Item	n	%	*M*	*SD*
Knowledge of Professional Advocacy – Publications				
8. I gained knowledge of professional advocacy from publications**.**				
Yes	311	79.7		
No	79	20.3		
Total	390	100		
9. If yes, degree of knowledge gained from professional advocacy from publications**.**				
ACA				
Strongly Disagree	1	0.3		
Disagree	4	1.3		
Somewhat Disagree	2	0.7		
Neither Agree nor Disagree	6	2.0		
Somewhat Agree	75	25.0		
Agree	126	42.0		
Strongly Agree	86	28.7		
Total	300	100	5.91	0.98
Regional association of ACA (Midwest, North Atlantic, Southern or Western)				
Strongly Disagree	8	9.4		
Disagree	13	15.3		
Somewhat Disagree	4	4.7		
Neither Agree nor Disagree	19	22.4		
Somewhat Agree	11	12.9		
Agree	25	29.4		
Strongly Agree	5	5.9		
Total	85	100	4.26	1.82

Table 14 (continued from page 102)

Item	n	%	*M*	*SD*
State Association of ACA				
Strongly Disagree	8	5.6		
Disagree	10	7.0		
Somewhat Disagree	2	1.4		
Neither Agree nor Disagree	23	16.2		
Somewhat Agree	30	21.1		
Agree	46	32.4		
Strongly Agree	23	16.2		
Strongly Agree	142	100.0	5.02	1.66
Division of ACA				
Strongly Disagree	5	3.5		
Disagree	13	9.2		
Somewhat Disagree	2	1.4		
Neither Agree nor Disagree	20	14.1		
Somewhat Agree	25	17.6		
Agree	51	35.9		
Strongly Agree	26	18.3		
Total	142	100.0	5.14	1.64
Chi Sigma Iota				
Strongly Disagree	6	7.2		
Disagree	11	13.3		
Somewhat Disagree	3	3.6		
Neither Agree nor Disagree	16	19.3		
Somewhat Agree	18	21.7		
Agree	18	21.7		
Strongly Agree	11	13.3		
Strongly Agree	83	100	4.53	1.80

Table 14 (continued from page 103)

Item	n	%	*M*	*SD*
Other professional association (APA, NASW, etc.)				
Strongly Disagree	4	2.9		
Disagree	7	5.1		
Somewhat Disagree	0	0.0		
Neither Agree nor Disagree	11	8.0		
Somewhat Agree	35	25.4		
Agree	51	37.0		
Strongly Agree	30	21.7		
Total	138	100	5.46	1.43

Research Question 2 also asked professional counselors to indicate whether they gained knowledge of professional advocacy from websites sponsored by local, state, regional, and national American Counseling Association (ACA) and/or CSI. Descriptive survey statistics were calculated on inventory responses to items 10-11. The comparisons of the descriptive statistics and frequencies for each item and statistical results for Research Question 2 are presented in Table 15. Less than half, 43.3% (n = 169), reported gaining knowledge of professional advocacy from websites.

Respondents (n = 159) reported gaining knowledge from the ACA website; 92% of those respondents (n = 153) endorsed some level of agreement, ranging from somewhat agree to strongly agree. The mean of this group was 5.99 with a standard deviation of 0.99. Participants (n = 50) indicated some level of agreement as to whether they gained knowledge from a regional association of ACA (i.e., Midwest, North Atlantic, Southern or Western) website, and of those 56% (n = 28) indicated some level of agreement with a mean of 4.66 and a standard deviation of 1.61. Respondents (n = 77) indicated a 70.2 % level of agreement that they received knowledge

from websites from ACA state associations with a mean of 5.12 and a standard deviation of 1.61. Respondents (n = 72) received knowledge from ACA divisions at 75.8% with a mean of 5.25 and a standard deviation of 1.56. Of those who responded receiving knowledge from CSI (n = 33), 51.5% responded favorably with a mean of 4.58 and a standard deviation of 1.64. Participants (n = 79) also responded to the "other" website source where 82.3% indicated some level of agreement with a mean of 5.34 and standard deviation of 1.46. A higher mean indicates a stronger agreement with the statement regarding professional advocacy beliefs; lower means indicate a stronger disagreement. Higher scores on knowledge gained from websites indicated a high level of agreement. ACA websites had the most responses and the highest percentage of agreement (92%) in gaining knowledge about professional advocacy. Only half of the participants responded receiving knowledge to state and division websites at a 70-76% agreement, and Regional and CSI sources had the least responses and lowest percentages.

Respondents were asked to list if they gained knowledge of professional advocacy from websites of professional association(s) other than ACA or CSI. Many of the responses represented ACA national, regional, state and local websites. Additional responses indicated specialties within the counseling, psychology and social work fields. The full list of responses is presented in Appendix D.

Table 15
Frequency Distribution for Items 11-12 Research Question 2

Item	n	%	*M*	*SD*
11. I gained knowledge of professional advocacy from websites.				
Yes	169	43.3		
No	221	56.7		
Total	390	100.0		

Table 15 (continued from page 105)

Item	n	%	*M*	*SD*
12. If yes, degree of knowledge gained from professional advocacy from websites				
ACA				
Strongly Disagree	1	0.6		
Disagree	2	1.3		
Somewhat Disagree	0	0.0		
Neither Agree nor Disagree	3	1.9		
Somewhat Agree	34	21.4		
Agree	67	42.1		
Strongly Agree	52	32.7		
Total	159	100	5.99	0.99
Regional association of ACA (Midwest, North Atlantic, Southern or Western)				
Strongly Disagree	2	4.0		
Disagree	6	12.0		
Somewhat Disagree	0	0.0		
Neither Agree nor Disagree	14	28.0		
Somewhat Agree	10	20.0		
Agree	13	26.0		
Strongly Agree	5	10.0		
Total	50	100	4.66	1.61
State Association of ACA				
Strongly Disagree	3	3.9		
Disagree	6	7.8		
Somewhat Disagree	0	0.0		
Neither Agree nor Disagree	14	18.2		
Somewhat Agree	15	19.5		
Agree	25	32.5		
Strongly Agree	14	18.2		
Total	77	100	5.12	1.61

Table 15 (continued from page 106)

Item	n	%	*M*	*SD*
Division of ACA				
Strongly Disagree	1	1.4		
Disagree	7	9.7		
Somewhat Disagree	1	1.4		
Neither Agree nor Disagree	9	12.5		
Somewhat Agree	16	22.2		
Agree	22	30.6		
Strongly Agree	16	22.2		
Total	72	100	5.25	1.56
Chi Sigma Iota				
Strongly Disagree	0	0.0		
Disagree	5	15.2		
Somewhat Disagree	3	9.1		
Neither Agree nor Disagree	8	24.2		
Somewhat Agree	8	24.2		
Agree	3	9.1		
Strongly Agree	6	18.2		
Total	33	100	4.58	1.64
Other professional association (APA, NASW, etc.)				
Strongly Disagree	3	3.8		
Disagree	4	5.1		
Somewhat Disagree	0	0.0		
Neither Agree nor Disagree	7	8.9		
Somewhat Agree	20	25.3		
Agree	32	40.5		
Strongly Agree	13	16.5		
Total	79	100	5.34	1.46

Additional research for Question 2 was conducted on whether professional counselors gained knowledge of professional advocacy modeled or taught by various individuals. Descriptive survey statistics were calculated on inventory responses to items 14-15 to answer this question. The comparisons of the descriptive statistics and frequencies for each item and statistical results for Research Question 2 are presented in Table 16. Most participants, 76.9% (n = 300), reported gaining knowledge of professional advocacy modeled or taught by others.

Respondents (n = 274) reported gaining knowledge modeled or taught by a colleague with a counseling degree; 87.1% of those respondents (n = 247) endorsed some level of agreement, ranging from somewhat agree to strongly agree. The mean of this group was 5.84 with a standard deviation of 1.41. Participants (n = 224) also indicated agreement as to whether they gained knowledge modeled or taught by colleague with a related degree, and of those, 81.6% (n = 183) indicated agreement with a mean of 5.38 and a standard deviation of 1.58. Respondents (n = 216) indicated a 75.9% level of agreement that they received knowledge of professional advocacy modeled or taught by LPC/LMHC supervisor with a mean of 5.29 and a standard deviation of 1.70. Respondents (n = 206) reported receiving knowledge modeled or taught by "other" supervisor; 73.3% responded favorably with a mean of 5.14 and a standard deviation of 1.78. A higher mean indicates a stronger agreement with the statement regarding modeling professional counselor advocacy. High scores on knowledge gained from individuals who modeled or taught professional advocacy indicated a high level of agreement. Overall, participants reported gaining knowledge of professional advocacy from all four types of models with the most individuals endorsing gaining that knowledge modeled by colleagues with a counseling degree.

Table 16
Frequency Distribution for Items 14-15 for Research Question 2

Item	n	%	*M*	*SD*
Knowledge of Professional Advocacy				
14. I gained knowledge of professional advocacy modeled of taught by others.				
Yes	300	76.9		
No	90	23.1		
Total	390	100		
15. If yes, degree of knowledge modeled or taught by others.				
Modeled/taught by colleague with counseling degree				
Strongly Disagree	6	2.2		
Disagree	13	4.7		
Somewhat Disagree	3	1.1		
Neither Agree nor Disagree	5	1.8		
Somewhat Agree	42	15.3		
Agree	105	38.3		
Strongly Agree	100	36.5		
Total	274	100	5.84	1.41
Modeled/taught by colleague with related degree				
Strongly Disagree	8	3.6		
Disagree	16	7.1		
Somewhat Disagree	5	2.2		
Neither Agree nor Disagree	12	5.4		
Somewhat Agree	46	20.5		
Agree	87	38.8		
Strongly Agree	50	22.3		
Total	224	100	5.38	1.58

Table 16 (continued from page 109)

Item	n	%	*M*	*SD*
Modeled/taught by LPC/LMHC supervisor				
Strongly Disagree	9	4.2		
Disagree	18	8.3		
Somewhat Disagree	5	2.3		
Neither Agree nor Disagree	20	9.3		
Somewhat Agree	38	17.6		
Agree	69	31.9		
Strongly Agree	57	26.4		
Total	216	100	5.29	1.70
Modeled/taught by other supervisor				
Strongly Disagree	12	5.8		
Disagree	18	8.7		
Somewhat Disagree	6	2.9		
Neither Agree nor Disagree	19	9.2		
Somewhat Agree	38	18.4		
Agree	65	31.6		
Strongly Agree	48	23.3		
Total	206	100	5.14	1.78

Research Question 3

Professional counselors indicated in Research Question 3 whether they believe that they have the skills to participate in professional advocacy efforts. Descriptive survey statistics were calculated on inventory responses to items 16-23. The comparisons of the descriptive statistics and frequencies for each item and statistical results for Research Question 3 are presented in Table 17. Most participants, 91.0% (n = 355), endorsed some level of agreement, ranging from somewhat agree to strongly agree for item 16, that they take an educational approach to conduct professional advocacy. The mean of this group was 5.81 with a standard deviation of 1.08.

Participants indicated some level of agreement for item 17, acceptance (i.e., inclusive nature, embracing differences), and of those 97.1% (n = 379) indicated some level of agreement with a mean of 6.18 and a standard deviation of 0.82. Respondents indicated a 98.4% (n = 384) level of agreement on Item 18, "relationship building (i.e., communication skills, listening skills) with a mean of 6.39 and a standard deviation of 0.78. Responses to Item 19 indicated that 91.2% (n = 356) participants agreed at some level that they have "emotional independence," with a mean of 5.96 and a standard deviation of 1.00. The response to Item 20, "realistic goal setting (i.e., assess needs, define goals, implement research-based interventions, evaluate outcomes), elicited 354 favorable responses at 90.7% with a mean of 5.88 and a standard deviation of 1.04. Participants responded to Item 21 and 360, or 92.3%, indicated that they agree to some level that they have time management and organizational skills. This item had a mean of 5.87 and a standard deviation of 1.02. Nearly 86% (n = 335) of participants responded to Item 22 and endorsed the skill of public speaking. The mean was 5.64 and the standard deviation was 1.41. Writing skills, Item 23, was endorsed by 361 participants (92.6%) with a mean of 5.92 and standard deviation of 1.11. Essentially, most participants agreed that they have the skills to conduct professional advocacy. Acceptance and relationship building had the highest percentage of agreement with 97% and 98.4% respectively. Participants agreed the least with the skill of public speaking at 86%. Higher scores on professional counselors' beliefs that they have the skill level to conduct professional advocacy indicated a high level of agreement with means ranging from 5.64 – 6.39.

Table 17
Frequency Distribution for Items 19-26 for Research Question 3

Item	n	%	*M*	*SD*
I believe that I have the following skills to conduct professional advocacy:				
16. Take an educational approach				
Strongly Disagree	3	0.8		
Disagree	5	1.3		
Somewhat Disagree	4	1.0		
Neither Agree nor Disagree	23	5.9		
Somewhat Agree	82	21.0		
Agree	171	43.8		
Strongly Agree	102	26.2		
Total	390	100	5.81	1.08
17. Acceptance (i.e., inclusive nature, embracing differences)				
Strongly Disagree	2	0.5		
Disagree	1	0.3		
Somewhat Disagree	0	0.0		
Neither Agree nor Disagree	8	2.1		
Somewhat Agree	38	9.7		
Agree	201	51.5		
Strongly Agree	140	35.9		
Total	390	100	6.18	0.82
18. Relationship building (i.e., communication skills, listening skills)				
Strongly Disagree	2	0.5		
Disagree	0	0.0		
Somewhat Disagree	0	0.0		
Neither Agree nor Disagree	4	1.0		
Somewhat Agree	31	7.9		

Table 17 (continued from page 112)

Item	n	%	*M*	*SD*
Agree	151	38.7		
Strongly Agree	202	51.8		
Total	390	100	6.39	.78
19. Emotional independence				
Strongly Disagree	3	0.8		
Disagree	0	0.0		
Somewhat Disagree	4	1.0		
Neither Agree nor Disagree	27	6.9		
Somewhat Agree	52	13.3		
Agree	188	48.2		
Strongly Agree	116	29.7		
Total	390	100	5.96	1.00
20. Realistic goal setting (i.e., assess needs, define goals, implement research-based interventions, evaluate outcomes)				
Strongly Disagree	2	0.5		
Disagree	3	0.8		
Somewhat Disagree	6	1.5		
Neither Agree nor Disagree	25	6.4		
Somewhat Agree	66	16.9		
Agree	179	45.9		
Strongly Agree	109	27.9		
Total	390	390	5.88	1.04
21. Time management and organizational skills				
Strongly Disagree	2	0.5		
Disagree	1	0.3		
Somewhat Disagree	6	1.5		
Neither Agree nor Disagree	21	6.4		
Somewhat Agree	90	23.1		

Table 17 (continued from page 113)

Item	n	%	*M*	*SD*
Agree	156	40.0		
Strongly Agree	114	29.2		
Total	390	100	5.87	1.02
22. Public speaking				
Strongly Disagree	8	2.1		
Disagree	14	3.6		
Somewhat Disagree	13	3.3		
Neither Agree nor Disagree	20	5.1		
Somewhat Agree	84	21.5		
Agree	131	33.6		
Strongly Agree	120	30.8		
Total	390	100	5.64	1.41
23. Writing skills				
Strongly Disagree	4	1.0		
Disagree	5	1.3		
Somewhat Disagree	5	1.3		
Neither Agree nor Disagree	15	3.8		
Somewhat Agree	74	19.0		
Agree	160	41.0		
Strongly Agree	127	32.6		
Total	390	100	5.92	1.11

Research Question 4

Research Question 4 asked professional counselors to what degree they believe that they have the qualities (interest/passion, commitment, resilience/persistence, toughness/force, life-long learner attitude and self-confidence) to participate in professional advocacy efforts. Descriptive survey statistics were calculated on inventory responses to items 24-29. The comparisons of the descriptive statistics and frequencies for each item and statistical results for

Research Question 4 are presented in Table 18. Most participants, 86.1% (n = 337), endorsed some level of agreement, ranging from somewhat agree to strongly agree for item 24, that they have interest and passion (i.e., drive, enthusiasm) to conduct professional advocacy. The mean of this group was 5.69 with a standard deviation of 1.30. Participants (n = 261) indicated that they agree with Item 25 and at some level they have commitment, to conduct professional advocacy, with a mean of 5.72 and a standard deviation of 1.26. Respondents indicated a 90.5% (n = 354) level of agreement on Item 26, resilience and persistence, with a mean of 5.82 and a standard deviation of 1.17. Responses to Item 27 indicated that 198 participants agreed at some level that they consider themselves tough and forceful with a mean of 4.83 and a standard deviation of 1.49. Item 28, life-long learner, elicited the most responses regarding qualities used to conduct professional advocacy (n = 380) at an overwhelming 97.5% with a mean of 5.88 and a standard deviation of 1.04. Responses to Item 29 were nearly as high, at 95.1%, indicating that respondents agree to some level that they have the self-confidence. This item had a mean of 6.05 and a standard deviation of 0.95. Participants held a high level of agreement with the qualities of life-long learner, self-confident, and resilience/persistence. Interest had a somewhat high level of agreement with 86.1%; but commitment and tough/forceful attributes had the lowest with 67% and 50.8%, respectively.

Table 18
Frequency Distribution for Item 24-29 for Research Question 4

Item	n	%	*M*	*SD*
Qualities for Professional Advocacy				
I believe that I have the following qualities to conduct professional advocacy:				

Table 18 (continued from page 115)

Item	n	%	*M*	*SD*
24. Interest/Passion (i.e., drive, enthusiasm)				
Strongly Disagree	5	1.3		
Disagree	10	2.6		
Somewhat Disagree	11	2.8		
Neither Agree nor Disagree	27	6.9		
Somewhat Agree	86	22.1		
Agree	132	33.8		
Strongly Agree	119	30.5		
Total	390	100	5.69	1.30
25. Commitment				
Strongly Disagree	4	1.0		
Disagree	8	2.1		
Somewhat Disagree	16	4.1		
Neither Agree nor Disagree	21	5.4		
Somewhat Agree	80	20.5		
Agree	148	37.9		
Strongly Agree	113	29.0		
Total	390	100	5.72	1.26
26.Resilience, persistence				
Strongly Disagree	3	0.8		
Disagree	6	1.5		
Somewhat Disagree	12	3.1		
Neither Agree nor Disagree	15	3.8		
Somewhat Agree	89	22.8		
Agree	143	36.7		
Strongly Agree	122	31.3		
Total	390	100	5.82	1.17

Table 18 (continued from page 116)

Item	n	%	*M*	*SD*
27. Tough, forceful				
Strongly Disagree	8	2.1		
Disagree	27	6.9		
Somewhat Disagree	39	10.0		
Neither Agree nor Disagree	58	14.9		
Somewhat Agree	121	31.0		
Agree	85	21.8		
Strongly Agree	52	13.3		
Total	390	100	4.83	1.49
28. Life-long learner				
Strongly Disagree	2	0.5		
Disagree	0	0.0		
Somewhat Disagree	1	0.3		
Neither Agree nor Disagree	7	1.8		
Somewhat Agree	35	9.0		
Agree	120	30.8		
Strongly Agree	225	57.7		
Total	390	100	6.42	0.85
29. Self-confident				
Strongly Disagree	2	0.5		
Disagree	2	0.5		
Somewhat Disagree	4	1.0		
Neither Agree nor Disagree	11	2.8		
Somewhat Agree	60	15.4		
Agree	178	45.6		
Strongly Agree	133	34.1		
Total	390	100	6.05	0.95

Research Question 5

Professional counselors were asked in Research Question 5 to indicate to what degree they participate in professional advocacy efforts. Descriptive survey statistics were calculated on inventory responses to items 30-42. The comparisons of the descriptive statistics and frequency for each item and statistical results for Research Question 5 are presented in Tables 18-22. Table 19 presents questions regarding educating others about the profession. Nearly 80% of participants (n = 309) indicated some level of agreement with Item 30, that they educate other professionals (i.e., social workers, psychologists, psychiatrists, nurses, administrators, and educators) about counselor preparation, licensure and abilities. The mean and standard deviation for this group were 5.36 and 1.60, respectively. More participants (n = 358) indicated some level of agreement to Item 31, that they educate other professionals (i.e., social workers, psychologists, psychiatrists, nurses, administrators, and educators) about their role as a counselor. The mean for this group was 4.87 and standard deviation was 1.13. Participants (n = 326) indicated that they agree with Item 32 and at some level they educate other professionals (i.e., social workers, psychologists, psychiatrists, nurses, administrators, and educators) about the similarities and differences of counseling to other professions. The mean for this group was 5.52 and the standard deviation was 1.40. Most respondents identified, at a rate of 83.5 to 91.7%, that they educate other professionals about their: a) counselor preparation, licensure and abilities, b) role as a counselor, and c) similarities and differences of counseling to other professions.

Table 19
Frequency Distribution for Items 30-32 for Research Question 5

Item	n	%	*M*	*SD*
Advocacy Efforts				
30. I educate other professionals (i.e., social workers, psychologists, psychiatrists, nurses, administrators, and educators) about counselor preparation, licensure and abilities.				
Strongly Disagree	12	3.1		
Disagree	28	7.2		
Somewhat Disagree	12	3.1		
Neither Agree nor Disagree	29	7.4		
Somewhat Agree	82	21.0		
Agree	129	33.1		
Strongly Agree	98	25.1		
Total	390	100.0	5.36	1.60
31. I educate other professionals (i.e., social workers, psychologists, psychiatrists, nurses, administrators, and educators) about the role of a counselor.				
Strongly Disagree	10	2.6		
Disagree	10	2.6		
Somewhat Disagree	12	3.1		
Somewhat Agree	80	20.5		
Agree	156	40.0		
Strongly Agree	122	31.3		
Total	390	100.0	4.87	1.13
32. I educate other professionals (i.e., social workers, psychologists, psychiatrists, nurses, administrators, and educators) about the similarities and differences of counseling to other professions.				
Strongly Disagree	9	2.3		
Disagree	15	3.8		
Somewhat Disagree	10	2.6		

Table 19 (continued from page 119)

Item		n	%	*M*	*SD*
	Neither Agree nor Disagree	30	7.7		
	Somewhat Agree	94	24.1		
	Agree	137	35.1		
	Strongly Agree	95	24.4		
	Total	390	100.0	5.50	1.40

Building alliances, Items 33-34, are also a part of professional advocacy efforts. The comparisons of the descriptive statistics and frequencies for each item and statistical results related to alliances for Research Question 5 are presented in Table 20. Participants (n = 336) indicated some level of agreement with Item 33 indicating that 86.2% of participants believe that they build alliances with other professionals (i.e., social workers, psychologists, psychiatrists, nurses, administrators, and educators) regarding consumer and/or professional issues. The mean and standard deviation for this group were 5.76 and 1.26, respectively. Slightly more participants (n = 346) indicated some level of agreement to Item 34, that they build alliances with other counselors (school, mental health, rehabilitation, college, private practice, etc.) regarding consumer and/or professional issues regarding consumer and/or professional issues. The mean for this group was 5.77 and standard deviation was 1.39.

Table 20
Frequency Distribution for Items 33-34 for Research Question 5

Item	n	%	*M*	*SD*
Advocacy Efforts (continued)				
33. I build alliances with other professionals (i.e., social workers, psychologists, psychiatrists, nurses, administrators, and educators) regarding consumer and/or professional issues.				
Strongly Disagree	2	0.5		
Disagree	11	2.8		
Somewhat Disagree	12	3.1		
Neither Agree nor Disagree	29	7.4		
Somewhat Agree	69	17.7		
Agree	143	36.7		
Strongly Agree	124	31.8		
Total	390	100.0	5.76	1.26
34. I build alliances with other counselors (school, mental health, rehabilitation, college, private practice, etc.) regarding consumer and/or professional issues.				
Strongly Disagree	3	0.8		
Disagree	7	1.8		
Somewhat Disagree	10	2.6		
Neither Agree nor Disagree	24	6.2		
Somewhat Agree	79	20.3		
Agree	158	40.5		
Strongly Agree	109	27.9		
Total	390	100.0	5.77	1.39

Professional counselors were asked about their ability to conduct, promote or create as part of conducting advocacy activities. Items 35-37 measure these efforts and the comparisons of these descriptive statistics and frequencies for each item and statistical results for Question 5 are presented in Table 21. Only 47.4% participants (n = 185) indicated some level of agreement with Item 35, that they conduct service projects in the community representing the counseling

profession. The mean and standard deviation for this group were 4.17 and 1.84, respectively. Less than one-third of respondents (n = 114) indicated that they agree to some level with Item 36, that they create multi-media activities informing the public about client issues and awareness of the counseling profession participants. The mean of this group was 3.38 and standard deviation was 1.75. Only 17.7% of participants (n = 69) agree to some level that they conduct and publish research on the counseling theories and techniques that they use. The mean for this group is 2.70 and standard deviation was 1.78 indicating a very low agreement with this statement.

Table 21
Frequency Distribution for Items 35-37 for Research Question 5

Item	n	%	*M*	*SD*
Advocacy Efforts (continued)				
35. I conduct service projects in the community representing the counseling profession.				
Strongly Disagree	26	6.7		
Disagree	82	21.0		
Somewhat Disagree	34	8.7		
Neither Agree nor Disagree	63	16.2		
Somewhat Agree	65	16.7		
Agree	82	21.0		
Strongly Agree	38	9.7		
Total	390	100.0	4.17	1.84
36. I create multi-media activities informing the public about client issues and/or awareness of the counseling profession.				
Strongly Disagree	49	12.6		
Disagree	123	31.5		
Somewhat Disagree	39	10.0		
Neither Agree nor Disagree	65	16.7		

Table 21 (continued from page 122)

Item	n	%	*M*	*SD*
Somewhat Agree	57	14.6		
Agree	39	10.0		
Strongly Agree	18	4.6		
Total	390	100.0	3.38	1.75
37. I conduct and publish research on the counseling theories and techniques that I use.				
Strongly Disagree	122	31.3		
Disagree	125	32.1		
Somewhat Disagree	18	4.6		
Neither Agree nor Disagree	56	14.4		
Somewhat Agree	28	7.2		
Agree	25	6.4		
Strongly Agree	16	4.1		
Total	390	100.0	2.70	1.78

Previous research and literature has indicated that professional identity is related to professional advocacy (Lafleur, 2007; Remily & Herlihy, 2010). Items 38-41 measure these efforts. The comparisons of these descriptive statistics and frequencies for each item and statistical results for Question 5 are presented in Table 22. Participants (n = 185) indicated some level of agreement with Item 38, indicating that they educate, model and promote prevention and wellness strategies. The mean and standard deviation for this group were 5.67 and 1.27, respectively. Nearly all respondents, 98.9%, indicated that they agree to some level with Item 39, that they belong to one or more professional associations for counselors. The mean of this group was 6.51 and standard deviation was 0.73. More than 75% of the participants (n = 301) agree to some level that they attend at least one conference for the counseling profession a year. The mean for this group was 5.64 and standard deviation was 1.70. Only 28.2% of the

respondents indicated some level of agreement with Item 41, indicating that the participants belong to one or more boards or committees within the counseling profession. The mean for this group was 3.18 with a 2.15 standard deviation. Most participants indicated a high level of agreement that they belong to a professional association (98.9%) and three-fourths agree to attending a conference once a year. Less than half of the participants indicated that they educate, model and promote prevention and wellness strategies and less than one-third is indicated that they are on a board or committee within the counseling profession.

Table 22
Frequency Distribution for Items 38-41 for Research Question 5

Item	n	%	*M*	*SD*
Advocacy Efforts (continued)				
38. I educate, model and promote prevention and wellness strategies.				
Strongly Disagree	6	1.5		
Disagree	8	2.1		
Somewhat Disagree	11	2.8		
Neither Agree nor Disagree	21	5.4		
Somewhat Agree	97	24.9		
Agree	140	35.9		
Strongly Agree	107	27.4		
Total	390	100.0	5.67	1.27
39. I belong to one or more professional association for counselors.				
Strongly Disagree	2	0.5		
Disagree	1	0.3		
Somewhat Disagree	0	0.0		
Neither Agree nor Disagree	1	0.3		
Somewhat Agree	11	2.8		

Table 22 (continued from page 124)

Item	n	%	*M*	*SD*
Agree	148	37.9		
Strongly Agree	227	58.2		
Total	390	100.0	6.51	0.73
40. I attend at least one conference for the counseling profession a year.				
Strongly Disagree	7	1.8		
Disagree	34	8.7		
Somewhat Disagree	13	3.3		
Neither Agree nor Disagree	35	9.0		
Somewhat Agree	31	7.9		
Agree	99	25.4		
Strongly Agree	171	43.8		
Total	390	100.0	5.64	1.70
41. I belong to one or more board or committee within the counseling profession.				
Strongly Disagree	93	23.8		
Disagree	144	36.9		
Somewhat Disagree	10	2.6		
Neither Agree nor Disagree	33	8.5		
Somewhat Agree	13	3.3		
Agree	48	12.3		
Strongly Agree	49	12.6		
Total	390	100.0	3.18	2.15

Professional counselors were asked to indicate their agreement with Item 42 which measured their agreement with whether they participate in legislative activities. The descriptive statistics, frequencies and statistical results for Item 42 of Question 5 are presented in Table 23. Participants (n = 163) indicated some level of agreement with Item 42, indicating that they participate in legislative activities such as letter writing campaigns and contacting members of

congress regarding job opportunities, scope of practice, and systemic barriers to employment for counselors. The mean and standard deviation for this group were 3.68 and 2.03, respectively.

Table 23
Frequency Distribution for Items 42 for Research Question 5

Item	n	%	*M*	*SD*
Advocacy Efforts (continued)				
42. I participate in legislative activities such as letter writing campaigns and contacting members of congress regarding job opportunities, scope of practice, and systemic barriers to employment for counselors.				
Strongly Disagree	66	16.9		
Disagree	99	25.4		
Somewhat Disagree	22	5.6		
Neither Agree nor Disagree	40	10.3		
Somewhat Agree	69	17.7		
Agree	57	14.6		
Strongly Agree	37	9.5		
Total	390	100.0	3.68	2.03

Research Question 6

Professional counselors were asked to what degree they believe that it is important to participate in professional counselor advocacy efforts. Items 43-47 measure these beliefs. Comparisons of these descriptive statistics and frequencies for each item and statistical results for Question 6 are presented in Table 24. Overwhelmingly, 97.7% of participants (n = 381) indicated a high level of agreement with Item 43, that "I think it is important to advocate for the profession of counseling." The mean and standard deviation for this group was 6.43 and 0.79, respectively. As noted, there was little variability among the respondents in their endorsement of this item. Respondents (n = 378) also overwhelmingly indicated a 96.9% agreement for Item 44, that counselors must improve their public and professional image with a mean of 6.38 and

standard deviation of 0.82. Almost half of the respondents agreed to some degree with Item 45, that I have lost clients due to the lack of insurance coverage for counselors. The mean was 4.38 and standard deviation was 2.12. Almost 42% of respondents (n = 163) also agreed with Item 46 to some level that they have been denied jobs in schools, mental health or other settings due to their degree or license as a counselor. The mean was 3.82 and standard deviation was 2.19. Similarly, 41.8% of participants indicated some level of agreement with Item 47, that they have the need to advocate for themselves other than for the profession of counseling. The mean of was 4.22 and standard deviation was 1.68. Respondents overwhelmingly agreed with the statements regarding the importance of advocating for the profession of counseling and counselors need to improve the public and professional image of counselors. Lower percentages within the category of importance and need are reflected in the statements regarding losing clients due to lack of insurance coverage, being denied jobs, and having a need to advocate for self other than for the profession.

Table 24
Frequency Distribution for Items 43-47 for Research Question 6

Item	n	%	*M*	*SD*
Importance of Advocacy				
43. I think it is important to advocate for the profession of counseling.				
Strongly Disagree	0	0.0		
Disagree	1	0.3		
Somewhat Disagree	3	0.8		
Neither Agree nor Disagree	5	1.3		
Somewhat Agree	32	8.2		
Agree	128	32.8		
Strongly Agree	221	56.7		
Total	390	100.0	6.43	0.79

Table 24 (continued from page 127)

Item	n	%	*M*	*SD*
44. I believe counselors must improve the public and professional image of counselors				
Strongly Disagree	0	0.0		
Disagree	1	0.3		
Somewhat Disagree	2	0.5		
Neither Agree nor Disagree	9	2.3		
Somewhat Agree	35	9.0		
Agree	133	34.1		
Strongly Agree	210	53.8		
Total	390	100.0	6.38	0.82
45. I have lost clients due to the lack of insurance coverage for counselors				
Strongly Disagree	50	12.8		
Disagree	60	15.4		
Somewhat Disagree	11	2.8		
Neither Agree nor Disagree	87	22.3		
Somewhat Agree	27	6.9		
Agree	64	16.4		
Strongly Agree	91	23.3		
Total	390	100.0	4.38	2.12
46. I have been denied jobs in schools, mental health or other settings due to my degree/license as a counselor.				
Strongly Disagree	74	6.4		
Disagree	87	14.9		
Somewhat Disagree	12	5.9		
Neither Agree nor Disagree	66	31.0		
Somewhat Agree	36	16.4		
Agree	43	16.2		
Strongly Agree	72	9.2		
Total	390	100.0	3.82	2.19

Table 24 (continued from page 128)

Item	n	%	*M*	*SD*
47. I have had the need to advocate for myself other than for the profession of counseling.				
Strongly Disagree	25	6.4		
Disagree	58	14.9		
Somewhat Disagree	23	5.9		
Neither Agree nor Disagree	121	31.0		
Somewhat Agree	64	16.4		
Agree	63	16.2		
Strongly Agree	36	9.2		
Total	390	100.0	4.22	1.68

Research Question 7

Participants were asked to indicate to what degree they believe there are barriers to participating in professional counselor advocacy. Items 48-59 list barriers which were used to measure these beliefs. Comparisons of these descriptive statistics and frequencies for each item and statistical results for Question 7 are presented in Table 25. More than half of the participants (n = 203) endorsed some level of agreement, ranging from somewhat agree to strongly agree for Item 48, indicating that they believe that lack of leadership in the counseling field is a barrier to conducting professional advocacy. The mean of this group was 4.43 with a standard deviation of 1.62. Participants (n = 245) indicated some level of agreement for item 49, agreeing that the lack of collaboration within the profession on legislative advocacy initiatives is a barrier to professional counselor advocacy. The mean for this group was 4.80 and the standard deviation was 1.51. Respondents indicated a 73.1% (n = 285) level of agreement on Item 50 indicating an agreement that roadblocks caused by other professionals (i.e., psychologists, social workers) was a barrier to professional counselor advocacy. This group had a mean of 5.27 and a standard

deviation of 1.56. Responses to Item 51 indicated that 69.8% of participants (n = 272) agreed at some level that insufficient knowledge of professional advocacy strategies was a barrier. The mean for this group was 5.00 with a standard deviation of 1.52. Only 20% of respondents indicated some level of agreement with Item 52, that the inability to explain credentials, what I do as counselor, and/or how my profession compares to others is a barrier to professional counselor advocacy. The mean for this group was 2.76 and the standard deviation was 1.68. Only 35.4% indicated that Item 53, lack of position, is a barrier to professional advocacy. The mean was 3.66 and standard deviation was 1.83. Participants responded at 57.2% agreement that insufficient funds, Item 54, are a barrier to professional advocacy. The mean for this group was 4.69 and the standard deviation was 1.71. More than 75% of the respondents (n = 296) indicated that Item 55, not enough time, was a barrier to professional advocacy. The mean of this group was 5.32 with a 1.48 standard deviation. More than one-third of respondents (n = 139) agreed to some level that lack of skill level to advocate, Item 56, is a barrier to professional advocacy. This item had a mean of 3.62 and a standard deviation of 1.73. Only 18.2% of respondents (n = 71) agreed that a barrier to advocacy is being satisfied with the status of the counseling profession. This group had a mean of 3.04 and a standard deviation of 1.55. Only 14% agreed to Item 58, that they would be seen as a "trouble maker." The mean for this group was 2.68 with a standard deviation of 1.56. Only 5.9% of respondents endorsed Item 59, "other" barriers with a 3.47 mean and a 1.38 standard deviation. The top three barriers assessed by participants include not enough time (75%), roadblocks caused by other professionals (73.1%), and insufficient knowledge of professional advocacy strategies (69.8%). The lowest responses range from lack of skill level to advocate (35.6%), lack of position (35.4%), inability to explain credentials (20%),

satisfied with status of the counseling profession (18.2%), and the statement "I would be seen as a 'trouble-maker'" (14%).

Table 25
Frequency Distribution for Items 48-59 for Research Question 7

Item	n	%	*M*	*SD*
Barriers to Professional Advocacy				
I believe that the following are barriers to conducting professional advocacy:				
48. Lack of leadership in the counseling field				
Strongly Disagree	18	4.6		
Disagree	47	12.1		
Somewhat Disagree	35	9.0		
Neither Agree nor Disagree	87	22.3		
Somewhat Agree	85	21.8		
Agree	87	22.3		
Strongly Agree	31	7.9		
Total	390	100.0	4.43	1.62
49. Lack of collaboration within the profession on legislative advocacy initiatives				
Strongly Disagree	12	3.1		
Disagree	29	7.4		
Somewhat Disagree	27	6.9		
Neither Agree nor Disagree	77	19.7		
Somewhat Agree	99	25.4		
Agree	105	26.9		
Strongly Agree	41	10.5		
Total	390	100.0	4.80	1.51

Table 25 (continued from page 131)

Item	n	%	*M*	*SD*
50. Roadblocks caused by other professionals (i.e., psychologists, social workers)				
Strongly Disagree	6	1.5		
Disagree	27	6.9		
Somewhat Disagree	19	4.9		
Neither Agree nor Disagree	53	13.6		
Somewhat Agree	87	22.3		
Agree	94	24.1		
Strongly Agree	104	26.7		
Total	390	100.0	5.27	1.56
51. Insufficient knowledge of professional advocacy strategies				
Strongly Disagree	9	2.3		
Disagree	28	7.2		
Somewhat Disagree	30	7.7		
Neither Agree nor Disagree	51	13.1		
Somewhat Agree	95	24.4		
Agree	124	31.8		
Strongly Agree	53	13.6		
Total	390	100.0	5.00	1.52
52. Inability to explain my credentials (training, education, etc.), what I do as a counselor, and/or how my profession compares to others				
Strongly Disagree	105	26.9		
Disagree	118	30.3		
Somewhat Disagree	52	13.3		
Neither Agree nor Disagree	37	9.5		
Somewhat Agree	45	11.5		
Agree	24	6.2		
Strongly Agree	9	2.3		
Total	390	100.0	2.76	1.68

Table 25 (continued from page 132)

Item	n	%	*M*	*SD*
53. Lack of position				
Strongly Disagree	58	14.9		
Disagree	82	21.0		
Somewhat Disagree	28	7.2		
Neither Agree nor Disagree	84	21.5		
Somewhat Agree	71	18.2		
Agree	40	10.3		
Strongly Agree	27	6.9		
Total	390	100.0	3.66	1.83
54. Insufficient funds				
Strongly Disagree	15	3.8		
Disagree	49	12.6		
Somewhat Disagree	21	5.4		
Neither Agree nor Disagree	82	21.0		
Somewhat Agree	69	17.7		
Agree	98	25.1		
Strongly Agree	56	14.4		
Total	390	100.0	4.69	1.71
55. Not enough time				
Strongly Disagree	4	1.0		
Disagree	23	5.9		
Somewhat Disagree	22	5.6		
Neither Agree nor Disagree	45	11.5		
Somewhat Agree	92	23.6		
Agree	108	27.7		
Strongly Agree	96	24.6		
Total	390	100.0	5.32	1.48

Table 25 (continued from page 133

Item	n	%	*M*	*SD*
56. Lack of skill level to advocate				
Strongly Disagree	48	12.3		
Disagree	85	21.8		
Somewhat Disagree	48	12.3		
Neither Agree nor Disagree	70	17.9		
Somewhat Agree	77	19.7		
Agree	48	12.3		
Strongly Agree	14	3.6		
Total	390	100.0	3.62	1.73
57. Satisfied with status of the counseling profession				
Strongly Disagree	61	15.6%		
Disagree	114	29.2%		
Somewhat Disagree	79	20.3%		
Neither Agree nor Disagree	65	16.7%		
Somewhat Agree	36	9.2%		
Agree	27	6.9%		
Strongly Agree	8	2.1%		
Total	390	100.0%	3.04	1.55
58. I would be seen as a “trouble maker”				
Strongly Disagree	99	25.4		
Disagree	134	34.4		
Somewhat Disagree	38	9.7		
Neither Agree nor Disagree	64	16.4		
Somewhat Agree	29	7.4		
Agree	20	5.1		
Strongly Agree	6	1.5		
Total	390	100.0	2.68	1.56

Table 25 (continued from page 134)

Item	n	%	*M*	*SD*
59. Other				
Strongly Disagree	70	17.9		
Disagree	22	5.6		
Somewhat Disagree	3	0.8		
Neither Agree nor Disagree	271	69.5		
Somewhat Agree	7	1.8		
Agree	7	1.8		
Strongly Agree	10	2.6		
Total	390	100.0	3.47	1.38

Research Question 8

Participants were asked to indicate by short-answer format what they think the barriers are to participating in professional counselor advocacy efforts. Of the 390 respondents who reported that there are barriers to conducting professional counselor advocacy, 59 chose to answer item 60, which asked participants to mention any barriers to conducting professional advocacy that were not mentioned in Section V, Barriers to Advocacy. Eight of the participants indicated that the they did not have any barriers and listed "none," "NA", "n/a" and "None that I can think of" as responses. Several respondents listed more than one barrier, increasing the number of supporting quotes to a total of 65 responses.

Item 60 was analyzed by the grounded theory approach, which utilizes an open coding technique (see Cohen, Manion, & Morrison, 2007). The data were specifically analyzed by: 1) reading and re-reading open-ended responses from participants, 2) coding this data according to the emerging themes, 3) re-reading responses to organize sub-themes within the data until reaching saturation, and 4) counting the frequency of those themes. The themes and sub-themes described below are listed along with supporting quotes in Table 26. Participants (n=59)

responded with open-ended input regarding barriers. While the total of respondents who provided written comments was a small percent of the total, the qualitative nature of the individual comments was instructive in shedding light on these important advocacy issues. The themes presented add additional data to support respondent's perceptions of advocacy.

Five major issue-based themes and several sub-themes were identified in the data. The first theme, negative or weak inter-professional relations, was cited by 21 participants (32%) and is defined as the relationship between counselors and other professions. Several sub-themes included: a) roadblocks by social workers, psychologists, licensure bodies and legislators regarding legislation (e.g., Medicare, Tricare, Department of Defense, Veterans Administration); b) lack of support and recognition from employers, the community, licensure boards and other professions; and c) lack of knowledge by legislators about mental health and the role of counselors. The second theme, negative or weak intra-professional relations, was identified by 12 participants (18%) and is explained as the relationship among counselors regardless of division or specialty. Two sub-themes that emerged were: a) disjointed profession (diversity of education and training, inconsistency in requirements for licensure, lack of reciprocity among states, "contamination by others professions") and b) lack of support from leaders and fellow counselors (ACA, licensure boards, divisions, level of education). The third theme, attitude toward professional advocacy, was identified by 12 individuals (18%). The sub-themes included: a) lack of involvement of students/interns; b) lack of importance/need (ex: comparison between professional counselors' and other professionals' ability to conduct professional advocacy, need for more counselors to advocate); c) lack of belief that professional advocacy would be useful/effective; and d) lack of passion.

The fourth theme, power differential/limited position was noted by 11 participants (17%). The sub-themes identified were: a) limited job-opportunities and positions in relation to other professions, b) lack of negotiating power, and c) limited time, resources and money. Several individuals indicated that they are unable to get positions that other mental health professionals were able to obtain. One stated, "It seems to me that LC Social Workers may do counseling, but a counselor may not do social work, which limits job opportunities." Another informed that, "…in Florida my license as an LPC is not acceptable for counseling positions. I have been hired because of being an RN." Still another stated, "State, Federal, and County level jobs for counseling are few or rare." The lack of positions available are a cause to advocate but also are a barrier to advocating due to the lack of position counselors have within the major entities that assist in developing legislative policy to address consumer needs.

The fifth theme, lack of knowledge/experience, was identified by 6 participants (9%) and includes the lack of experience in the field, insufficient training in advocacy and counselor identity, and knowledge of issues and laws that affect counselors. Individual challenges/concerns were noted by 3 respondents (5%) and include barriers such as physical challenges, cultural background and stress. Analysis of these data identifies negative or weak inter-professional relations (33%) as the largest barrier self-reported. Several of the barriers follow with a range of 17-18% each; negative or weak intra-professional relations (18%), attitude towards professional advocacy (18%), and power-differential/limited position (17%). The most problematic area that professional counselors need to address, based on these data, is the relationship both intra- and inter-professionally which accounts for 50% of the barriers listed in this report.

Table 26

Themes from responses to item 60 for Research Question 8

Themes	*n*	Supporting Quotes
Negative or weak inter-professional relations - Roadblocks by social workers, psychologists, licensure bodies and legislators (regarding Medicare, Tricare, DOD, and VA) - Lack of support and recognition from employer, community, licensure boards, and other professions - Lack of knowledge by legislators about mental health and counselors	21	• *"Federal legislation that has been blocked by Department of Defense, (DOD) and the Veterans Administration (VA) implementation policies"* • *"When it comes to laws pertaining to counseling it often feels like the government doesn't care."* • *"…for the Medicare legislat[ors] to allow us to be recognized…"* • *"Government legislation that is unfavorable to the counseling profession"* • *"[Lawmakers] lack of knowledge of mental health"* • *"Lack of knowledge and understanding regarding school counselors and professional counselors."* • *"Lawmakers do not make it a priority"* • *"Lack of connection(s) to leadership and legislature"* • *"Lack of sophistication regarding the varying laws across states that have been passed in the past that exclude counselors, in favor of previously licensed professionals (especially psychologists);"* • *"The House of Rep. continues to block the counseling profession the ability and opportunity to treat Medicare, or Tricare covered individuals without supervision by an MD. S"*

Table 26 (continued from page 138)

Themes	*n*	Supporting Quotes
Negative or weak inter-professional relations (continued)		• *"Political positions"* • *"Lack of social acceptance for periodic counseling"* • *"Lack of community interest"* • *"Lack of support from employer ([I] work in a not for profit, state funded community mental health agency)"* • *"Lack of support from other counseling professionals"* • *"Need more support for what we do for the community and the importance of our field"* • *"…for NASW to not block us …"* • *"I believe the LCSW's are a barrier to counselors, also…"* • *"Roadblocks caused by licensure bodies (i.e. the state of California's board of behavioral sciences)"* • *"Lack of respect between disciplines (other professionals)"* • *"Sometimes the distinctions between mental health professions distract from the common purpose between them, and create adversarial and territorial dynamics that don't serve the public good"*

Table 26 (continued from page 139)

Themes	*n*	Supporting Quotes
Negative or weak Intra-professional relations - Disjointed profession - Lack of support from ACA, licensure boards, and other counselors	12	• *"TPA has always advocated against it's own masters level professionals"* • *"Contamination by counseling psychologists who want counseling licenses who dilute the profession"* • *"Diversity of educational & training requirements"* • *"Unwillingness of divisions to give up specialty turf to unify profession"* • *"Lack of reciprocity between states"* • *"Disjointedness between levels of the profession - we don't value each other, support each other, help each other.* • *"Division in counseling profession (i.e. school, professional, MFT, etc)"* • *"Inconsistencies in requirements for licensed counselors across country."* • *"Lack of consensus and unity among counseling divisions regarding the profession of counseling"* • *"Variation in licenses (i.e. LMHP, LPC, LIMHP, etc) in states"* • *"State licensure boards providing insufficient support"* • *"Lack of support and/or follow through by the National (ACA) organization regarding advocacy for the counseling profession. The ACA can often be too passive about advocacy."*

Table 26 (continued from page 140)

Themes	*n*	Supporting Quotes
Attitude toward professional advocacy - Lack of involvement of Students/Interns - lack belief of effectiveness - lack passion - lack importance/ need	12	• *"Aspiring professional counselor"* • *"I am currently a student and do not have my licensure yet"* • *..."I look forward to advocating when I am employed full-time in the counseling field."* • *"I'm still a student"* • *"We must stand up for our clients thus advocate so trouble maker is true but okay."* • *"Attitude"* • *"Lack of belief that it would be useful/ effective."* • *"Lack of passion"* • ***"****Need more LPC's to advocate..."* • *"The members of the mental health field who do not perceive advocacy as vital"* • *"Social work has a stronger advocacy. Psychologist also have a strong advocacy and tougher demands for profession"* • *"Lack of understanding of importance of professional as opposed to client advocacy"*

Table 26 (continued from page141)

Themes	*n*	Supporting Quotes
Power deferential/limited position - Limited job opportunities/positions - Lack of negotiating power - Limited time, resources and money	11	• *"It seems to me that LC Social Workers may do counseling, but a counselor may not do social work, which limits job opportunities."* • *"Lack of time being allocated by employer"* • *"Financial"* • *"Amount of time spent in the field"* • *"I am currently working full-time as a self-employed, state registered family day care provider and going part-time to school to complete my last LPC course."* • *"Lack of negotiating power with insurance companies"* • *"Lack of accessibility"* • *"We don't get paid enough to get taken seriously!!!!!!!!!"* • *"Lack of opportunity"* • *"…in Florida my license as an LPC is not acceptable for counseling positions I have been hired because of being an RN"* • *"State, Federal, and County level jobs for counseling are few or rare.*

Table 26 (continued from page 142)

Themes	*n*	Supporting Quotes
Lack of knowledge/experience - Experience in field - Insufficient training in advocacy and counselor identity - Knowledge of issues/laws affecting counselors	6	• *"Lack of experience within the field"* • *"Lack of knowledge"* • *"Lack of "knowledge of what issues are most affecting the majority of the counseling profession"* • *"Lack of sophistication regarding federal laws that exclude counselors"* • *"Insufficient counselor identity training, promotion, and advocacy in graduate schools."* • *"Lack of sophistication regarding the varying laws across states that have been passed in the past that exclude counselors, in favor of previously licensed professionals (especially psychologists)"* • *"Physical challenges that may hinder travel, obtaining meeting protocols, etc."* • *"Cultural background"* • *"Stress"*

Note. Five major issue-based themes were identified in the data: 1) negative or weak inter-professional relations, 2) negative or weak intra-professional relations, 3) attitude toward professional advocacy, 4) power differential/limited position, 5) lack of knowledge/experience. Three participants listed individual challenges/concerns.

Research Question 9

Participants were asked to indicate to what degree they feel they receive support from colleagues, counselor educators, supervisors, and associations, in participating in professional advocacy efforts. Descriptive statistics were calculated on inventory responses to items 61-64.

Comparisons of these descriptive statistics and frequencies for each item and statistical results for Question 9 are presented in Table 27. More than 80% of the participants (n = 318) endorsed some level of agreement, ranging from somewhat agree to strongly agree for Item 61, indicating that they receive support from colleagues to advocate for the profession. The mean of this group was 5.43 with a standard deviation of 1.34. Over 69% of participants (n = 271) indicated some level of agreement for Item 62, agreeing that they receive support from counselor educators and professors to advocate for the profession. The mean for this group was 5.17 with a standard deviation of 1.65. Respondents (n = 231) indicated some level of agreement for Item 63, that they receive support from supervisors to advocate for the profession. The mean for this group was 4.75 with a standard deviation of 1.74. More than 78% of respondents (n = 305) indicated some level of agreement with Item 54, that they receive support from associations to advocate for the profession. The mean for this group was 5.45 with a standard deviation of 1.29. Participants reported receiving the most support from colleagues (80%) and associations (78%). Although better than average, the responses for counselor educators (69%) and supervisors (59%) showed that they were less supportive than the other two categories.

Table 27
Frequency Distribution for Items 61-64 for Research Question 9

Item	n	%	*M*	*SD*
Perceived Support				
61. I receive support from colleagues to advocate for the profession.				
Strongly Disagree	7	1.8		
Disagree	10	2.6		
Somewhat Disagree	15	3.8		
Neither Agree nor Disagree	40	10.3		

Table 27 (continued from page 144)

Item	n	%	*M*	*SD*
Somewhat Agree	100	25.6		
Agree	134	34.4		
Strongly Agree	84	21.5		
Total	390	100.0	5.45	1.34
62. I receive support from counselor educators and professors to advocate for the profession.				
Strongly Disagree	16	4.1		
Disagree	22	5.6		
Somewhat Disagree	17	4.4		
Neither Agree nor Disagree	64	16.4		
Somewhat Agree	67	17.2		
Agree	112	28.7		
Strongly Agree	92	23.6		
Total	390	100.0	5.17	1.65
63. I receive support from supervisors to advocate for the profession.				
Strongly Disagree	25	6.5		
Disagree	29	7.5		
Somewhat Disagree	28	7.2		
Neither Agree nor Disagree	74	19.1		
Somewhat Agree	73	18.9		
Agree	95	24.5		
Strongly Agree	63	16.3		
Total	387	100.0	4.75	1.74
64. I receive support from associations to advocate for the profession.				
Strongly Disagree	5	1.3		
Disagree	8	2.1		
Somewhat Disagree	13	3.4		
Neither Agree nor Disagree	57	14.7		

Table 27 (continued from page 145)

Item	n	%	*M*	*SD*
64. I receive support from associations to advocate for the profession				
Somewhat Agree	84	21.6		
Agree	142	36.6		
Strongly Agree	79	20.4		
Total	388	100.0	5.45	1.29

Factor Analysis Used to Assist in the Analysis of Research Questions 10-15

While it wasn't initially part of the original design for instrument development, a principal components factor analysis with varimax rotation was conducted to minimize the number of variables in the analysis of Research Questions 10-15 and thus to simplify the interpretation items that I deemed similar in the questionnaire. This exploratory factor analysis involved the generation of a correlational matrix, extraction of initial factor data, rotation and interpretation of the generated factors, and the construction of subscales to use in further analysis. This process is recommended in the literature as a means of reducing a large number of items from a survey into a small number of components for ease in analysis (Costello & Osborne, 2005; DiStefano, Zhu, & Mindrila, 2009; Hair et al., 2006; Line, 1994). After the correlational matrix was constructed, the extraction method yielded three components identified by using the eigenvalues greater than 1.00. The practice of using eigenvalues greater than 1.00 to establish the number of isolated factors is documented in the research literature and is standard when using statistical programs such as SPSS (Flynn-Thapalia, 2011) The factors were then rotated using the varimax rotation method with Kaiser normalization which produced a rotated factor matrix and allowed for the exploration of the factor loadings which were used to interpret

the meaning of the factors. DiStefano et al. suggest that this factor rotation is optimal and allows for researchers to determine which factors are linked together with the understanding that an item is more closely linked to a factor the higher the absolute value of the loading (ranging from -1.0 to 1.0). He also posits that the pattern identified by the factor loadings can be used to interpret the underlying factors and is typically dependent on the decisions made by the researcher. Although the cut-off value is admittedly arbitrary, Distefano et al. (2009) has indicated that it is common practice to establish a cut-off marker to consider the item's relationship to each factor and to use as a criterion for using the factor loadings to justify summing the identified items into a summed score (subscale) for meaning, parsimony, and any further analysis. For this study, .40 was used as the minimum for the cutoff. Finally, summated scores were developed by adding the original scores for each of the items and developing the newly constructed factors. This non-refined method has been documented in research literature and since these scales are exploratory this method preserves the variability in the original data as recommended by Hair et al. (2006). Names were then given to the factors based on the knowledge of the literature and previous research.

The advocacy activities, items 30-42, were analyzed producing three factors that were extracted from the original 13 items. The findings from the analysis are presented in Table 28. Items 30-32 seemed to have the most commonality to the first factor, renamed professional counselor self-advocacy with loadings of 0.72, 0.87 and 0.79. Factor 2, renamed community outreach and involvement, is comprised of items 35, 36, 37, 42 with loadings of 0.57, 0.55, 0.63, 0.44, respectively. Items 33-34 had high loadings, 0.79 and 0.79 for the third factor, renamed professional alliance building. The remaining items had minimal associations to the factors. Item 38 had a low association and was equally distributed through all factors (0.28, 0.26, and 0.23).

Item 39 had an even lower association with the three factors (0.19, 0.21, and 0.09). Item 40 was shown to be related to both factor 1 and 2, but had a fairly low association to them (0.23, 0.35). In light of the findings and the research literature cited, correlations were calculated using Factor 1, professional counselor self-advocacy; Factor 2, community outreach and involvement; Factor 3, professional alliance building, and the remaining items 38-40.

Table 28

Principal Components Factor Analysis with Varimax Rotation for Items 30-42 for Research Questions 10-15

Items	Factor		
	1	2	3
30. I educate other professionals (i.e., social workers, psychologists, psychiatrists, nurses, administrators, and educators) about counselor preparation, licensure and abilities.	**.719**	.206	.195
31. I educate other professionals (i.e., social workers, psychologists, psychiatrists, nurses, administrators, and educators) about the role of a counselor.	**.869**	.175	.210
32. I educate other professionals (i.e., social workers, psychologists, psychiatrists, nurses, administrators, and educators) about the similarities and differences of counseling to other professions.	**.793**	.175	.193
33. I build alliances with other professionals (i.e., social workers, psychologists, psychiatrists, nurses, administrators, and educators) regarding consumer and/or professional issues.	.231	.142	**.790**
34. I build alliances with other counselors (school, mental health, rehabilitation, college, private practice, etc.) regarding consumer and/or professional issues.	.266	.192	**.792**

Table 28 (continued from 148)

Items	Factor		
	1	2	3
35. I conduct service projects in the community representing the counseling profession.	.116	.**568**	.340
36. I create multi-media activities informing the public about client issues and/or awareness of the counseling profession.	.124	.**589**	.250
37. I conduct and publish research on the counseling theories and techniques that I use.	.096	.**546**	.070
38. I educate, model and promote prevention and wellness strategies.	.279	.263	.225
39. I belong to one or more professional association for counselors.	.194	.210	.092
40. I attend at least one conference for the counseling profession a year.	.236	.347	.041
41. I belong to one or more board or committee within the counseling profession.	.099	.**624**	.011
42. I participate in legislative activities such as letter writing campaigns and contacting members of congress regarding job opportunities, scope of practice, and systemic barriers to employment for counselors.	.176	**.439**	.096

Note. Boldface indicates significant factor loadings.

Research Question 10

This study was completed to determine whether there is a relationship between professional counselor's perception of their ability to advocate for the profession and their perception of their involvement in professional advocacy activities. Pearson product moment correlations were used to answer this research question using a conservative alpha level to determine significance (p. <.01). Data were gathered from Item 1 and from items related to

advocacy activities, factors 1-3 and Items 38-40. The first correlation was computed between Factor 1, professional counselor self-advocacy and Item 1, I know how to advocate for the profession. A significant correlation with a small effect size was found (r (390) = .340, r^2 = .116. p < .000) between the two variables. The second correlation was computed between Factor 2, outreach and involvement, and Item 1, I know how to advocate for the profession. A significant correlation with a small effect size was found (r (390) = .390, r^2 = .152. p < .000) between the two variables. The third correlation was computed between Factor 3, alliance building, and Item 1, I know how to advocate for the profession. A significant correlation with a marginal effect size was found (r (390) = .306, r^2 = .094. p < .000) between the two variables. The fourth correlation was computed between Item 38, I educate, model and promote prevention and wellness strategies and Item 1, I know how to advocate for the profession. A significant correlation with a small effect size was found (r (390) = .199, r^2 = .040. p < .000) between the two variables. The fifth correlation was computed between Item 39, I belong to one or more professional associations for counselors, and Item 1, I know how to advocate for the profession. A significant correlation with a small effect size was found (r (390) = .241, r^2 = .058. p < .000). The sixth correlation was computed between Item 40, I attend at least one conference for the profession a year and Item 1, I know how to advocate for the profession. A significant correlation with a small effect size was found (r (390) = .218, r^2 = .048. p < .000). Based on the results of these correlations, participants indicated that they agree highly that they would be involved in outreach and involvement activities if they perceive they know how to advocate. Also, since I know how to advocate for the profession was significantly correlated to all factors related professional counselor advocacy activities, participants indicated that if they know how

to advocate they will conduct all professional self-advocacy activities. The means and standard deviations for Question 10 are listed Table 29.

Table 29
Means and Standard Deviations for items 1 and 33-45 for Research Question 10 (n = 390)

Item	*M*	*SD*
1. I know how to advocate for the profession.	5.06	1.48
Advocacy Activities:		
Factor 1. Professional counselor self-advocacy	15.73	3.69
Factor 2. Outreach and involvement	17.11	6.57
Factor 3. Alliance building	11.53	2.28
38. I educate, model and promote prevention and wellness strategies.	5.67	1.27
39. I belong to one or more professional association for counselors.	6.51	0.73
40. I attend at least one conference for the counseling profession a year.	5.64	1.70

Note. Factors 1-3 are the factors created by the principal components factor analysis with varimax rotation conducted to minimize the number of variables. This method simplifies the interpretation of the factors and assists in validating the instrument. Scores for factors 1-3 could range from 3- 21 while scores for items 38-40 range from 1-7

Research Question 11

One of the purposes of the study was to determine if there was a correlation between professional counselors' level of participating in professional advocacy efforts and their perceived level of skill to engage in professional advocacy activities. Pearson product moment correlations were used to answer this research question and data were gathered from advocacy skills, Items 16-23, and from items related to advocacy activities, factors 1-3 and items 38-40. A

conservative alpha level was used to determine significance ($p. < .01$). Means and standard deviations for Question 11 are listed in Table 30.

The first set of correlations for Question 11 was computed between Factor 1, professional counselor self-advocacy and items 16-23. A significant correlation with a large effect size was found (r (390) = .425, r^2 = .181. $p < .000$) between professional counselor self-advocacy and take an educational approach. Significant correlations with small effect sizes were found between professional counselor self-advocacy and Item 17, acceptance (r (390) = .362, r^2 = .131. $p <$ .000); Item 18, relationship building (r (390) = .333, r^2 = .111. $p < .000$); Item 19, emotional independence (r (390) = .287, r^2 = .082. $p < .000$); Item 20, realistic goal setting (r (390) = .305, r^2 = .093. $p < .000$); Item 22, public speaking (r (390) = .349, r^2 = .122. $p < .000$), Item 23 writing skills(r (390) = .243, r^2 = .059. $p < .000$) and Item 21, time management and organizational skills.

The second set of correlations for Question 11 was computed between Factor 2, outreach and involvement, and items 16-23. The means and standard deviations are presented in Table 29. Significant correlations with small effect sizes were found between Factor 2, outreach and involvement, and Item 16, (r (390) = .289, r^2 = .084. $p <.000$; Item 20, (r (390) = .343, r^2 = .118. $p < .000$); Item 22, (r (390) = .357, r^2 = .127. $p < .000$) and Item 23, (r (390) = .235, r^2 = .055. $p < .000$). Outreach and involvement produced significant correlations with small effect sizes with Item 17, (r (390) = .200, r^2 = .040. $p < .000$; Item 18, (r (390) = .173, r^2 = .030. $p < .001$); Item 19, (r (390) = .183, r^2 = .033. $p < .000$) and Item 21 (r (390) = .229, r^2 = .052. $p < .000$).

The third set of correlations for Question 11 was computed between Factor 3, alliance building, and items 16-23. A significant correlation with a medium effect size (r (390) = .386, r^2 = .149. $p < .000$) was found between alliance building and Item 16, take an educational

approach. Significant correlations with medium effect sizes were found between Factor 3, alliance building and Item 17, (r (390) = .291, r^2 = .085 p <.000; Item 18, (r (390) = .337, r^2 = .114. p < .000); Item 19, (r (390) = .240, r^2 = .058. p < .000); Item 20, (r (390) = .340, r^2 = .116. p < .000) Item 21, (r (390) = .264, r^2 = .070. p < .000); Item 22, (r (390) = .250, r^2 = .063. p < .000); and Item 23, (r (390) = .205, r^2 = .042. p < .000 producing a small effect size.

The fourth set of correlations for Question 11 was computed between Item 38, I educate, model and promote prevention and wellness, and items 16-23. Significant correlations with small effect sizes were found between Item 38 and Item 16, take an educational approach (r (390) = .275, r^2 = .076. p <.000); Item 17 acceptance (r (390) = .256, r^2 = .066. p < .000); Item 18, relationship building (r (390) = .264, r^2 = .070. p < .000); Item 19, emotional independence, (r (390) = .231, r^2 = .053. p < .000); and Item 22, public speaking (r (390) = .299, r^2 = .090. p < .000). Significant correlations with small effect sizes were also found between Item 38 and Item 20, realistic goal setting (r (390) = .230, r^2 = .053. p <.000; Item 21, time management/ organizational skills (r (390) = .197, r^2 = .039. p < .000); Item 23, writing skills (r (390) = .180, r^2 = .032. p <.000).

The fifth set of correlations for Question 11 was computed between Item 39, I belong to one or more professional association for counselors and items 16-23. Significant correlations were found between item 39 and Item 17, (r (390) = .151, r^2 = .023. p <.003; Item 18, (r (390) = .147, r^2 = .022. p < .004); Item 19, (r (390) = .176, r^2 = .031. p < .000); Item 20, (r (390) = .140, r^2 = .020. p < .006); and Item 22, public speaking (r (390) = .171, r^2 = .030. p < .001) producing small effect sizes.

The sixth set of correlations for Question 11 was computed between Item 40, I attend at least one conference for the profession a year and items 16-23. Significant correlations with

small effect sizes were found between Item 40 and Item 16, (r (390) = .162, r^2 = .026. p <.001; Item 17, (r (390) = .163, r^2 = .027. p < .001); Item 18, (r (390) = .156, r^2 = .024. p < .002); Item 19, (r (390) = .170, r^2 = .029. p < .001); Item 20, (r (390) = .142, r^2 = . 020. p < .005); Item 21, (r (390) = .147, r^2 = . 022. p < .004); and Item 22, (r (390) = .149, r^2 = .022. p < .003). Based on these results, the more professional counselors believe that they have skills the more they will conduct these advocacy activities. Also, belonging to a professional association does not related to counselors taking an educational approach or using writing skills to advocate. The results also indicate that it is necessary to take an educational approach when involved in professional self advocacy and outreach and involvement activities. Attending a conference did not produce any significant correlations to any of the advocacy activities, indicating that attending a conference does not have a strong relationship to professional counselors advocating.

Table 30
Means and Standard Deviations for Items 16-23, Factors 1-3 and Items 38-40 for Research Question 11 (n =390)

Item	*M*	*SD*
I believe that I have the following skills to conduct professional advocacy:		
16. Take an educational approach	5.81	1.08
17. Acceptance (i.e. inclusive nature, embracing differences)	6.18	0.82
18. Relationship building (i.e. communication skills, listening skills)	6.39	0.78
19. Emotional independence	5.96	1.00
20. Realistic goal setting (i.e. assess needs, define goals, implement research-based interventions, evaluate outcomes)	5.88	1.04
21. Time management and organizational skill	5.87	1.02

Table 30 (continued from page 154)

Item	*M*	*SD*
22. Public speaking	5.64	1.41
23. Writing skills	5.92	1.12
Advocacy Activities:		
Factor 1. Professional counselor self-advocacy	15.73	3.69
Factor 2. Outreach and involvement	17.11	6.57
Factor 3. Alliance building	11.53	2.28
38. I educate, model and promote prevention and wellness strategies.	5.67	1.27
39. I belong to one or more professional association for counselors.	6.51	0.73
40. I attend at least one conference for the counseling profession a year.	5.64	1.70

Note. Factors 1-3 are the factors created by the principal components factor analysis with varimax rotation conducted to minimize the number of variables. This method simplifies the interpretation of the factors and assists in validating the instrument. Scores for factors 1-3 could range from 3- 21 while items 38-40 could range from 1-7.

Research Question 12

The study was conducted to determine if there was a correlation between professional counselors' perceived level of participation in professional advocacy efforts and their perception of their professional advocacy qualities. Pearson product moment correlations were used to answer this research question using a conservative alpha level to determine significance (p. <.01). Data were gathered from advocacy qualities, items 24-29, and from items related to advocacy activities, factors 1-3 and items 38-40. The means and standard deviations for Question 12 are listed in Table 31.

Correlations were computed for Factor 1, professional counselor self-advocacy, and items 24-29. Significant correlations with small effect sizes were found between professional counselor self-advocacy and Item 24 interest/passion, (r (390) = .293, r^2 = .086. p < .000); Item 25, commitment (r (390) = .256, r^2 = .066. p < .000); Item 26, resilience (r (390) = .258, r^2 = .067. p < .000); Item 27, tough/forceful (r (390) = .335, r^2 = .112. p < .000); Item 29, self-confident (r (390) = .329, r^2 = .108. p < .000). Professional counselor self-advocacy was correlated to Item 28, producing a significant correlation with a small effect size (r (390) = .216, r^2 = .033. p < .000).

Correlations for Question 12 were computed between Factor 2, outreach and involvement and items 24-29. Factor 2, outreach and involvement was significantly correlated to Item 24, (r (390) = .328, r^2 = .106. p <.000); Item 25, (r (390) = .347, r^2 = .120. p <.000); Item 26, (r (390) = .301, r^2 = .091. p <.000); Item 27, (r (390) = .291, r^2 = .085. p <.000); and Item 29, (r (390) = .256, r^2 = .066 p <.000), producing small effect sizes. Outreach and involvement was also correlated to Item 28, (r (390) = .207, r^2 = .043. p <.000) producing a significant correlation and small effect size.

The third set of correlations for Question 12 was computed between Factor 3, alliance building, and items 24-29. A significant correlation with a small effect size (r (390) = .371, r^2 = .138. p < .000) was found between alliance building and Item 24, Interest/passion (i.e., drive, enthusiasm). Significant correlations with small effect sizes were found between Factor 3, alliance building, and Item 25, (r (390) = .316, r^2 = .10. p <.000); Item 26, (r (390) = .320, r^2 = .102. p < .000); Item 27, (r (390) = .247, r^2 = .061 p < .000); Item 28, (r (390) = .241, r^2 = .000. p < .000); and Item 29, (r (390) = .271, r^2 = .073. p < .000).

Correlations for Question 12 were computed between Item 38, I educate, model and promote prevention and wellness and items 24-29. Item 38 and Item 29, *(r* (390) = .285, r^2 = 081. p < .000) produced a significant correlation with a small effect size. Significant correlations with small effect sizes were found between item 38 and Item 24, interest and passion (*r* (390) = .208, r^2 = .043. p < .000); Item 25, commitment (*r* (390) = .184, r^2 = .034. p < .000); Item 26, resilience/persistence (*r* (390) = .205, r^2 = .042. p < .000); and Item 27, tough/forceful (*r* (390) = .200, r^2 = .040. p < .000); and Item 28, life-long learner (*r* (390) = .202, r^2 = 041. p <.000).

The fifth set of correlations for Question 12 was computed between Item 39, I belong to one or more professional association for counselors and items 24-29. A significant correlation with small effect size was found between item 39 and Item 28, (*r* (390) = .156, r^2 = 024. p <.002).

The sixth set of correlations for Question 12 was computed between Item 40, I attended at least one conference for the profession a year and items 24-29. Significant correlations with small effect sizes were found between Item 40 and Item 24, (*r* (390) = .135, r^2 = .018. p <.008); Item 25, (*r* (390) = .138, r^2 = .019. p < .007); and Item 27, (*r* (390) = .139, r^2 = .019. p < .006).

The results indicate that if counselors believe they have these qualities then they could engage in professional advocacy activities. Alliance-building produced the only medium effect size for this research question with the quality interest/passion indicating that those with this quality are more likely to be involved in professional advocacy. It is also important to note that belonging to one or more associations was correlated with only a small effect to one quality, life-long learner.

Table 31
Means and Standard Deviations for items 24-29 and Factors 1-3 and Items 38-40 for Research Question 12 (n = 390)

Item	*M*	*SD*
I believe I have the following qualities to conduct professional advocacy:		
24. Interest/Passion (i.e. drive, enthusiasm)	5.69	1.30
25. Commitment	5.72	1.26
26. Resilience, persistence	5.82	1.18
27. Tough, forceful	4.85	1.49
28. Life-long learner	6.42	0.85
29. Self-confident	6.05	0.95
Advocacy Activities:		
Factor 1. Professional counselor self-advocacy	15.73	3.69
Factor 2. Outreach and involvement	17.11	6.57
Factor 3. Alliance building	11.53	2.28
38. I educate, model and promote prevention and wellness strategies.	5.67	1.27
39. I belong to one or more professional association for counselors.	6.51	0.73
40. I attend at least one conference for the counseling profession a year.	5.64	1.70

Note. Factors 1-3 are the factors created by the principal components factor analysis with varimax rotation conducted to minimize the number of variables. This method simplifies the interpretation of the factors and assists in validating the instrument. Scores for factors 1-3 could range from 3-21 while scores for items 38-40 could range from 1-7.

Research Question 13

The study was conducted to determine if there was a correlation between professional counselors' level of participating in professional advocacy efforts and their perception of the importance or need to advocate. Pearson product moment correlations were used to answer this research question using a conservative alpha level to determine significance (p. <.01). Data were gathered from questions related to the importance and need to advocate, items 43-47 and from items related to advocacy activities, factors 1-3 and items 38-40. The means and standard deviations for Question 13 are listed Table 32.

Factor 1, professional counselor self-advocacy and items 43-47 produced significant correlations. A medium effect size was found between Factor 1 and Item 44, I believe counselors must improve the public and professional image of counselors (r (390) = .242, r^2 = .059. p < .000) and a small effect size was found between Factor 1 and Item 43, I think it is important to advocate for the profession of counseling (r (390) = .233, r^2 = .054. p < .000). The second set of correlations for Question 13 was computed between Factor 2, outreach and involvement and items 43-47. Significant correlations with small effect sizes were found between Factor 2, outreach and involvement and Item 43, (r (390) = .220, r^2 = .048. p <.000) and Item 44, (r (390) = .234, r^2 = .055. p <.000). Correlations were computed between Factor 3, alliance building and items 43-47 and a significant correlation with a small effect size was found between Factor 3, alliance building and Item 43, (r (390) = .272, r^2 = .074. p <.000). A significant correlation with a small effect size was found between Factor 3 and Item 44, (r (390) = .233, r^2 = .054. p <.000). Correlations for Question 13 were computed between Item 38, I educate, model and promote prevention and wellness and items 43-47. Only one significant correlation with a small effect size was found between Item 38 and Item 44, (r (390) = .149, r^2 = .022. p < .003). Item 39, I

belong to one or more professional association for counselors was correlated to items 43-47. A significant correlation with small effect size was found between Item 39 and Item 43, (r (390) = .249, r^2 = 062. p < .000) and a significant correlation with a small effect size was found between item 39 and Item 44, (r (390) = .159, r^2 = 025. p <.002). Correlations for Question 13 were computed between Item 40, I attend at least one conference for the profession a year and items 43-47. Significant correlations with a small effect size were found between Item 40 and Item 43, (r (390) = .170, r^2 = .029. p <.001) and between Item 40 and Item 44, (r (390) = .173, r^2 = .030. p < .001).

The results indicate that counselors who are concerned about improving the public and professional image of counselors and the importance of advocating for the profession of counseling (r (390) = .233, r^2 = .054. p < .000) are likely to conduct professional counselor self-advocacy. I educate, model and promote prevention and wellness strategies also shows a relationship to I believe that counselors must improve the public and professional image of counselors. This correlation means that if counselors want to improve the public opinion of the counseling profession they could educate, model and promote prevention and wellness strategies. Several importance/need items (e.g., lack of insurance coverage, and I have a need to advocate for myself other than for the profession of counseling) shared no significant correlations with advocacy activities, meaning that these items do not compel counselors to participate in professional advocacy activities.

Table 32
Means and Standard Deviations for items 43-47 and Factors 1-3 and Items 38-40 for Research Question 13. (n = 390)

Item	*M*	*SD*
Importance/Need to Advocate:		
43. I think it is important to advocate for the profession of counseling	6.43	.794
(continued)		
44. I believe counselors must improve the public and professional image of counselors	6.38	.817
45. I have lost clients due to the lack of insurance coverage for counselors	4.38	2.12
46. I have been denied jobs in schools, mental health or other settings due to my degree/license as a counselor	3.82	2.19
47. I have a need to advocate for myself other than for the profession of counseling	4.22	1.68
Advocacy Activities:		
Factor 1. Professional counselor self-advocacy	15.73	3.69
Factor 2. Outreach and involvement	17.11	6.57
Factor 3. Alliance building	11.53	2.28
38. I educate, model and promote prevention and wellness strategies.	5.67	1.27
39. I belong to one or more professional association for counselors.	6.51	0.73
40. I attend at least one conference for the counseling profession a year.	5.64	1.70

Note. Factors 1-3 are the factors created by the principal components factor analysis with varimax rotation conducted to minimize the number of variables. This method simplifies the

interpretation of the factors and assists in validating the instrument. Scores for factors 1-3 could range from 3-21 while scores for items 38-40 could range from 1-7.

Research Question 14

One of the purposes of the study was to determine if there was a correlation between professional counselors' level of participating in professional advocacy efforts and their perception of the barriers to advocating. Pearson product moment correlations were used to answer this research question using a conservative alpha level to determine significance (p. <.01). Data were gathered from barriers to advocating, Items 48-59 and from items related to advocacy activities, factors 1-3 and items 38-40. The means and standard deviations for Question 14 are listed in Table 33.

The first correlations were computed between Factor 1, professional counselor self-advocacy and items 48-59. A significant negative correlation with a medium effect size was found (r (390) = -.372, r^2 = .138. p < .000) between professional counselor self-advocacy and Item 56, satisfied with the status of the counseling profession and a correlation with a medium effect size, for Item 52, inability to explain my credentials (training, education, etc.), what I do as a counselor, and/or how my profession compares to others (r (390) = -.224, r^2 =.050. p < .000). Significant negative correlations with small effect sizes were found between professional counselor self-advocacy and Item 53, lack of position (r (390) = -.165, r^2 = .027. p < .001) and item 58, I would be seen as a "trouble-maker" (r (390) = -.134, r^2 = .018. p < .008) Professional counselor self-advocacy was positively correlated to Item 50, roadblocks caused by other professionals (i.e. psychologists, social workers). The correlation was significant and had a small effect size (r (390) = .176, r^2 = .030. p < .000).

The second set of correlations for Question 14 was computed between Factor 2, outreach and involvement, and items 48-59. Factor 2, and Item 55, not enough time had a significant and

negative correlation with a small effect size (r (390) = -.260, r^2 = .068. p < .000). Significant negative correlations with small effect sizes were found between Factor 2 and Item 52, inability to explain my credentials (training, education, etc.), what I do as a counselor, and/or how my profession compares to others (r (390) = - .203, r^2 = .041. p <.000) and Item 54, insufficient funds (r (390) = -.164, r^2 = .027. p < .001). Positive, significant correlations were also found between Factor 2 and Item 48, lack of leadership in the counseling field (r (390) = .205, r^2 = .042. p < .000) and Item 49, lack of collaboration within the profession on legislative advocacy initiatives (r (390) = .176, r^2 = .030. p < .000). Correlations were also computed between Factor 3, alliance-building and items 48-59. A significant positive correlation with a small effect size was found between Factor 3, alliance building and Item 49, (r (390) = .132, r^2 = .017. p < .009).

The fourth set of correlations for Question 14 was computed between Item 38, "I educate, model and promote prevention and wellness" and items 48-59. Item 38 and Item 55, not enough time (r (390) = -.232, r^2 = .054. p <.000) produced a significant, negative correlation with a medium effect size. Significant, negative correlations with small effect sizes were found between Item 38 and Item 51, insufficient knowledge of professional advocacy strategies (r (390) = -.170, r^2 = .029. p <.001; Item 52, (r (390) = -.209, r^2 = .044. p < .000) and Item 57, (r (390) = -.210, r^2 = .044. p < .000).

The fifth set of correlations for Question 14 was computed between Item 39, I belong to one or more professional association for counselors and items 48-59. Significant, negative correlations with small effect sizes were found between item 39 and Item 52, Inability to explain my credentials (training, education, etc.), what I do as a counselor, and/or how my profession compares to others (r (390) = -.169, r^2 = .029. p <.001); Item 55, not enough time (r

(390) = -.169, r^2 = .029. p < .001) and a positive correlation with Item 57, satisfied with the status of the counseling profession (r (390) = .146, r^2 = .021. p < .004).

The final correlations for Question 14 were computed between Item 40, I attend at least one conference for the profession a year and items 48-59. A significant, positive correlation with a small effect size was found between Item 40 and Item 49, lack of collaboration within the profession on legislative advocacy initiatives (r (390) = .157, r^2 = .025. p <.002) and a significant, negative correlation existed between Item 40 and Item 55, not enough time (r (390) = -.173, r^2 = .030. p < .001).

Results indicate that there is both a negative and positive statistically significant correlation between the professional counselors' level of participating in professional advocacy activities and their perception of barriers to advocating. All of the professional advocacy activities have negative relationships to several barriers which indicates that the more professional counselors conduct professional advocacy activities the less they perceive there are barriers or the less they perceive there are barriers the more they participate in advocacy. Positive correlations were noted between professional-self advocacy and roadblocks caused by other professionals (i.e., psychologists, social workers) denoting that the more participants perceived there were roadblocks, the more they reported self-advocating. Extremely important is the fact that outreach and involvement was positively correlated to the lack of leadership in the counseling field and to lack of collaboration within the profession on legislative advocacy initiatives, indicating that the more professional counselors were involved in outreach and involvement the more they perceived that there is a lack of leadership in the field and of collaboration within the profession on legislative advocacy initiatives.

Table 33
Means and Standard Deviations for items 48-59 and Factors 1-3 and Items 38-40 for Research Question 14. (n = 390)

Item	*M*	*SD*
Barriers:		
48. Lack of leadership in the counseling field	4.80	1.51
49. Lack of collaboration within the profession on legislative advocacy initiatives	5.27	1.56
50. Roadblocks caused by other professionals (i.e. psychologists, social workers)	5.00	1.52
51. Insufficient knowledge of professional advocacy strategies	2.76	1.68
52. Inability to explain my credentials (training, education, etc.), what I do as a counselor, and/or how my profession compares to others	3.66	1.83
53. Lack of position	4.69	1.71
54. Insufficient funds	5.32	1.48
55. Not enough time	3.62	1.73
56. Lack of skill level to advocate	3.04	1.55
57. Satisfied with the status of the counseling profession	2.68	1.56
58. I would be seen as a "trouble maker"	3.47	1.38
59. Other	4.43	1.62
Advocacy Activities:		
Factor 1. Professional counselor self-advocacy	15.73	3.69
Factor 2. Outreach and involvement	17.11	6.57
Factor 3. Alliance building	11.53	2.28

Table 33 (continued from page 165)

Item	*M*	*SD*
38. I educate, model and promote prevention and wellness strategies.	5.67	1.27
39. I belong to one or more professional association for counselors.	6.51	0.73
40. I attend at least one conference for the counseling profession a year.	5.64	1.70

Note. Factors 1-3 are the factors created by the principal components factor analysis with varimax rotation conducted to minimize the number of variables. This method simplifies the interpretation of the factors and assists in validating the instrument. Scores for factors 1-3 could range from 3-21 while scores for items 38-40 could range from 1-7.

Research Question 15

The final research question was completed to determine if there was a correlation between professional counselors' level of participating in professional advocacy efforts and their perceived level of support they received from counselor educators, supervisors, associations and colleagues. Pearson product moment correlations were used to answer this research question using a conservative alpha level to determine significance (p. <.01). Data were gathered from the questions related to support for advocating, Items 61-64, and from items related to advocacy activities, factors 1-3 and items 38-40. The means and standard deviations for Question 15 are listed in Table 34.

The first set of correlations for Question 15 was computed between Factor 1, professional counselor self-advocacy, and items 61-64. A significant, positive correlation with a medium effect size was found (r (390) = .265, r^2 = .019. p < .000) between professional counselor self-advocacy and Item 62, I receive support from counselor educators and professors to advocate for the profession. Significant positive correlations with small effect sizes were found between

professional counselor self-advocacy and Item 61, I receive support from colleagues to advocate for the profession (r (390) = .145, r^2 =.021. p < .004) and Item 64, I receive support from associations to advocate for the profession (r (390) = .187, r^2 = .035. p < .000). Correlations were also completed between Factor 2 and Items 61-63. Factor 2, outreach and involvement and Item 61, counselors receive support from colleagues to advocate for the profession produced a significant and positive correlation with a small effect size (r (390) = .239, r^2 = .014. p < .000). Significant positive correlations with small effect sizes were found between Factor 2 and Item 62, I receive support from counselor educators and professors to advocate for the profession (r (390) = .216, r^2 = .047. p <.000) and Item 63, support from supervisors to advocate for the profession (r (387) = .161, r^2 = .026. p < .002) and Item 64, support from associations to advocate for the profession (r (388) = .182, r^2 = .033. p < .000).

Correlations for Question 15 were computed between Factor 3, alliance-building and items 61-64. A significant, positive correlation with a medium effect size was found between Factor 3, alliance building and Item 61 (r (390) = .254, r^2 = .065. p < .009). Significant, positive correlations with small effect sizes were found between Factor 3 and Item 62, (r (390) = .165, r^2 = .027. p <.001) and Item 63, (r (387) = .178, r^2 = .032. p < .000) and Item 64, (r (388) = .150, r^2 = .023. p < .003). The fourth correlations for Question 15 were completed between Item 38, I educate, model and promote prevention and wellness, and items 61-64 producing significant, positive correlations with small effect sizes between Item 38 and Item 61, (r (390) = .206, r^2 = .042. p <.000) and Item 64, (r (388) = .153, r^2 = .023. p <.003).

Correlations were computed between Item 39, I belong to one or more professional association for counselors and items 61-64 producing significant, positive correlations between item 39 and Item 61, (r (390) = .169, r^2 = .029. p <.001) and Item 64, (r (388) = .140, r^2 = .020.

$p < .006$). Each had small effect sizes. Item 40, I belong to at least one conference for the profession a year and items 61-64 were also correlated. Significant, positive correlations with small effect sizes were found between Item 40 and Item 61, I receive support from colleagues to advocate for the profession (r (390) = .182, r^2 = .033. p <.000); Item 62, I receive support from counselor educators and professors to advocate for the profession (r (390) = .158, r^2 = .025. p < .002) and Item 64, I receive support from associations to advocate for the profession (r (388) = .142, r^2 = .020. p < .005).

The results suggests that the greater the level of support from leaders in the field, the more professional counselors will be involved in advocacy activities related to outreach and involvement and alliance building. These two professional advocacy activities were the only two items that were correlated to counselors reporting that they received support from supervisors to advocate for the profession, indicating that professional counselors are more apt to advocate with outreach and involvement and alliance building type activities if they receive support from supervisors. Overall, the results indicate that professional counselors are more apt to be involved in advocacy activities if they feel support from their colleagues, supervisors, counselor educators and professional associations.

Table 34
Means and Standard Deviations for items 60-64 and Factors 1-3 and Items 38-40 for Research Question 15.(n = 390)

Item	*M*	*SD*
61. I receive support from colleagues to advocate for the profession.	5.45	1.34
62. I receive support from counselor educators and professors to advocate for the profession.	5.17	1.65
63. I receive support from supervisors to advocate for the profession.	4.75	1.74

Table 34 (continued from page168)

Item	*M*	*SD*
64. I receive support from associations to advocate for the profession.	5.45	1.29
Advocacy Activities:		
Factor 1. Professional counselor self-advocacy	15.73	3.69
Factor 2. Outreach and involvement	17.11	6.57
Factor 3. Alliance building	11.53	2.28
38. I educate, model and promote prevention and wellness strategies.	5.67	1.27
39. I belong to one or more professional association for counselors.	6.51	0.73
40. I attend at least one conference for the counseling profession a year.	5.64	1.70

Note. Factors 1-3 are the factors created by the principal components factor analysis with varimax rotation conducted to minimize the number of variables. This method simplifies the interpretation of the factors and assists in validating the instrument. Scores for factors 1-3 could range from 3-21 while scores for items 38-40 could range from 1-7.

Summary

This chapter presented the results of this research study. The results of research questions 1-15 were reported. Research questions 1- 5 were asked to explore the knowledge, skills and qualities endorsed by professional counselors. The results indicated that of the 390 participants, 305 (78.2%) agreed at some level that they know how to advocate for the profession and nearly 43% of the respondents reported they strongly agree that they know how to advocate. When asked about the sources where this knowledge was gained, most participants, 79.7% (n = 311) reported gaining knowledge of professional advocacy from publications and that the knowledge

was modeled or taught by others 76.9% (n = 300) Surprisingly, results related to the educational program indicated that 47% of the respondents did not gain knowledge of professional advocacy from their educational program and of those who reportedly gained knowledge, nearly 30% reported not gaining much knowledge. Approximately 64% of the participants also reported that they gained knowledge of professional advocacy from conferences and workshops and less than half of the participants, 43.3% (n = 169) reported gaining knowledge of professional advocacy from websites.

Respondents were also asked to report the sources (i.e., educational programs, conferences and workshops, publications, websites, and by modeling) of their knowledge. Participants reportedly gained most knowledge from their master's educational programs in counselor education. ACA sources (conferences, publications, etc.) were noted most often followed by the "other" category, which represented sources other than ACA (national, regional, state and local). Generally, the results indicated that ACA state and division associations also had high representation, but Chi Sigma Iota and regional conferences and workshops received the least endorsement. Participants reported gaining knowledge of professional advocacy from all four types of individuals; colleagues with a counseling degree, colleagues with related degree, LPC/LMHC supervisor, and other supervisor. Most individuals (87.1%) endorsed gaining knowledge through observing professional advocacy modeled by colleagues with a counseling degree.

Most participants agreed that they have all the skills listed to conduct professional advocacy. Acceptance and relationship building had the highest percentage of agreement with 97% and 98.4% respectively. All items indicated a high level of agreement with means ranging from 5.64 – 6.39. Participants held a high level of agreement with the quality of life-long learner

overwhelming at 97.5%, self-confidence at 95.1%, and resilience/persistence at 90.5%. Interest and passion had a somewhat high level of agreement with 86.1%; and commitment and tough/forceful attributes had the lowest level of agreement with 67% and 50.8%, respectively.

Most participants indicated a high level of agreement that they belonged to a professional association (98.9%) which is probably directly related to the fact that the sample was taken from the ACA database. Respondents identified at a rate of 77.1% to 91.7% that they attended at least one conference a year, built alliances with other professionals (e.g., social workers, psychologists, psychiatrists, nurses, administrators, and educators), built alliances with other counselors (e.g., school, mental health, rehabilitation, college, private practice), and educated other professionals about advocacy issues (88.2%).

For question 6, respondents overwhelmingly agreed with the statements of I think it is important to advocate for the profession of counseling (n = 381, 97.7%) and I believe counselors must improve the public and professional image of counselors (n = 378, 96.9%). Lower percentages within the category of importance and need are reflected in the statements regarding losing clients due to lack of insurance coverage (50.2%), being denied jobs (42%), and having a need to advocate for self other than for the profession (41.8%).

Respondents were asked to indicate to what degree they believed that there are barriers to participating in professional counselor advocacy for Question 7, Items 48-59. The top three barriers included not enough time (75%), roadblocks caused by other professionals (73.1%), and insufficient knowledge of professional advocacy strategies (69.8%). Lack of leadership in the counseling field (52%), lack of collaboration within the profession on legislative activities (62.8%), and insufficient funds (57.2) were each endorsed by a majority of the participants. The lowest responses were from lack of skill level to advocate (35.6%), lack of position (35.4%),

inability to explain credentials (20%), satisfied with status of the counseling profession (18.2%) and the statement I would be seen as a "trouble-maker" (14%).

Of the 390 respondents who reported that there were barriers to conducting professional counselor advocacy, only 59 respondents chose to answer item 60. The question was analyzed by the grounded theory approach, which utilized an open coding technique (see Cohen, Manion, & Morrison, 2007). Five major issue-based themes were identified in the responses: 1) negative or weak inter- professional relations (32%); 2) negative or weak intra-professional relations, (18%) 3) attitude toward professional advocacy (18%); 4) power differential/limited position (17%); 5) and lack of knowledge/experience, (9%). Three participants noted individual challenges/concerns. Findings identified negative or weak inter-professional relations (33%) as the largest barrier self-reported. The most problematic area that professional counselors reported the need to address was relationship, both intra- and inter-professionally, which accounted for 50% of the barriers listed.

Participants reported receiving the most support from colleagues (80%) and associations (78%). Although the findings had better than majority percentages, professional counselors perceived that counselor educators (69%) and supervisors (59%) were somewhat less supportive than the other two categories.

Positive significant correlations were found between professional counselors' perceived involvement in professional advocacy activities and all of the factors. Knowing how to advocate for the profession was significantly correlated to all factors related to professional counselor advocacy activities. In addition, the activities for outreach and involvement (r (390) = .390, r^2 = .152. p < .000) had the largest effect size of the group indicating a correlation with a small to

medium effect size. Participants indicated that they would be involved in outreach and involvement activities if they perceive they know how to advocate.

The activities related of professional counselor self-advocacy, outreach and involvement, alliance building and educating, modeling and promoting prevention and wellness strategies correlated significantly to all eight skills and belonging to one or more professional association for counselors was correlated to six. The analyses of taking an educational approach produced the strongest effects of this group when correlated to the activities of professional self advocacy (r (390) = .425, r^2 = .181. p < .000) and outreach and involvement (r (390) = .386, r^2 = .149. p < .000), and indicated the necessity of approaching professional self advocacy and outreach and involvement activities from an educational approach. Attending a conference did not produce any significant relationships to any of the advocacy activities, indicating that attending conferences does not have a strong relationship to professional counselors advocating.

Correlations between professional counselors' advocacy qualities and their involvement in advocacy activities produced one medium, and several small effect sizes. Professional counselor self-advocacy, outreach and involvement, and alliance building all produced positive relationships with all of the advocacy qualities, indicating that if counselors believe they have these qualities then they could engage in professional advocacy activities. Alliance building produced the strongest correlation for this research question with the quality interest/passion, indicating that those with this quality are more likely to be involved in professional advocacy. It is also important to note that belonging to one or more associations was only mildly correlated to one quality, being a life-long learner.

Participating in professional advocacy efforts was correlated to counselors' perception of the importance or need to advocate. The importance of advocating and the belief that counselors

must improve the public and professional image of counselors were correlated to professional self-advocacy, outreach and involvement, alliance building, I belong to one or more professional association for counselors, and I attend at least one conference for the counseling profession a year, producing mostly small effect sizes. This indicated that counselors who are concerned about these two issues are likely to conduct those advocacy activities. I educate, model and promote prevention and wellness strategies also showed a relationship to I believe that counselors must improve to public and professional image of counselors. This correlation suggests that if counselors want to improve the public opinion of the counseling profession they could educate, model and promote prevention and wellness strategies. Several importance/need items such as losing clients due to the lack of insurance coverage and having a need to advocate for self other than for the profession of counseling shared no significant correlations with advocacy activities.

Many significant negative and some positive correlations were found between barriers and professional advocacy activities. All of the professional advocacy activities had negative relationships to several barriers. In order of frequency, they were: inability to explain my credentials (training, education, etc.), what I do as a counselor, and/or how my profession compares to others (noted 4 times); not enough time (noted 3 times); satisfied with the status of the counseling profession (noted 2 times); lack of position, I would be seen as a trouble maker; insufficient funds; and insufficient knowledge (all noted one time). This indicates that the more professional counselors conduct professional advocacy activities the less they perceive there are barriers, or the less they perceive there are barriers the more they participate in advocacy. Positive correlations were noted between professional-self advocacy and roadblocks caused by other professionals (i.e., psychologists, social workers) denoting that the more participants

perceived there were roadblocks, the more they reported self-advocating. Extremely important is the fact that outreach and involvement was positively correlated to the lack of leadership in the counseling field and to lack of collaboration within the profession on legislative advocacy initiatives indicating that the more professional counselors were involved in outreach and involvement the more they perceived that there is a lack of leadership in the field and of collaboration within the profession on legislative advocacy initiatives.

Outreach and involvement and alliance building produced significant correlations for all support entities. These two professional advocacy activities were the only two items that were correlated to receiving support from supervisors to advocate for the profession. In comparison, the remaining professional advocacy activities, professional counselor self-advocacy, educating, modeling and promoting prevention and wellness, belonging to one or more professional association for counselors and attending at least one conference for the profession a year were not positively correlated to participants reportedly receiving support from supervisors to advocate for the profession.

Overall, results of this study indicated that professional counselors believe that they participate in professional advocacy activities. Participants reported that they believe they also have the knowledge, skills, and qualities to conduct those professional advocacy activities. They endorsed the importance and need to conduct professional advocacy due to needing to improve the public and professional image of counselors. Participants indicated the top three barriers to be not enough time, roadblocks caused by other professionals, and insufficient knowledge of professional advocacy strategies; however, participants generally find support to advocate in colleagues, counselor educators, supervisors and professional associations. All variables have a positive relationship to professional counselors conducting professional advocacy activities.

Additionally, several barriers produced significant, negative relationships with advocacy activities.

CHAPTER FIVE

DISCUSSION

This chapter summarizes and discusses the findings from this research study. Limitations, implications for professional counselors, counselor educators and supervisors, and leaders in the field, recommendations for future research and conclusions are also provided.

Purpose of Study

The purpose of this study was to identify the perceptions of professional counselor advocacy held by counselors of different backgrounds. The literature has suggested a number of factors that influence the attitudes of professionals towards professional counselor advocacy initiatives (Eriksen, 1999; Field & Baker, 2004; Myers & Sweeney, 2004; Patrick, 2007; White & Semivan, 2006), including knowledge of professional advocacy principles, skills and traits, actual advocacy activities utilized, perceived barriers to professional advocacy, and perceived support to advocate. The results of this study provided insight into professional counselors' willingness and ability to advocate on behalf of the profession by identifying the attitudes of counseling professionals regarding their knowledge of professional advocacy (and where they gained this knowledge), skills and qualities endorsed; advocacy activities practiced; opinions on the importance of and need to advocate; barriers encountered; and support gained from various entities. By exploring the relationship between counseling professionals' attitudes toward professional counselor advocacy and their perceived level of conducting professional counselor advocacy activities, the results of the study provided insight into professional counselors' willingness and ability to advocate on behalf of the profession. These findings are discussed in the next section.

Discussion of Findings

This study was built on several qualitative studies (Eriksen, 1999; Field & Baker, 2004; White & Semivan, 2006) and one quantitative study (Myers & Sweeney, 2004). These studies were conducted to conceptualize and define professional counselor advocacy as well as to identify skills, values, beliefs and the actual process of advocacy for clients and the profession. The studies delved into the perceived reasons and motivations for professional counselor advocacy and noted several barriers to advocating. While the existing research defines professional advocacy and assists the profession in related concepts, it does not provide information on the beliefs of average professional counselors in the field of professional counselor advocacy. My study assessed professional counselors' perceptions of activities, knowledge about professional counselor advocacy and the avenue in which they gained this knowledge, skills and qualities, importance/need, barriers and support of professional counselor advocacy. I also examined what participants perceived as their barriers to advocacy.

I created the *Professional Counselor Advocacy Inventory* (PCAI) for this study with the specific purpose of determining professional counselors' perceptions of their level of: (a) involvement, b) knowledge and where they gained this knowledge, (c) skill, (d) qualities, (e) importance and need (f) identified barriers, and (f) support related to professional counselor advocacy.

Discussion of Participants' Perceived Efforts to Conduct Professional Counselor Advocacy

One the most important objectives of this study was to examine the perceived level of involvement in professional advocacy activities by professional counselors who are professional members of ACA. Several variables related to professional advocacy activities were analyzed.

Another important objective of this study was to determine the relationship between professional counselors' inclination to be involved in professional counselor activities and their perception of their knowledge, skill level, qualities, importance/need, barriers, and support for professional advocacy. The relationships between the efforts to conduct advocacy and the other variables will be discussed in the remaining discussion sections of this chapter. This section focuses on the frequency of advocacy activities that were endorsed by the participants.

Many of the professional advocacy activities that were researched were highly endorsed; however, several were not. Participants indicated a high level of agreement that they belong to a professional association (98.9%). This high percentage may be directly related to the fact that the sample was taken from the ACA database. ACA is a professional association; therefore, the respondents would agree with this statement merely due to the fact that they are members. Activities related to alliance building, educating others, and attending one conference per year held high endorsement ratings of 77.1% to 91.7%. These results regarding alliance building support the finding of White and Semivan's (2006) qualitative study which identified the main theme of collaboration/ systemic intervention (for client, colleagues and organization) in order to advocate for both the client and profession, Eriksen's study (1999) which identified a need for intra-professional collaboration due to internal conflict within ACA and its subgroups, and Myers and Sweeney's research (2004) in which their respondents endorsed that they implement coalitions with professional groups (59%).

The findings also support the research regarding educating the public about professional counselor roles, educational backgrounds and similarities and differences to other professions. Field and Baker's (2003) study identified that advocating for the profession is one of the key elements of advocacy. One participant in the study alluded to educating others about the

counselor role when she stated, "We have to be advocates of our profession because nobody else in the whole school understands our position and or what it is we are supposed to do…it is a daily struggle, from my perspective, not to be dumped upon" (Field & Baker, 2004, p. 59).

These results are also pertinent to the historical relationships between professional counselors and psychologists, which have been discussed in the literature (Gale & Austin, 2003; Goodyear, 2000) because the relationships can be directly affected by the beliefs of professional counselors' ability to foster alliances. McDaniels, one of the professionals interviewed by Gale and Austin, warned that professional counselors must create intra-professional relations and work together to advocate because "there are people who would deny [professional counselors] the opportunity to work in ways, and with groups, that are best reached through counseling" (Gale & Austin, p. 206).

In contrast to professional self-advocacy activities, outreach and involvement such as conducting service projects (47.4%), participating in legislative activities (41.8%), participating on a board or committee (28.2), or creating multi-media activities (29.2%) were less endorsed in the PCAI study. These low percentages are a contradiction to the qualitative research of White and Semivan's (2006) study which identified the importance of: 1) providing community service while promoting knowledge of the field, 2) implementing change through becoming more involved in professional organizations, and 3) political legislative action. Respondents to the Myers and Sweeney (2004) study reported pursuing legislative action on behalf of jobs for professional counselors and ensuring equal access to employment with other professionals and parity of pay for counselors with other mental health professionals (69%). These participants, who were leaders in the field, identified with the participating in legislative activities nearly 20% more than the PCAI study (41.8%). Also in the Meyers and Sweeney study, media opportunities

(e.g., radio, television) (48%), written material such as literature and information (63%) and advocacy training packets (47%) were frequently employed advocacy activities endorsed more highly than the 29.2% reported in this study. The comparison between my study and the Myers and Sweeny study (2006) shows that the average professional counselor with a professional membership in ACA reports participating in outreach and involvement at a lower rate than did the leaders in the Myers and Sweeney study. The results of my study suggest that those who are leaders in the field and who are older, more seasoned, more involved in leadership roles, and have more than those in education are more involved in advocacy activities than the average professional counselor.

Also important to note, leaders in the counseling field have addressed the need for professional counselors to receive suitable compensation for their services in all settings and to have the freedom to provide services within their scope of practice through market place recognition. This idea was identified as one of the advocacy themes developed through CSI (2007). Objectives were developed to identify professional counselors as competent service providers, to stress that professional counselors have access to employment and/or compensation across settings for services these counselors are qualified to perform, and for professional counselors to be recognized in the media and elsewhere as providing valuable service to clients, families, organizations, and the general public. These ideals were not represented well by the participants of the study who are professional members of ACA and who are involved as members of professional associations. These findings do not bode well for the field since those who are not members are even less likely than the participants to be involved in advocacy. The less the profession as a whole is involved in professional advocacy, especially during the current

climate of budget cuts and layoffs, the more difficulties counselors will have securing positions, increasing the awareness of their expertise, and being able to help clients.

The most problematic outreach and involvement activity were the low number of respondents agreeing at a very low level (17.7%, $M = 2.70$, $SD = 1.78$) that they conduct and publish research on the counseling theories and techniques that they use. These statistics were disheartening since the literature and research stresses the effectiveness of using scientific research to further the counseling profession and the services counselors provide (CSI, 2007; Patrick, 2007; White & Semivan, 2006). White and Semivan (2006) identified research/ publishing as one of the main successful actions of professional advocacy. This could be because the majority of their participants were 30 to 59 years of age and 92% held two or more leadership positions. Research and publishing is an important advocacy tool because counselors need to both advocate for the profession and learn more about issues concerning their clientele. By doing so, they not only help their clientele and community as a whole, but the profession would acknowledge them as experts in the field of counseling. Professional counselors can practice with a master's degree and do not need to learn how to or are not expected to conduct research; therefore, the results are representative of this fact.

Discussion of Participants' Perceived Knowledge of Professional Counselor Advocacy

A main objective of this study was to examine whether professional counselors perceive that they know how to advocate for the profession and if so where they gained this knowledge. Another objective was to determine if there was a relationship between the participants' level of participating in professional advocacy activities and their knowledge of professional advocacy. Several variables were analyzed to answer these questions and include the 15 items related to knowledge and sources of knowledge as well as the 11 advocacy activities. Frequencies were

completed for the first portion of this analysis and then correlations were calculated using a conservative *p* value of .01 to minimize the potential of a Type I error.

First, the results of the frequencies indicated that of the 390 participants, 305 (78.2%) agreed to some level that they know how to advocate for the profession, indicating that there were a significant number of individuals from the sample who agreed that they know how to advocate. These findings expand on the qualitative studies that sought to define professional advocacy by ranking the level of knowledge. White and Semivan's (2006) study identified knowledge/skill level as one of the top themes related to advocacy. Participants from Field and Baker's (2004) study reportedly gained knowledge through counselor education programs. These studies discussed the definition of professional advocacy, but did not give quantitative data to determine if they believed that the participants were not knowledgeable, nor did the research find out where knowledge was gained.

Surprisingly, the results from the PCAI regarding educational program revealed that 47% of the respondents did not gain knowledge of professional advocacy from their educational program and of those who reportedly gained knowledge, nearly 30%, reported not gaining much. The results signified that beginning counselors are not well prepared in professional advocacy due to this lack of education. These results identify a discrepancy between what participants report and what the profession encourages in the CACREP *Standards*, advocacy competencies, and CSI advocacy themes. If the profession is effective in teaching professional advocacy through the standards, competencies and themes, more respondents would have gained knowledge from their programs and would have reported gaining more than reported. The profession adopted the CACREP 2009 *Standards* (CACREP, 2007), which includes curriculum that teaches the role and processes of advocating for the profession as well as the processes of

advocating in an effort to eradicate systemic barriers to access, equality and the overall achievement of clients. In addition, the profession developed and encouraged its members to utilize advocacy competencies which includes teaching self-advocacy skills (Lewis et al., 2003), and advocacy themes identified by CSI, which encourages counseling programs to adopt CACREP accreditation standards and teach advocacy for clients and the profession within their curriculum (CSI, 2007). Only 47% of the participants of the PCAI study noted that they gained knowledge of professional advocacy from their educational program. If counselor educators and counselor education programs would have adopted and effectively taught professional advocacy, as promoted by the themes, competencies and standards, the number may have been higher.

In my study, participants reported that they received the most knowledge regarding professional advocacy from publications (79.7%), from modeling by a significant counselor (76.9%), conferences and workshops (64%), then from their master's or doctoral program (53.1%) and last from websites (43.3%). Most knowledge was gained from ACA conferences and workshops (93.5%), publications (95.7%), and websites (93.5%) demonstrating that ACA as an entity is providing a significant portion of the education for professional advocacy. The second highest percentages (84.1-89%) for conferences and workshops, publications and websites are held by the "other" category, the category that represented any other entity other than ACA (national, regional, state, division) or CSI. The high percentage can be partially explained by the fact that several participants had more than one degree, specialty and/or license. The responses to short-answer questions about the types of conferences and workshops attended, publications viewed, websites resourced seem to represent the wide variety of specialties endorsed by participants. Responses gave insight into many of the publication, conference and website sources accessed such as: substance abuse, play therapy, marriage and family, equine

assisted growth and learning (horse therapy), psychology, education, social work and professional golf; and licensure and national boards.

State and divisions (70-80%) came next in the rankings, still fairly high. Chi Sigma Iota (69.5%) and regional (66.3%) ranked the lowest. Overwhelmingly, participants endorsed ACA national, state and division conferences, conferences from their own specialty and finally CSI as resources for professional advocacy knowledge. Most participants, 76.9% (n = 300), reported gaining knowledge of professional advocacy modeled or taught by others. Overall, participants reported gaining knowledge of professional advocacy from all four types of colleagues with the most individuals, 87.1%, endorsing knowledge gained by observing professional advocacy modeled by colleagues with a counseling degree. These results support Field and Baker (2004) whose participants identified obtaining knowledge through the modeling of colleagues. Field and Baker, however, did not inquire about the degrees colleagues had which might have assisted in learning more about those who modeled professional advocacy.

Overall, the statistics regarding gaining knowledge from conferences, workshops and from modeling by colleagues support the findings of Field and Baker's (2004) whoidentified these as significant ways of gaining knowledge about professional advocacy. The only study that researched publications was the Myers and Sweeney study, which determined that 63% of the participants used advocacy-training packets (47%) to teach professional advocacy. The results of the short-answer section of my study did not support the use of media materials as means of gaining knowledge of professional advocacy. No study researched the use of websites to gain professional advocacy; however, most professions, including counseling, social work, and psychology have information on their websites on advocacy for their clients and for their

profession. So, while information is there and available, little is known about websites' use and efficacy related to professional advocacy.

Results from my study gave evidence that there is a relationship between the participants' level of knowledge and their involvement in professional counselor activities. Specifically, knowing how to advocate for the profession was significantly correlated to all factors related professional counselor advocacy activities. Additionally, outreach and involvement (r (390) = .390, r^2 = .152. p < .000) had a small effect size indicating a small correlation between the two. Based on the results of these correlations, participants indicated that they would be involved in professional advocacy, especially outreach and involvement activities, if they perceive they know how to advocate. This is important for counselor educators, supervisors and the leaders in the field to know, because they are in the positions to effect change by becoming more effective in their dissemination of information and teaching methods through educational programs, conferences, publications, websites and modeling.

Discussion of Participants' Perceived Skills of Professional Counselor Advocacy

Most participants agreed that they have the skills to conduct professional advocacy. Acceptance (97%) and relationship building (98.4%) had the highest percentage of agreement. Participants reported that public speaking was the least favored of the skills with a percentage of 86%. All items indicated a high level of agreement with means ranging from 5.64 – 6.39. These statistics support the qualitative studies and literature cited. Eriksen's (1999) qualitative research indicated that counseling skills and values such as take educational approach, inclusive nature of the counseling profession, relationship building, good communication and effective listening skills can be effective advocating skills with specialties within the counseling field, other mental health professions and others within the community. Field and Baker (2004) identified

fundamental counseling skills that can be translated into advocacy such as understanding and embracing differences, maintaining emotional independence, acceptance, and realistic goals and expectations. Public speaking and writing were discussed in the literature as skills necessary to advocate (Patrick, 2007).

Professional counselor self-advocacy, outreach and involvement, alliance building and educating, modeling and promoting prevention and wellness strategies correlated significantly to all eight skills and produced both medium and small effect sizes. This means that, especially for these types of advocacy activities, the more skills counselors endorse the more they will advocate. Belonging to one or more professional association for counselors was correlated to six skills but had no significant relationship to take an educational approach and writing skills. This denotes that fact that counselors belong to a professional association is not related to them taking an educational approach or using writing skills to advocate. The analyses between take an educational approach produced significant effect sizes when correlated to professional self - advocacy (r (390) = .425, r^2 = .181. p < .000) and outreach and involvement (r (390) = .386, r^2 = .149. p < .000), suggesting that it is necessary to take an educational approach when involved in professional self advocacy and outreach and involvement activities. Attending a conference did not produce any significant correlations to any of the advocacy activities, indicating that attending a conference does not have a strong relationship to professional counselors advocating. My study expanded the knowledge of professional advocacy skills discussed in Eriksen's (1999) and Field and Baker's (2004) qualitative studies, provided results regarding the variables of public speaking and writing which was discussed in the literature (Patrick, 2007), and gave evidence of a relationship between the participants' level of skill and their involvement in professional counselor activities.

Discussion of Participants' Perceived Qualities of Professional Counselor Advocacy

Participants held a high level of agreement with the quality of life-long learner at 97.5%, self-confident (95.1%), and resilience/persistence (90.5%). Interest and passion had a somewhat high level of agreement with 86.1%; but commitment and tough/forceful attributes had the lowest with 67% and 50.8%, respectively. The results support the values identified throughout the existing literature. None of the qualities were previously analyzed by quantitative means. Life-long learner was discussed in the professional advocacy literature only by Patrick (2007), and in my study received extremely high scores. White and Semivan (2006) identified interest and passion as one of the top five themes of advocacy. In Eriksen's (1999) qualitative study, confidence, tough/forceful, and resilience/persistence were identified as main advocacy qualities. Commitment and tough/forceful attributes were identified in Eriksen's qualitative study as themes, but received somewhat average scores on the PCAI study.

The results from the study validated the claim that there is a relationship between the participants' qualities and their involvement in professional counselor activities. No other research has examined these relationships. Professional counselor self-advocacy, outreach and involvement, and alliance building all produced positive relationships with all of the advocacy qualities, indicating that if counselors believe they have these qualities then they could engage in professional advocacy activities. Alliance-building and the quality, interest/passion, produced the largest effect between activities and qualities and demonstrates that those with this quality are more likely to be involved in professional advocacy. It is also important to note that belonging to one or more associations was only correlated with a small effect to one quality, life-long learner; however, the participants endorsed each of these variables at a high frequency.

Discussion of Participants' Perception of the Importance and Need for Professional Counselor Advocacy

Respondents overwhelmingly agreed at 97% with the statements of I think it is import to advocate for the profession of counseling and I believe counselors must improve the public and professional image of counselors. These data support the Myers and Sweeney (2004) who found that most leaders agreed that the profession needs to "improve the public and professional image of counselors" (p. 468). Nearly 80% rated advocacy of the profession as most important to the profession. In the present study, the general population of counselors held a higher percentage of agreement with the statement that the profession needs to improve their image. The statements regarding losing clients due to lack of insurance coverage (50.2%) and being denied jobs (42%) had lower scores for the category of importance and need. These scores may represent a subset of the population such as private practitioners or state and federal employees who are faced with these issues more frequently than a professional school counselor, counselor educator, or career counselor. The findings, regardless of the percentage, support Eriksen's (1999) qualitative research finding that losing clients and insurance coverage were real concerns that required professional advocacy. Literature on the advocacy competencies (Lewis et al., 2003) and social justice (Lee, 2007) have noted many reasons individuals would need to advocate and included all forms of disenfranchisement. Previous research has not identified the level a counselor is compelled to self-advocate. Participants in the PCAI study indicated a need to advocate for self other than for the profession at (41.8%) which maybe a high percentage within the sampling of the general population, and warrants further research to determine the reasons professional counselors would advocate for self other than for the profession.

Results supported the relationship between the participants' beliefs about the importance and need to advocate and their involvement in professional counselor activities. Both the importance of advocating for the profession of counseling and the belief that counselors must improve the public and professional image of counselors were correlated to most of the advocacy activities (professional self-advocacy, outreach and involvement, alliance building, belonging to one or more professional association for counselors, and attending at least one conference for the counseling profession a year) producing both medium and small effect sizes. This indicates that counselors who are concerned about these two issues are likely to conduct those advocacy activities. Educating, modeling and promoting prevention and wellness strategies also shows a relationship to the belief that counselors must improve the public and professional image of counselors. This suggested that if counselors want to improve the public opinion of the counseling profession they could educate, model and promote prevention and wellness strategies. Several importance/need items (losing clients due to the lack of insurance coverage, being denied jobs in schools, mental health or other settings due to degree/license as a counselor, and having a need to advocate for self other than for the profession of counseling) shared no significant correlations with advocacy activities. This is important to note, especially for the leaders in the field, because if there is no relationship between those variables and professional advocacy activities, then those who believe that there are barriers to their employment, livelihood or client's needs, did not indicate to even a weak significance that they were involved in any activities to remedy these problems.

Discussion of Participants' Perception of the Barriers to Conduct Professional Counselor Advocacy Activities

Regarding the degree respondents believed there are barriers to participating in professional counselor advocacy, the top three barriers proffered by participants included not enough time (75%), roadblocks caused by other professionals (73.1%), and insufficient knowledge of professional advocacy strategies (69.8%). The high percentage regarding insufficient time supports the idea that counselors lacked time to make an impact and was a higher percentage that the results to a similar question in Myers and Sweeney's (2004) study, which respondents indicated a 39% agreement with the barrier of not enough time to deal with advocacy. This discrepancy may be due to the fact that Myers and Sweeney surveyed leaders in the field with an average of 21 years in the field with more than half reporting having doctoral degrees and one in five reporting being a counselor educator. My participants were mostly licensed professionals, 68% at least practicing clinically, with an average of 14 years in the field and only 10% being counselor educators. Clinicians may not have time to advocate, whereas educators and other leaders may have more time for professional advocacy, or perhaps they may be willing to make more time.

The results for the item, roadblocks caused by other professionals, support both Eriksen's (1999) study which identified conflict between the counseling profession and other professions and Myers and Sweeney's (2004) study which indicated that participants rated opposition by other providers (51%), resistance of public policy makers (42%) and a written response that politics as key barriers to professional advocacy. The open-ended portion of the question regarding barriers in my study indicated that roadblocks by professionals were a key element of one of the main themes, negative intra-professional relations. This means that not only did

respondents of the PCAI acknowledge that roadblocks were a significant barrier quantitatively; they also indicated this in open format. The results related to insufficient knowledge of professional advocacy strategies supports the research of Myers and Sweeney (2004) in which participants reported they lacked training in advocacy (41%). Also in my study, the open-ended question regarding barriers elicited responses from only 9% of those who responded and indicated lack of experience in the field, insufficient training in advocacy and counselor identity, and knowledge of issues and laws that affect counselors as areas for training.

The results support Eriksen's (1999) study which identified conflict between the counseling profession and other professions as a barrier to advocacy causing public uncertainty, loss of status with legislators, insurance companies and other funding sources, confusion over decision makers, and success by groups merely because of the most Political Action Committee funds. Findings from this study also support Myers and Sweeney (2004) in that participants rated opposition by other providers (51%) with fairly high percentages and provided written responses that politics were key barriers to professional advocacy.

Additionally, in the PCAI study, lack of leadership in the counseling field (52%), lack of collaboration within the profession on legislative activities (62.8%), and insufficient funds (57.2) were each endorsed by more than half of the participants. The lowest responses range from lack of skill level to advocate (35.6%), lack of position (35.4%), inability to explain credentials (20%), satisfied with status of the counseling profession (18.2%) and the statement "I would be seen as a 'trouble-maker'" (14%). These results support Eriksen's (1999) research in which participants reported concern that they lacked resources such as sufficient funds and time to make an impact. The participants of this study, however, disagreed at nearly 66% to ideas identified in Eriksen's research that counselors believe that they lack position and are satisfied

with the status of the counseling profession; therefore, the results of this study did not support her study. Lack of advocacy leadership (39%) and lack of collaboration (47%), which were identified by participants of Myers and Sweeney's (2004) study, were supported. However, the participants in my study endorsed these items at a higher level than the leaders who participated in their study. Support by colleagues is discussed as a main theme of professional advocacy by Field and Baker (2004) and their results indicated a need to increase the support to advocate. Conversely, the results of my study did not support Field and Bakers' qualitative study in which participants indicated that being seen as a "trouble maker" may be a barrier to professional advocacy. This issue was not advanced by the participants of my study, and in fact it was noted surprisingly by one participant as "… trouble maker is true but okay."

Five major issue-based themes and several sub-themes were identified in the qualitative inquiry into barriers to professional counselors participating in professional advocacy activities. The themes were: 1) negative or weak inter-professional relations including roadblocks by others, lack of support, and lack of knowledge by legislators about mental health and the role of counselors; 2) negative or weak intra-professional relations including subthemes of a disjointed profession and lack of support from leaders and fellow counselors; 3) attitude toward professional advocacy (18%) including lack of involvement of students/interns; lack of importance/need, need for more counselors to advocate; lack of belief that professional advocacy would be useful/effective; and, lack of passion; 4) power differential/limited position (17%) including limited job-opportunities and positions in relation to other professions, lack of negotiating power, and limited time, resources and money; 5) lack of knowledge/experience (9%). Three respondents listed individual concerns related to culture, stress and disability. The most problematic area that professional counselors need to address, based on these data, was the

need to improve both negative or weak inter-intra-professional relations, which accounts for 50% of the barriers listed in this report; however only 60 (15%) of the individuals provided short answers regarding barriers. This small number needs to be taken into account when interpreting the results.

Discussion of Participants' Perception of their Support for Professional Counselor Advocacy

Participants reported receiving the most support from colleagues (80%) and associations (78%). Although the findings had better than average percentages, professional counselors perceived that counselor educators (69%) and supervisors (59%) were less supportive than the other two categories. These results are supported by the research by Field and Baker (2004) whose study identified supporting counseling colleagues as professional advocacy; however since theirs was a qualitative study the results were only exploratory in nature and not generalizable to the general professional counselor population.

Results from my study did show evidence of significant relationships between professional counselors' beliefs related to support for professional advocacy and their perceived level of participating in professional advocacy efforts. Outreach and involvement and alliance building produced significant correlations for all support entities, suggesting that the greater the level of support from leaders in the field, the more professional counselors will be involved in advocacy activities related to outreach and involvement and alliance building. These two professional advocacy activities were the only two items that were correlated to I receive support from supervisors to advocate for the profession, indicating that professional counselors are more apt to advocate through outreach and involvement and alliance building type activities if they receive support from supervisors. Overall, the results identified that professional counselors are

more apt to be involved in advocacy activities if they feel support from their colleagues, supervisors, counselor educators and professional associations.

Limitations and Delimitations of the Study

Limitations of this study relate to the design of the instrument, sampling bias, and collection of the data. The first limitation is in the design of the survey and includes item construction. It is possible that the survey instrument may not have accurately measured professional counselors' perceptions of their level of involvement, knowledge and where they gained this knowledge, skill, qualities, importance and need, identified barriers, and support related to professional counselor advocacy. The survey, as is true for any survey, is not able to account for changes in opinion that may have occurred over time and therefore is limited to the perceptions of participants at the time the survey was taken. Although the definition of professional advocacy was provided at the beginning of the instrument, participants still could have perceived the term to mean different things.

Another limitation, sampling bias, may have impacted the study. Since the participants were not required to respond to or complete the instrument, professional members of the American Counseling Association (ACA) who completed the survey may not have been representative of professional counselors within ACA, or for that matter of the professional counselor community. Of the 2,998 surveys sent to potential respondents, 452 were returned, representing a 15% rate of return. However, after accounting for incomplete surveys 390 (13%) were usable. Also, since all participants are ACA members, they may be more interested in the topic of professional advocacy than the general population of professional counselors and therefore create sampling bias.

Surveying members of ACA does not allow for a complete representation of the entire population of professional counselors and causes disproportionate results; however, the membership in ACA and in counseling is largely white and female. Difficulties in sampling characteristics include the disproportionate number of European/White (84.1%) participants sampled. The age range is disproportionate as well. In the study, 21-25 year olds were represented by 11.9%, 26-35 year olds (17.9%), 36-55 year olds (46%) 56-68 year olds (30%), 69 year olds + (1.8%) ACA has 11.9% of 21-25 year olds, 26-35 year olds (29.7%) 36-55 year olds (38%), 56-68 year olds (18%) and 69 year olds + category had 2.5% representation. The numbers are based on the general ACA population and the study is represented by the professional membership. Additionally, this sampling was taken from the professional member category of ACA which does not distinguish members who are professional counselors from those who are members with a professional degree and therefore the percentages may be either more or less diverse than ACA characteristics. Likewise, participants reported several types of professional counselor licenses including LPCs (63%), LMHCs (13%), LRCs (1%,) and 42% who selected that they had another type of license than those prelisted. This sampling bias is representative of professionals having more than one license in the profession and is symbolic of the disjointed nature of the profession. This creates an issue regarding generalization in that caution should be used in generalizing the findings to the entire population. Most states were represented in the survey; however, no statistical analysis can be completed on the proportions due to the fact that ACA does not categorize their database by state and professional membership.

Those who are interested in professional advocacy or have a need to advocate professionally due to their individual or professional experiences may have skewed the sample

and represent a large portion of the respondents. Likewise, respondents could have opted out of taking the survey due to disinterest in professional advocacy. This would result in a lower response rate from that group of respondents and possible misrepresentation of that group. Another limitation of sampling, which may misrepresent the entire population of professional counselors, may have been the possibility that professional counselors who are professional members of ACA may have a stronger sense of professional identity and in turn see value in continuing education, keeping up with current trends in the field, and making contributions to research in the area of professional advocacy.

Collection of data methods, such as the use of email, is always a limitation. Because the survey was delivered electronically, only those who had access to email and the internet at the time of survey delivery were able to participate.

A final limitation could be that professional counselors with all of their roles and responsibilities may not have had time to respond to the survey resulting in a low response rate.

In order to make the study more manageable, several delimitations were implemented. First, ACA provided a random sample of 3000 professional members from their national database. This sample allowed for participants to be surveyed from all geographic locations; however, this delimited the pool to ACA professional members. Since professional members of ACA were surveyed, this excluded masters' students, doctoral students, and counselors in training unless individuals purchased a professional membership. Individuals who are not members of an organization or who are only members of state or local professional organizations were not included in the sample. These delimitations, although necessary, had the possibility of skewing the results.

Implications for Professional Counselors, Counselor Educators, Supervisors and Leaders in the Field

The results of this study were intended to bring greater insight into professional counselors' willingness and ability to advocate on behalf of the profession by identifying the attitudes of counseling professionals regarding advocacy skills practices, their knowledge of professional advocacy (and where they gained this knowledge), skills and qualities endorsed; opinions on the importance and need to advocate; barriers encountered; and support gained from various entities, as well as, by exploring the relationship between counseling professionals' attitudes toward professional counselor advocacy and their perceived level of conducting professional counselor advocacy activities. By building on several qualitative studies and one quantitative study (Eriksen, 1999; Field & Baker, 2004; Myers & Sweeney, 2004; White & Semivan, 2006) conducted to conceptualize and define professional counselor advocacy as well as to identify various beliefs about professional advocacy, the results of this study contribute to the knowledge base on professional advocacy of professional counselors.

As a result of this study, professional counselors could increase their ability and level of involvement in professional advocacy in several ways. First, counselors can request that counselor educators and supervisors include coursework or curriculum on professional advocacy as recommended in the 2009 CACREP *Standards*, CSI advocacy themes, and advocacy competencies adopted in 2003 by the profession. These initiatives can increase the knowledge, skills and qualities of professional advocacy for counselors. Asking professors and supervisors to include more literature or coursework in professional advocacy may increase the knowledge counseling students and interns gain through their program in counselor education. Second, professional counselors could increase their involvement in outreach and involvement activities.

Professional counselors in the field could partner with counselor educators, supervisors and other colleagues to conduct community outreach and service projects providing multi-media for both clients and the profession, therefore creating a presence in the community and becoming seen as experts on counseling issues. Professional counselors could partner with counselor educators to conduct and publish research about counseling and client issues. Additionally, counselors could become more active through participating in legislative activities and participating on a board or committee for the betterment of both clients and the profession. Third, professional counselors could self-advocate by using their innate counselor skills to educate others about professional counselors and the profession. Since most professional counselors reported that it is important to improve the public and professional image of counselors, perhaps they would not be opposed to getting involved in professional self-advocacy and educating, modeling and promoting prevention and wellness. Fourth, professional counselors should not only educate others, but must learn more about other professions and collaborate with them to build intra- and inter-professional relations to diminish the roadblocks caused within the profession and with other professionals, as well as find ways to educate legislators and build relationships with them for the betterment of clients and the profession. Last, professional counselors should consult the CSI website to identify and develop ways that they can increase their involvement in professional advocacy activities.

Counselor educators, supervisors and the association's hierarchy are the leaders in the field and can guide the profession through action, modeling, education, and research. First, counselor educators can infuse professional advocacy teaching into coursework or curriculum as recommended in the 2009 CACREP *Standards*, CSI advocacy themes, and advocacy competencies adopted in 2003 by the profession.

Counselor educators and supervisors can include professional advocacy as a part of supervision by assisting supervisees in taking action for clients and to conduct professional self-advocacy. If necessary, supervisors could also act with or on behalf of supervisees who are disenfranchised for individual or professional reasons. Second, counselor educators can partner with professional counselors in the field to conduct community outreach, service projects and provide multi-media outlets for both clients and the profession. Counselor educators can partner with counselor educators to conduct and publish research about counseling and client issues. Additionally, counselor educators and supervisors could encourage and model for their students and supervisees to be more active through participating in legislative activities and participating on a board or committee for the betterment of both clients and the profession. Third, counselor educators and supervisors can challenge their students, supervisees, colleagues and themselves to be more active in order to improve the public and professional image of counselors. Counselor educators and supervisors could spearhead campaigns to learn about other professions, collaborate with them and to build intra- and inter-professional relations. They could find ways to educate legislators and build relationships with them for the betterment of clients and the profession. Last, counselor educators, supervisors and other leaders in the field should access the CSI website for pertinent information about professional advocacy, lesson plans, and examples of media activities such as counselor awareness activities to assist in building this professional advocacy curriculum.

Implications for Future Research

Since the research on professional advocacy among professional counselors was limited to mostly qualitative studies, this study offers new information on the involvement of counselors in professional advocacy and their perception of their knowledge and where they gained that

knowledge, skills, qualities, importance and need, barriers and support of professional counselor advocacy. Future research should continue to focus on these aspects of professional advocacy for professional counselors. This study provided a survey of several variables related to professional advocacy. Each category could be expanded or refined to develop a better understanding of the topics. For instance, knowledge, skills and qualities all relate to the ability of the professional counselor to engage in professional advocacy activities. These ideas could be researched further to develop further knowledge of their commonalities and differences.

My study explored only professional counselors' perceptions of their action, knowledge, and abilities. Action research could assess these activities directly to assess what is being done. The focus could be on a particular state or issue. Effectiveness could be gauged through pre- and post-tests, or qualitatively through interviews or participant observations of the effectiveness of professional advocacy activities.

This study focused on the perceptions of professional counselors who are professional members of ACA. Other researchers could focus on counselor educators or supervisors to learn more about their experiences in supporting their students and supervisees in professional advocacy. Since students commented that they are only students when asked about barriers, a quantitative, qualitative or mixed method study could tease out more information to assist in learning more about students' experiences. Statements regarding losing clients due to lack of insurance coverage (50.2%) and being denied jobs (42%) produced lower scores for the category of importance and need. This may represent the opinions of a subset of the population such as private practitioners or state and federal employees who are faced with these issues more frequently than a professional school counselor, counselor educator, or career counselor and may warrant additional study.

Future research could delve into some of the conflicting findings of this study. Having a need to advocate for self other than for the profession had a somewhat high score of 41% within the sampling of the general population. What is the reason for this percentage? How do professional counselors define "other reasons to advocate other than for the profession of counseling?" Could it be related to discrimination against individuals based on personal issues such as race, gender, disability, and/or age or could the phenomena be related to professional counselors wanting to help their clients or even colleagues advocate for themselves?

Qualitative or quantitative studies could inquire further into the reasons why taking an educational approach highly correlated to professional self-advocacy (r (390) = .425, r^2 = .181. p < .000) and outreach and involvement (r (390) = .386, r^2 = .149. p < .000), or that alliance-building was highly correlated to interest/passion indicating that those with this quality are more likely to be involved in professional advocacy. Also it would be crucial to find out more information about why importance and need factors such as losing clients due to the lack of insurance coverage and being denied jobs in schools, mental health or other settings due to my degree/license as a counselor, and I have a need to advocate for myself other than for the profession of counseling shared no significant correlations with advocacy activities.

Another area of interest is professional counselors' lack of involvement in outreach and involvement such as conducting service projects, participating in legislative activities, participating on a board or committee or creating multi-media activities, and conducting and publishing research on counseling theories and techniques used. These areas could be researched to further the ability of the profession to address these weaknesses. Additionally, research could be conducted on what the implications mean in relation to the idea that the more professional counselors are involved in outreach and involvement activities, the more they indicate that there

is a lack of leadership in the counseling field and lack of collaboration within the profession on legislative advocacy initiatives.

This study could be replicated to provide a more representative sample of the nation's professional counselors or samples could be made based on geographic areas to gain more information from one area. Researchers could offer both paper and electronic versions of the survey to increase the pool of recipients and attract those counselors who are not members of a professional national associations or leaders in the field.

Conclusions

The findings of this study described the involvement of professional counselors in professional advocacy activities and their perception of their knowledge and where they gained that knowledge, skills, qualities, importance and need, barrier and support of professional counselor advocacy. The results explored the sources professional counselors use to gain knowledge of professional advocacy and the barriers that counselors face when attempting to be involved in professional advocacy activities. Other goals of this study included determining if there were relationships between participants' perceived involvement in professional counselor advocacy activities and their beliefs regarding their ability to advocate based on their perceived knowledge, skills, qualities, importance and need, barriers and support for professional advocacy.

Results of this study indicated that professional counselors believed that they participate in professional advocacy activities. Participants also reported that they believe they have the knowledge, skills, and qualities to conduct those professional advocacy activities. Respondents reported not gaining knowledge of professional advocacy from their educational program and of those who reportedly gained knowledge, nearly 30%, reported not gaining much knowledge. The

study did find that participants received most knowledge regarding professional advocacy from publications, then from modeling by a significant counselor, conferences and workshops, then from their master's or doctoral program, and last from websites. Overwhelmingly, participants reported receiving most knowledge from ACA national resources and second from other sources such as from resources related to subspecialties like substance abuse, play therapy, marriage and family, equine assisted growth and learning (horse therapy), other professions such as psychology, education, social work professional golf, licensure and licensure and national boards. They endorsed the importance and need to conduct professional advocacy most due to needing to improve the public and professional image of counselors.

Participants indicated the top three barriers are not enough time, roadblocks caused by other professionals, and insufficient knowledge of professional advocacy strategies; however, they generally found support to advocate in colleagues, counselor educators, supervisors and professional associations. Knowledge, skill, qualities, importance/need, barriers and support produced positive relationships when correlated to professional advocacy activities meaning that if they have endorse these variables, they will be more involved in professional counselor self-advocacy. Additionally, several barriers produced significant, negative relationships with advocacy activities indicating that if they perceive barriers they are less likely to be involved in those advocacy activities. These findings are important for professional counselors, counselor educators, supervisors and the leaders in the field to know, because by understanding both the individual and collective strengths and weaknesses of professional advocacy education, professional counselors will be more likely to be involved in professional advocacy and thus be in a better position to effect change for those they serve and the profession itself.

References

Abrahamson, D. J., Steele, A. P., & Abrahamson, L. S. (2003). Practice, policy and parity: The politics of persistence. *Professional Psychology: Research and Practice, 34*, 535-539.

Adams, M., Blumenfield, W.J., Castenada. R., Hackman, H.W., Peters, M. L., & Zunigan, X. (Eds.). (2000). *Readings for diversity and social justice: An anthology on racism, antisemitism, sexism, hetoreosexism, abelism, and classism*. New York, NY: Routledge.

Addams, J. (1910). *Twenty years at Hull-House: With autobiographical notes*. New York, NY: Macmillan.

Agahe Portman, T.A., & Portman, G. L. (2002). Empowering students for social justice: A structured group approach. *Journal for Specialists in group work, 27*(1), 16-31.

American Counseling Association. (n.d). Resources. May 9, 2007 from http://www.counseling.org/Resources/

American Counseling Association. (n.d.) Public Policy. Retrieved May 9, 2007 from http://www.counseling.org/ PublicPolicy/PositionPapers.aspx.

American Counseling Association. (n.d.). Call to Action. Retrieved February 21, 2010 from http://capwiz.com/counseling/home/

American Counseling Association. (2006). *ACA in the News: Averbach takes first place in ACA Foundation essay contest.* Retrieved May 9, 2007 from http://www.counseling.org/ PressRoom/NewsReleases.aspx?AGuid=3152ae36-851b-4dd8-90c7-bb57e7573b4b#First

American Counseling Association. (2010). Legislative Update / Latest News: Health Bill Changes Don't Include Medicare Coverage of Counselor Retrieved April, 21, 2010 from http://www.counseling.org/PublicPolicy/LegislativeUpdate.aspx?AGuid=9d1ea59e-9155-4154-8816-25821b34808e

American School Counselor Association (2007). *Position statement: Comprehensive programs.* Retrieved August 10, 2007, from http://www.schoolcounselor.org/content.cfm?L1=1000&L2=9

Arredondo, P., Toporek, R., Brown, R., Jones, J., & Locke, D. C. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*(1), 42-78.

American Psychological Association (APA). (n.d.). Government Relations. http://www.apa.org/about/gr/index.aspx

Atkinson, D. R., Froman, T., Romo, J., & Mayton II, D. M. (1977). The role of the counselor as social activist: Who supports it? *The School Counselor, 25,* 85-91.

Barker, E., Locke, J., Hume, D., Rousseau, J.-J., & Hopkins, G. (1960). *Social contract: Essays by Locke, Hume, and Rousseau*. London, England: Oxford University Press.

Bemak, F. (1998). Interdisciplinary collaboration for social change: Redefining the counseling profession. In C. C. Lee & G. R. Walz (Eds.), *Social action: A mandate for counselors* (pp. 279-292). Alexandria, VA: American Counseling Association.

Bemak, F. (2005). Advocacy as a critical role for urban school counselors: Working toward equity and social justice. *Professional School Counselor, 8*(3), 196-203.

Brown, S. D., & Lent, R. W. (Eds.) (1992). *Handbook of Counseling Psychology*. New York, NY: Wiley.

Chi Sigma Iota (2007). Advocacy themes. Retrieved February 10, 2006 from http://www.csi-net.org/displaycommon.cfm?an=1&subarticlenbr=530.

Cohen, L., Manion, L., & Morrison, K. (2007). *Research Methods in Education* (6th ed.). London, England: Routledge.

Comas-Diaz, L. (1987). Feminist therapy with mainland Puerto Rican women. *Psychology of Women Quarterly, 11*, 461-474.

Conyne, R. K. (1983). Two critical issues in primary prevention: What it is and how to do it. *The Personnel and Guidance Journal, 61*(6), 331-334.

Costello, A. B., & Osborne, J. W. (2005). Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical Assessment, Research & Evaluation, 10*(7). Retrieved from http://pareonline.net/getvn.asp?v=10&n=7

Council for Accreditation of Counseling and Related Educational Programs (CACREP). (2009). *2009 CACREP Standards*. Retrieved April 17, 2009, from http://67.199.126.156/doc/2009%20Standards.pdf.

Daniels, L. G., (2002). The Relationship between Counselor Licensure and Aspects of Empowerment. *Journal of Mental Health Counseling, 24*, 213-223.

DiStefano, C., Zhu, M. & Mîndrilă D. (2009). Understanding and using factor scores: considerations for the applied researcher. *Practical Assessment, Research & Evaluation*, 14(20). Retrieved April 13, 2011 from http://pareonline.net/pdf/v14n20.pdf

Dworkin, E.P., & Dworkin, A.L., (1971). The activist counselor. *Personnel and Guidance Journal, 49*, 748-753.

Earle, J.(1990) Counselor/advocates: changing the system: A low cost option solves a lot of problems. *Public Welfare*, *48*(3), 16-23.

Eldridge, W. D. (1983). Affirmative action and the use of power in clinical counseling. *Counseling and values, 27*(2), 66-75.

Eriksen, K. (1997). *Making an impact: A handbook on counselor advocacy.* Washington DC: Taylor and Francis/Accelerated Development.

Eriksen, K. (1999). Counselor advocacy: A qualitative analysis of leaders' perceptions, organizational activities, and advocacy documents. *Journal of Mental Health Counseling, 21*, 33 – 47.

Enns, C. Z. (1993). Twenty years of feminist counseling and therapy: From naming biases to implementing multifaceted practice. *The Counseling Psychologist*, *21*(1), 3-87.

Fall, K. A., Levitov, J. E., Jennings, M., & Eberts, S. (2000). The public perception of mental health professions: An empirical examination. *Journal of Mental Health Counseling, 22,* 122-134.

Field, J. E., & Baker, S. (2004). Defining and examining school counselor advocacy. P*rofessional School Counseling, 8,* 56-63.

Gale, A. U., & Austin, B. D. (2003). Professionalism's challenges to professional counselors' collective identity. *Journal of Counseling and Development, 81,* 3-10.

Goodman, J., & Waters, E. 2000). Advocating on behalf of older adults. In J. Lewis and L.J. Bradley (Eds.) *Advocacy in counseling: Counselors, clients & community (pp. 79-88).* Greensboro, NC: ERIC Counseling and Student Services Clearing House.

Haberman, F. W. (1971). Jane Addams – The Nobel Peace Prize 1931, In *Nobel Lectures, Peace 1926-1950,* Amsterdam: Elsevier Publishing Company: Retrieved September 24, 2009, from http://nobelprize.org/nobel_prizes/peace/laureates/1931/addams-bio.html

Hair, Jr., J. F., Black, W. C., Babin, B. J., Anderson, R. E., & Tatham, R. L. (2006). *Multivariate Data Analysis* (6th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.

Hobbes, T., & Gaskin, J. C. (1998). *Leviathan*. Oxford, England: Oxford University Press.

House, R. M., & Hayes, R. L. (2002). School counselors: Becoming key players in school reform. *Professional School Counseling 5,* 249-256.

Institute of Medicine. (2010). *Provision of mental health services under TRICARE.* Retrieved April 20, 2010 from http://www.iom.edu/Reports/2010/Provision-of-Mental-Health-Counseling-Services-Under-TRICARE.aspx

Jennings, K. (1994). *Becoming visible: A reader in gab and lesbian history for high school and college students*. Los Angeles, CA: Alyson.

Karlin, B. E., & Duffy, M. (2004). Geriatric mental health policy: Impact on service delivery and directions for effecting change. *Professional Psychology: Research and Practice, 35*, 509-519.

Katz, J. H. (1985). The sociopolitical nature of counseling. *The Counseling Psychologist*, *13*, 615-624.

Klein, P. (1994). *An easy guide to factor analysis*. New York, NY: Routledge.D'Andrea, M., & Daniels, J. (2000). Youth Advocacy. In J. Lewis and L.J. Bradley (Eds.) *Advocacy in counseling: Counselors, clients & community (pp. 71-78).* Greensboro, NC: ERIC Counseling and Student Services Clearing House.

Lafleur, L. B. (2007). *Counselors' perception of identity and attitudinal differences between counselors and other mental health professionals*. Unpublished doctoral dissertation, University of New Orleans, New Orleans.

Leahy, M. J., Chan, F., & Saunders, J. L. (2003). Job functions and knowledge requirements of certified rehabilitation counselors in the 20th century. *Rehabilitation Counseling Bulletin, 46*, 66-81.

Lee, C. C. (1998). Counselors as agents of social change. In C. C. Lee & G. R. Waltz (Eds.), *Social action: A mandate for counselors* (pp. 3-14). Alexandria, VA: American Counseling Association.

Lee, C. C. (Ed.). (2007). *Counseling for social justice* (2nd ed.). Alexandria, VA: American Counseling Association.

Lee, C.C., & Waltz, G. R. (Eds.). (1998). *Social action: A mandate for counselors*. Alexandria, VA: American Counseling Association.

Lewis, J., Arnold, M.S., House, R., & Toporek, R. (2003). *Advocacy competencies*. Retrieved March 7, 2007, from www.counseling.org/Publications.

Lewis, J., & Bradley, L. (Eds.). (2000). *Advocacy in counseling: Counselors, clients & community.* Greensboro, NC: ERIC Counseling and Student Services Clearing House.

Lewis, S., & Bor, R. (1998). How counselling psychologists are perceived by NHS clinical psychologists. *Counseling Psychology Quarterly, 11*, 427-438.

Lorion, R. P., Iscoe, I., DeLeon, P. H., & VandenBos, G. R. (1996). *Psychology and public policy: Balancing public service and professional need.* Washington D.C.: American Psychological Association.

Kiselica, M.S., & Robinson, M. (2001). Bringing advocacy counseling to life: The history, issues and human dramas of social justice work in counseling. *Journal of Counseling and Development*, 79, 387-397.

Kurpuis, D. J., & Rozecki, T. (1992). Outreach, advocacy, and consultation: A framework for prevention and intervention. *Elementary School Guidance & Counseling, 26*, 176-190.

March, P.A. (1999). Ethical responses to media depictions of mental illness: An advocacy approach. *Journal of Humanistic Counseling, Education & Development, 38*, 70-80.

McWhirter, E.H. (1991). Empowerment in counseling. *Journal of counseling and development, 69*(3), 22-27.

McWhirter, E.H. (1997) Empowerment, social activism, and counseling. *Counseling and human development, 29(8),* 1-14.

Myers, J. E., (1995). Specialties in counseling: Rich heritage or force for fragmentation? *Journal of Counseling and Development, 74,* 115-116.

Myers, J. E., & Gill, C. S. (2004). Poor, rural and female: Under-studied, under-counseled, more at-risk. *Journal of Mental Health Counseling, 26,* 225-242.

Myers, J. E., Sweeney, T. J., & White, V. E. (2002). Advocacy for counseling and counselors: A professional imperative. *Journal of Counseling and Development, 80,* 394-402.

Myers, J. E., & Sweeney, T. J. (2004). Advocacy for the counseling profession: A national survey. *Journal of Counseling and Development, 82,* 466-471.

National Association of Social Workers. (2009a). *NASW Advocacy*. Retrieved on January 6, 2010 from https://www.socialworkers.org/advocacy/default.asp

National Association of Social Workers. (2009b). *Dorothy I. Height and Whitney M. Young, Jr. Social Work Reinvestment Act*. Retrieved January 6, 2010 from http://www.socialworkreinvestment.org/Content/ 111th/Factsheet2009.pdf

National Association of Social Workers. (2009c). Brenda Wade, MSW on "Precious", Mariah Carey as a Social Worker, and Director Lee Daniels. Retrieved January 6, 2009 from http://www.socialworkersspeak.org/hollywoodconnection/nasw-member-talks-to-director-about-mariah-carey-social-worker-depiction-in-precious.html

Osbourne, J. L., Collison, B. B., House, R.M., Gray, L. A., Firth, J., & Mary. L. (1998). Developing a social advocacy model for counselor education, *Counselor Education and Supervision, 37,* 190-203.

Patrick, P. K. (2007). *Contemporary issues in counseling*. Boston, MA: Pearson Education, Inc.

Pinderhughes, E. E. (1983). Empowerment for our clients and for ourselves. *Social Casework, 64*, 331-338.

Pistole, M. C. (2002). Mental health counseling: Identity and distinctiveness. Retrieved August 22, 2007, from Eric Digests, www.ericdigests.org/2002-4/mental-health.html.

Rawls, J. (1971). *A theory of justice*. Cambridge, MA: Belknap Press of Harvard University Press.

Remley, T.P., Jr., & Herlihy, B. (2010*). Ethical, legal and professional issues in counseling* (3rd ed.). Upper Saddle River, NJ: Pearson Education, Inc.

Stone, C. B. (2003). Counselors as advocates for gay, lesbian, and bisexual youth: A call for equity and action, *Multicultural Counseling and Development, 3*, 143-155.

Sue, D. W., Carter, R. T., Manuel-Casas, J., Fouad, N.A., Ivey, A.E., Jensen, M., LaFromboise, T. Manese, J.E., Ponterotto, J.G., & Vasquez, -Nutall, E. (1998) *Multicultural counseling competencies: Individual and organizational development*. Thousand Oaks, CA: Sage.

Sweeney, T. J. (1995). Accreditation, credentialing, professionalization: The role of specialties. *Journal of Counseling and Development, 74*, 117-125.

Takaki, R. (1993). *A different mirror: A history of multicultural America*. Boston, MA: Little Brown and Company.

Tanenbaum, S. J. (2005). Evidence-based practices as mental health policy: Three controversies and a caveat. *Health Affairs, 24*, 163-173.

Toporek, R.L. (2000). Developing a common language and framework for understanding advocacy in counseling. In J. Lewis & L. Bradley, (Eds.), *Advocacy in Counseling: Counselors, clients and community* (pp. 5-14). Greensboro, NC: Clearinghouse on Counseling and Student Services.

Toporek, R.L., & Reza, J.V. (2001). Context as a critical dimension of multicultural counseling: Articulating personal, professional, and institutional competence. *Journal of Multicultural Counseling and Development, 29*(1), 13-30.

Wallack, L., Dorfman, L., Jernigan, D., Themba, M. (1993). *Media advocacy and public health: Power for prevention.* Thousand Oaks, CA: Sage.

Weissberg, R. P., Kumpfer, K. L., & Seligman, M, E. P. (2003). Prevention that works for children and youth. *American Psychologist, 58,* 425-432.

Weist, M.D. (2003). Commentary: Promoting paradigmatic change in children and adolescent mental health and schools. *School Psychology Review, 32,* 336-341.

Wrenn, (1983). C. G. (1983). The fighting, risk-taking counselor. *The Personnel and Guidance Journal, 61*(6*),* 323-326.

Appendix A

Professional Counselor Advocacy Inventory

Professional Counselor Advocacy Inventory

This inventory takes approximately fifteen minutes to complete.

Professional counselor advocacy is a goal-oriented, multi-level process aimed to create change by using personal and professional skills to promote, empower, support, and/or protect the growth and development of the professional, the profession and the consumers its serves. This process is developed by counselors and the profession itself having a strong professional identity and through advocacy strategies such as consumer education, professional education, legislative and community collaboration, and positive communication of individual counselors and the profession.

Section I – Knowledge of Professional Advocacy

The following is a question regarding your knowledge of professional advocacy. Rate the item using the scale Strongly Disagree to Strongly Agree to indicate your level of agreement with the statement.

	Level of Agreement							
	Not Applicable	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
1. I know how to advocate for the profession.	☐	☐	☐	☐	☐	☐	☐	☐

The following are questions regarding **where you gained your knowledge** of professional advocacy. For each item, indicate if you gained knowledge from that source. If you check yes for a source then rate each specific type of source using the scale Strongly Disagree (1) to Strongly Agree (7).

2. I gained knowledge of professional advocacy from my masters or doctoral educational program.

Yes ☐ No ☐

3. If yes, then rate to what degree you gained knowledge of professional advocacy from each educational program using the scale Strongly Disagree to Strongly Agree to indicate your level of agreement. Note: If you did not attend a specific educational program, then choose "Not Applicable" for that item.

	Level of Agreement							
	Not Applicable	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
Masters Program in Counseling	☐	☐	☐	☐	☐	☐	☐	☐
Masters Program in related field	☐	☐	☐	☐	☐	☐	☐	☐
Doctoral Program in Counseling	☐	☐	☐	☐	☐	☐	☐	☐
Doctoral Program in related field	☐	☐	☐	☐	☐	☐	☐	☐

4. If you gained this knowledge from an education program in a field other than counseling, please indicate which field below:

5. I gained knowledge of professional advocacy from association conference(s) or workshop(s).

Yes ☐ No ☐

6. If yes, then indicate to what degree you gained knowledge of professional advocacy from each conference or workshop source using the scale Strongly Disagree to Strongly Agree to indicate your level of agreement. **Note: If you did not gain knowledge from a particular conference or workshop source, then choose "Not Applicable" for that item.**

	Level of Agreement							
	Not Applicable	**Strongly Disagree**	**Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**
American Counseling Association conference or workshop	☐	☐	☐	☐	☐	☐	☐	☐
Regional Association of ACA (Midwest, North Atlantic, Southern and Western regions) conference or workshop	☐	☐	☐	☐	☐	☐	☐	☐
Division of ACA conference or workshop	☐	☐	☐	☐	☐	☐	☐	☐
State Association of ACA conference or workshop	☐	☐	☐	☐	☐	☐	☐	☐
Other Professional Association (APA, NASW, other) conference or workshop	☐	☐	☐	☐	☐	☐	☐	☐
Chi Sigma Iota workshop	☐	☐	☐	☐	☐	☐	☐	☐
Other association conference or workshop _	☐	☐	☐	☐	☐	☐	☐	☐

7. If you gained knowledge of professional advocacy from attending a conference or workshop of professional association(s) other than ACA or Chi Sigma Iota, please list them below:

8. I gained knowledge of professional advocacy from publications.

Yes ☐ No ☐

9. If yes, then indicate to what degree you gained knowledge of professional advocacy from each publication source using the scale Strongly Disagree to Strongly Agree to indicate your level of agreement: **Note: If you did not gain knowledge from a particular publication source, then choose "Not Applicable" for that item.**

	Level of Agreement							
	Not Applicable	**Strongly Disagree**	**Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**
American Counseling Association	☐	☐	☐	☐	☐	☐	☐	☐
Regional Association of ACA (Midwest, North Atlantic, Southern and Western regions)	☐	☐	☐	☐	☐	☐	☐	☐
Division of ACA	☐	☐	☐	☐	☐	☐	☐	☐
State Association of ACA	☐	☐	☐	☐	☐	☐	☐	☐
Other Professional Association (APA, NASW, other)	☐	☐	☐	☐	☐	☐	☐	☐
Chi Sigma Iota	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐

10. If you gained knowledge of professional advocacy from a publication source other than ACA or Chi Sigma Iota, please list them below:

11. I gained knowledge of professional advocacy from website(s).

Yes ☐ No ☐

12. If yes, then indicate to what degree you gained knowledge of professional advocacy from each website source using the scale Strongly Disagree to Strongly Agree to indicate your level of agreement: **Note: If you did not gain knowledge from a particular website source, then choose "Not Applicable" for that item :**

	Level of agreement							
	Not Applicable	**Strongly Disagree**	**Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**
American Counseling Association website	☐	☐	☐	☐	☐	☐	☐	☐
Regional Association of ACA (Midwest, North Atlantic, Southern and Western regions) website	☐	☐	☐	☐	☐	☐	☐	☐
Division of ACA website	☐	☐	☐	☐	☐	☐	☐	☐
State Association of ACA website	☐	☐	☐	☐	☐	☐	☐	☐

Chi Sigma Iota	☐	☐	☐	☐	☐	☐	☐	☐
Other website	☐	☐	☐	☐	☐	☐	☐	☐

13. If you gained knowledge of professional advocacy from the website(s) of professional association(s) other than ACA or Chi Sigma Iota, please list them below:

14. I gained knowledge of professional advocacy modeled or taught by others.

Yes ☐ No ☐

15. **If yes, then indicate to what degree you gained knowledge of professional advocacy modeled by others using the scale Strongly Disagree to Strongly Agree to indicate your level of agreement: for each item below:** Note: If you did not gain knowledge from a particular source, then choose Not Applicable for that item.

	Level of agreement							
	Not Applicable	**Strongly Disagree**	**Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**
Modeled/taught by colleague with counseling degree	☐	☐	☐	☐	☐	☐	☐	☐
Modeled/taught by colleague with related degree	☐	☐	☐	☐	☐	☐	☐	☐
Modeled/taught by LPC/LMHC supervisor	☐	☐	☐	☐	☐	☐	☐	☐
Modeled/taught by other supervisor	☐	☐	☐	☐	☐	☐	☐	☐

Section II - Professional Advocacy Skills and Qualities

Please read the following statement(s) regarding professional advocacy **skills** and indicate the extent to which you agree using the scale Strongly Disagree (1) to Strongly Agree (7).

	Level of Agreement						
I believe that I have the following skills for professional advocacy:	**Strongly Disagree**	**Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**
16. Take an educational approach	☐	☐	☐	☐	☐	☐	☐
17. Acceptance (i.e., inclusive nature, embracing differences).	☐	☐	☐	☐	☐	☐	☐
18. Relationship building (i.e., communication skills, listening skills)	☐	☐	☐	☐	☐	☐	☐
19. Emotional independence	☐	☐	☐	☐	☐	☐	☐
20. Realistic goal setting (assess needs, define goals, implement research/based interventions, evaluate outcomes)	☐	☐	☐	☐	☐	☐	☐
21. Time management and organizational skills	☐	☐	☐	☐	☐	☐	☐
22.Public speaking	☐	☐	☐	☐	☐	☐	☐
23. Writing skills	☐	☐	☐	☐	☐	☐	☐

Please read the following statement(s) regarding the **qualities** related to professional advocacy and indicate the extent to which you agree using the scale Strongly Disagree (1) to Strongly Agree (7).

	Level of Agreement						
	Strongly Disagree	**Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**
I believe I have the following qualities for professional advocacy:							
24. Interest/Passion (i.e., drive, enthusiasm)	☐	☐	☐	☐	☐	☐	☐
25. Commitment	☐	☐	☐	☐	☐	☐	☐
26. Resilience, persistence	☐	☐	☐	☐	☐	☐	☐
27. Tough, forceful	☐	☐	☐	☐	☐	☐	☐
28. Life-long learner	☐	☐	☐	☐	☐	☐	☐
29. Self-confident	☐	☐	☐	☐	☐	☐	☐

Section III– Advocacy Efforts

Please read the following statement(s) regarding professional advocacy **efforts** and indicate the extent to which you agree using the scale Strongly Disagree (1) to Strongly Agree (7).

	Level of Agreement						
	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
30. I educate other professionals (social workers, psychologists, psychiatrists, nurses, administrators, and educators) about the counselor preparation, licensure and abilities.	☐	☐	☐	☐	☐	☐	☐
31. I educate other professionals (social workers, psychologists, psychiatrists, nurses, administrators, and educators) about the role of a counselor.	☐	☐	☐	☐	☐	☐	☐
32. I educate other professionals (social workers, psychologists, psychiatrists, nurses, administrators, and educators) about the similarities and differences of counseling to other professions.	☐	☐	☐	☐	☐	☐	☐
33. I build alliances with other professionals (social workers, psychologists, psychiatrists, nurses, administrators, and educators) regarding consumer and professional issues.	☐	☐	☐	☐	☐	☐	☐
34. I build alliances with other counselors (school, mental health, rehabilitation, college, private practice, etc.) regarding consumer and professional issues.	☐	☐	☐	☐	☐	☐	☐
35. I conduct service projects representing the counseling profession in the community.	☐	☐	☐	☐	☐	☐	☐
36. I create multi-media activities informing the public about client issues and/or awareness of the counseling profession.	☐	☐	☐	☐	☐	☐	☐
37. I conduct and publish research on the counseling theories and techniques that I use.	☐	☐	☐	☐	☐	☐	☐
38. I educate, model and promote prevention and wellness strategies.	☐	☐	☐	☐	☐	☐	☐
39. I belong to one or more professional associations for counselors.	☐	☐	☐	☐	☐	☐	☐
40. I attend at least one conference for the counseling profession a year.	☐	☐	☐	☐	☐	☐	☐
41. I am on one or more board or committees within the counseling profession.	☐	☐	☐	☐	☐	☐	☐

42. I participate in legislative activities such as letter writing campaigns and contacting members of congress regarding job opportunities, scope of practice, and systemic barriers to employment for counselors.	☐	☐	☐	☐	☐	☐	☐

Section IV – Importance for and need to advocate

The following are questions related to the **importance** for and **need** to advocate. Rate each item using the scale Strongly Disagree (1) to Strongly Agree (7) to indicate your level of agreement with each statement.

	Level of Agreement						
	Strongly Disagree	**Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**
43. I think it is important to advocate for the profession of counseling.	☐	☐	☐	☐	☐	☐	☐
44. I believe counselors must improve the public and professional image of counselors	☐	☐	☐	☐	☐	☐	☐
45. I have lost clients due to the lack of insurance coverage for counselors	☐	☐	☐	☐	☐	☐	☐
46. I have been denied jobs in schools, mental health or other settings due to my degree/license as a counselor.	☐	☐	☐	☐	☐	☐	☐
47. I have had the need to advocate for myself other than for the profession of counseling	☐	☐	☐	☐	☐	☐	☐

Section V – Barriers to professional advocacy

The following are questions related to the **barriers** to professional advocacy. Rate each item using the scale Strongly Disagree (1) to Strongly Agree (7) to indicate your level of agreement with each statement.

	Level of Agreement						
I believe that the following are barriers to conducting professional advocacy:	**Strongly Disagree**	**Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**
48. Lack of knowledge of professional advocacy strategies.	☐	☐	☐	☐	☐	☐	☐
49. I lack the ability to explain my credentials (training, education, etc.) what I do as a counselor, and how my profession compares to others (i.e., social work, psychology).	☐	☐	☐	☐	☐	☐	☐
50. Lack of collaboration within the profession on legislative advocacy initiatives.	☐	☐	☐	☐	☐	☐	☐

51. Roadblocks caused by other professionals (i.e., psychologists, social workers).	☐	☐	☐	☐	☐	☐	☐
52. Satisfied with the status of the counseling profession	☐	☐	☐	☐	☐	☐	☐
53. Lack of position	☐	☐	☐	☐	☐	☐	☐
54. Lack of sufficient funds	☐	☐	☐	☐	☐	☐	☐
55. Lack of time	☐	☐	☐	☐	☐	☐	☐
56. Lack of leadership	☐	☐	☐	☐	☐	☐	☐
57. Lack of skill level to advocate	☐	☐	☐	☐	☐	☐	☐
58. People would see me as a "trouble maker"	☐	☐	☐	☐	☐	☐	☐
59. Other 60. _____	☐	☐	☐	☐	☐	☐	☐

Section VI – Support for Professional Advocacy:

The following are questions related to the **level of support** felt by counselors to conduct professional advocacy. Rate the items using the scale Strongly Disagree (1) to Strongly Agree (7) to indicate your level of agreement with each statement.

	Level of Agreement						
	Strongly Disagree	**Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**
61. I receive support from counselor educators/professors to advocate for the profession.	☐	☐	☐	☐	☐	☐	☐
62. I receive support from supervisors to advocate for the profession.	☐	☐	☐	☐	☐	☐	☐
63. I receive support from associations to advocate for the profession.	☐	☐	☐	☐	☐	☐	☐
64. I receive support from colleagues to advocate for the profession.	☐	☐	☐	☐	☐	☐	☐

Section I – Demographic Information. Please check the box that best describes you.

65. Gender: ○ Female ○ Male

66. Race/Ethnicity:

- ○ African American/Black
- ○ Asian American/Pacific Islander
- ○ European American/White
- ○ Hispanic/Latino
- ○ Middle Eastern
- ○ Native American/American Indian
- ○ Other _____

67. Disability Status:

- ○ Physical disability from birth
- ○ Acquired physical disability
- ○ Psychological disability
- ○ Developmental disability
- ○ No disability

68. Age: __ __ years (drop down)

69. Degree attained:

○ M.Ed. ○ M.A. ○ M.S. ○ Ph.D. ○ Other _____

70. License (Check all that apply):

- ○ Licensed Professional Counselor
- ○ Licensed Mental Health Counselor
- ○ Licensed Rehabilitation Counselor
- ○ Licensed Marriage and Family Therapist
- ○ Other _____

71. Primary specialty:

- ○ Mental Health Counseling
- ○ Professional School Counseling
- ○ Substance Abuse Counseling
- ○ Rehabilitation Counseling
- ○ Counselor Education
- ○ Supervision
- ○ Marriage and Family Counseling
- ○ Other _____

72. Primary setting:

- ○ Agency - Federal
- ○ Agency – State
- ○ Private Practice
- ○ Agency – Non-profit
- ○ College – counseling/advising
- ○ School
- ○ Agency – Private
- ○ College – counselor educator
- ○ Other_____

73. State in which you reside: _____ (drop down)

74. Years in the counseling field _____ (drop down)

Appendix B

IRB Approval Letter

University Committee for the Protection of Human Subjects in Research

University of New Orleans

Campus Correspondence

Principal Investigator: Louis V. Paradise

Co-Investigator: Michelle M. de la Paz

Date: June 21, 2010

Protocol Title: "Professional Counselors' Perception of Knowledge, Barriers, Support and Action of Professional Advocacy"

IRB#: 02June10

The IRB has deemed that the research and procedures described in this protocol application are exempt from federal regulations under 45 CFR 46.101category 2 due to the fact that this research will involve the use of interview procedures. Although information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects, any disclosure of the human subjects' responses outside the research wouldn't reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Exempt protocols do not have an expiration date; however, if there are any changes made to this protocol that may cause it to be no longer exempt from CFR 46, the IRB requires another standard application from the investigator(s) which should provide the same information that is in this application with changes that may have changed the exempt status.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project!

Sincerely,

Robert D. Laird, Chair
UNO Committee for the Protection of Human Subjects in Research

Appendix C

Electronic Messages to Participants

First Electronic Message

Dear Professional Counselor:

I am writing to request your assistance with my dissertation study titled *Professional Counselors' Perceptions of the Knowledge, Barriers, Support and Action of Professional Advocacy*. Please take approximately 15 minutes to read the following information and follow the hyperlink to complete the Inventory. **If you have already participated in this study by completing the PCAI thank you again for your participation.**

I have developed the PCAI that asks licensed professional counselors about their perceptions of their preparation, skills and qualities, and efforts of professional counselor advocacy. Additional information will be gathered regarding the importance/need, barriers, and support of professional counselor advocacy**.** I plan to use the data from the inventory to assist leaders in the field in educating and preparing future and current professional counselors, as well as helping professional counselors understand the advocacy methods colleagues are using to advocate for the profession and consumers. Your answers on the PCAI will provide important information that the profession can use to increase professional advocacy efforts and ultimately strengthening the profession.

There will be no way to identify you after you submit your answers, therefore all information that you provide is anonymous. The survey will take approximately 15 minutes to complete. Respondents *must* answer each item in order to proceed to the next section. If you are willing to assist me with this important part of my study, please click the following link to connect to the *Professional Advocacy Counselor Inventory*:

Follow this link to the Survey:
${l://SurveyLink?d=Take the Survey}

Or copy and paste the URL below into your internet browser:
${l://SurveyURL}

Follow the link to opt out of future emails:
${l://OptOutLink}

If you are not connected automatically, cut-and-paste the link into the address box on your web browser and then press enter.

You will **indicate your consent for participation in this study by completing and electronically submitting the PCAI**. As in most internet communication, you may have a record of exchange in a cache somewhere on your computer system or internet service provider's log file. As a precaution, I suggest that you clean out your temporary internet files and close your browser after submitting your survey. I want to remind you again that the information you are transmitting is unspecified and unidentifiable.

Your participation in this study is **entirely voluntary**; you may withdraw your consent and terminate participation at any time without consequence. The risks associated with this study are minimal. Some individuals may tire while answering the questions. If you would like additional information about this study or would like to discuss any discomforts you may experience, please send your request to the investigator of this study, Michelle M. de la Paz, by email at mdelapaz@uno.edu. You may also contact my faculty advisor, Dr. Louis V. Paradise, by email at LParadis@uno.edu or by telephone, 504-280-6026, for more information regarding this study.

Thank you in advance for your participation.

Sincerely,

Michelle M. de la Paz, M.Ed., LPC-S, LMFT, NCC
Doctoral Candidate
University of New Orleans
348 Bicentennial Education Building
University of New Orleans, Lakefront Campus 2000
Lakeshore Drive New Orleans, LA 70148

Second Electronic Message

Dear Professional Counselor:

This is the final reminder for those of you who have not had the opportunity to participate in my dissertation study titled *Professional Counselors' Perceptions of the Knowledge, Barriers, Support and Action of Professional Advocacy*. Please take approximately 15 minutes to read the following information and follow the hyperlink to complete the Inventory. **If you have already participated in this study by completing the PCAI thank you again for your participation.**

I developed the PCAI that asks licensed professional counselors about their perceptions of their preparation, skills and qualities, and efforts of professional counselor advocacy. Additional information will be gathered regarding the importance/need, barriers, and support of professional counselor advocacy**.** I plan to use the data from the inventory to assist leaders in the field in educating and preparing future and current professional counselors, as well as helping professional counselors understand the advocacy methods colleagues are using to advocate for the profession and consumers. Your answers on the PCAI will provide important information that the profession can use to increase professional advocacy efforts and ultimately strengthening the profession.

There will be no way to identify you after you submit your answers, therefore all information that you provide is anonymous. The survey will take approximately 15 minutes to complete. Respondents *must* answer each item in order to proceed to the next section. If you are willing to assist me with this important part of my study, please click the following link to connect to the *Professional Advocacy Counselor Inventory*:

Follow this link to the Survey:
${l://SurveyLink?d=Take the Survey}

Or copy and paste the URL below into your internet browser:
${l://SurveyURL}

Follow the link to opt out of future emails:
${l://OptOutLink}

If you are not connected automatically, cut-and-paste the link into the address box on your web browser and then press enter.

You will indicate your consent for participation in this study by completing and electronically submitting the PCAI. As in most internet communication, you may have a record of exchange in a cache somewhere on your computer system or internet service provider's log file. As a precaution, I suggest that you clean out your temporary internet files and close your

browser after submitting your survey. I want to remind you again that the information you are transmitting is unspecified and unidentifiable.

Your participation in this study is **entirely voluntary**; you may withdraw your consent and terminate participation at any time without consequence. The risks associated with this study are minimal. Some individuals may tire while answering the questions.

If you would like additional information about this study or would like to discuss any discomforts you may experience, please send your request to the investigator of this study, Michelle M. de la Paz, by email at mdelapaz@uno.edu. You may also contact my faculty advisor, Dr. Louis V. Paradise, by email at LParadis@uno.edu or by telephone, 504-280-6026, for more information regarding this study.

Thank you in advance for your participation.

Sincerely,

Michelle M. de la Paz, M.Ed., LPC-S, LMFT, NCC
Doctoral Candidate
University of New Orleans
348 Bicentennial Education Building
University of New Orleans, Lakefront Campus 2000
Lakeshore Drive New Orleans, LA 70148

Appendix D
List of Short-Answer Responses by Participants to the "other" category for Degree Attained, License, and Primary Specialty

List of Short-Answer Responses to "other" Degree Attained by Participants for Item 69
All but Dissertation (ABD)
Bachelor of Arts (BA)
Bachelor of Music in Music Therapy and working on my MA
Bachelor of Science P (BSP)
Currently working on Masters in Counseling
Doctor of Education (EdD)
Doctor of Medical Humanities (DMH)
Doctor of Ministry
Doctor of Philosophy (PhD)
Doctor of Psychology (PsyD)
Doctoral Program
Educational Specialist (EdS)
I have other Master Degrees other than Counseling, a student in counseling now
Master of Arts (MA)
Master of Arts (MA) in Communications; Master of Arts (MA) in Counseling
Master of Arts (MA) student
Master of Arts in Teaching (MAT)
Master of Divinity (M Div)
Master of Education (M.Ed.)
Master of Science (M.S.)
Master of Science in Education (MSE)
Master of Science in Education (MS.Ed.)
Master of Science in Education, Advanced Certificate (MS.Ed., Adv. Cert.)
Master of Social Work (MSW)
Master's degree in Counseling (M.C.)
Masters of Counseling
Master's Student
Plus 45 hours
Plus coursework in Doctor of Philosophy (PhD).
Registered Nurse (RN)
Student in Master of Science (MS) Mental Health Counseling

List of Short-Answer Responses to "other" License Attained by Participants for Item 70

Associate Licensed Counselor
Associate licensed counselor (pre-LPC)
Board Certified Professional Counselor
Career Counselor
Certified Addictions Counselor
Certified School Counselor
Certified School Counselor
Christian Counselor
Completing LPC hours
Counseling Psychology, unlicensed
Credentialed Distance Counselor
Credentialed Teacher
I am not an LPC
LADAC
LADAC
Law
LCSW
Licensed Alcohol/ Drug Counselor
Licensed Addiction Counselor
Licensed Alcohol & Drug Abuse Counselor
Licensed Alcohol and Drug Counselor
Licensed Cl. Soc. Worker
Licensed Clinical Professional Counselor
Licensed Clinical Alcohol and Drug Counselor
Licensed clinical counselor
Licensed Clinical Professional Counselor
Licensed Clinical Professional Counselor
Licensed Clinical Professional Counselor
Licensed Clinical Professional Counselor (IL)
Licensed Clinical Social Worker
Licensed Drug Abuse & Alcohol Counselor
Licensed Drug and Alcohol Counselor
Licensed professional Clinical counselor

Continued from page 233

List of Short-Answer Responses to "other" License Attained by Participants for Item 70

Licensed Professional Clinical Counselor
Licensed Professional Counselor Supervisor
Licensed Psychologist
Licensed psychologist
Licensed psychologist
Licensed psychologist
Licensed Psychologist
Licensed School Counselor
Licensed School Counselor
Licensed School Psychologist
Licensed Substance Abuse Counselor
Licensed substance abuse Counselor
Licensed Substance Abuse Therapist
LMHC board eligible
LPCC, LADC
Master Career Counselor
Mental Health Officer
Mental Health Service Provider
NA
National Certified Counselor
National Certified Counselor
Nationally Certified Counselor
NCC
NCC
NCC
NCC
NCC Working for Licensure
NCC, ATR
NCC, BCPC
NCC, CSAT
NCC, to be grandfathered in as a Licensed in 2011
no license, counseling certification
None
None

Continued from page 234

List of Short-Answer Responses to "other" License attained by Participants for Item 70

None
None
None
None
None at this time
not currently licensed
Not fully licensed yet as Mental Health Counselor, am licensed school counselor
Not licensed
not licensed; Resident in Counseling
Not yet licensed
On track Mental Health
PPC
PPS
Professional Clinical Counselor
Professional Clinical Counselor
Professional Teacher
Psychologist
Psychologist, Certified Family Therapist
Psychology
RN
RPT
RPT-Supervisor
School Counselor
School Counselor
semi retired previous licensed social worker
Spiritual Care Coordinator/Chaplain/Pastoral Counseling
Sr. Psych Examiner
Student
Student in counseling
Supervising Clinical Counselor PCC-S
trained Mediator
Un-licensed at this time
Wisconsin School Counselor
working toward lpcc in CA

List of Short-Answer Responses to "other" Specialty endorsed by Participants for Item 71

Addictions
Administration
Art Therapy
Barrier Resolution
Career
CAREER
Career Counseling
Career Counseling
Career Counselor
Career/Personal Counseling in Community College
Case Manager
children and teens
Clinic
College Career/Academic Counseling
college counseling
college counseling
college counselor
College/Career
Co-occurring Disorders
Director of Social Services
Eclectic
Educator
Emergency Mental Health
Faculty
Fertility/Sexuality
Health Education
Hospice/Bereavement/Life Transitions
Hypoanalysis
Industrial/Organizational
MH and SA
Military PTSD
NA
None
None

Continued from page 236

List of Short-Answer Responses to "other" Specialty endorsed by Participants for Item 71

None at this time
None student
Parent Educator in areas of ADHD, Autism, and other developmental disabilities
Pastoral Counseling
Physical
Play Therapy
Program Evaluation
Retired HS counselor now teaching at the university
School counseling
SOF
Stress Management
Student Affairs-Higher Education
Student in counseling
substance abuse, education and school counseling
Teaching/Behavioral Medicine
Transition & Special Ed
University CO Ctr Work
University Counseling Center
Vocational Counselor
VP of Programs in health related nonprofit
you cannot force me to answer, this is unethical!

Appendix E:
Lists of Associations where respondents Gained Knowledge from Various Sources (Items 4, 7, 10, 13)

List of Associations where respondents gained knowledge of Professional Advocacy from Masters and/or Doctoral Programs (other than local, state, regional and national ACA and Chi Sigma Iota)
Applied Clinical Psychology
Art Therapy, MA
Business Administration
Clinical Psychology
Counseling Psychology
Educational Leadership
Educational Leadership and Technology
Guidance and Counseling Masters Program
Higher Education
Medical Field for Patient Advocacy
Leadership
Marriage and Family Therapy
Master's program at Capella University
My parents the best educators, other masters and healers and teachers in my life, experiences with different cultural backgrounds, God my main master , etc.
Nonprofit management
Organizational Psychology
Psychology
Rehabilitation Counselor Education
Social Work
Sociology, MA
Spiritual Psychology MA, Clinical Psychology MA Pastoral Counseling, PhD
Therapeutic supervision was also helpful.
Field work with adults with intellectual disabilities

List of Associations where respondents gained knowledge of Professional Advocacy from Conferences and Workshops

(other than local, state, regional and national ACA and Chi Sigma Iota)

Alcohol and other Drug Abuse (AODA) conference sponsored by the University of Wisconsin System
American Art Therapy Association (AATA)
American Art Therapy Association (AATA), Indiana University Paul Munger Conference
American Association of Christian Counselors (AACC)
American Association of Marriage and Family Therapy (AAMFT)
American Mental Health Counselors Association (AMHCA)
American Psychological Association (APA) Division 35 – The Society for the Psychology of Women
American School Counselor Association (ASCA)
Association for Counselor Education and Supervision (ACES)
Association for Play Therapy (APT)
Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) - state, regional and national level
Association of Black Psychologists (ABPsi)
Association of Higher Education and Disability (AHEAD)
Choice Theory/Reality Therapy through the William Glasser Institute
Clinical Pastoral Supervision and Psychotherapy (CPSP)
Equine Assisted Growth and Learning Association (EAGALA)
Houston Eating Disorder Professionals
Illinois Counseling Association (ICA)
Institute of the Advancement of Human Behavior (IAHB)
Ladies Professional Golf Association LPGA
Legislative Institute with Scott Barstow
Licensed Clinical Professional Counselors of Maryland (LCPCM)
Licensed Professional Counselors Associations of North Carolina (LPCANC)
Louisiana Counseling Association (LCA)
Michigan Counseling Association (MCA)
Minnesota Career Development Association (MCDA) – regional
Mississippi Counseling Association (MCA)
Missouri Mental Health Counselors Association (MMHCA)
NADA
National Association for Alcoholism and Drug Abuse Counselors (NAADAC)

continued from page 240

List of Associations where respondents gained knowledge of Professional Advocacy from Conferences and Workshops

(other than local, state, regional and national ACA and Chi Sigma Iota)

National Association of Social Workers (NASW)

National Association of Victim Assistance through the Ohio Crisis Response Team

National Board of Certified Counselors (NBCC)

National Career Development Association (NCDA)

National Council on Rehabilitation Education (NCRE)

National Organization of Victim Assistance

NATTC

Networker Conferences

Nevada School Counselor Association (NvSCA)

Northern Virginia Licensed Professional Counselors (NVLPC)

Occupational Health Nursing Association

Pennsylvania Counseling Association (PCA)

Pennsylvania Mental Health Counselors Association (PAMHCA)

PESI, Continuing Education Seminars, Conferences, and Tele-Seminars

Phoenix Rising Yoga Therapy

Play therapy conferences and certificate program

Psychologists for Social Responsibility (PsySR)

School Counseling Workshop

State Association of ACA

Texas Association for Marriage and Family Therapists (TAMFT)

Texas Association for Play Therapy (TXAPT)

Texas Behavioral Health Institute

Texas Counseling Association (TCA)

The Baddour Center – Community for adults with intellectual disabilities

The Meadows, Illinois mental health

Union

Washington School Counseling Association (WSCA)

List of Associations where respondents gained knowledge of Professional Advocacy from Journals and Publications

(other than local, state, regional and national ACA and Chi Sigma Iota)

American Art Therapy Association (AATA)

American Association of Christian Counselors (AACC)

American Association of Marriage and Family Therapy (AAMFT)

American Association of Marriage and Family Therapy (AAMFT) - Family Therapy Magazine

American Association on Intellectual and Developmental Disabilities (AAIDD)

American Counseling Association (ACA) - Counseling Today The Journal

American Mental Health Counseling Association (AMHCA)

American Psychological Association (APA)

American School Counselor Association (ASCA)

American School Counselor Association (ASCA) Professional School Counseling Journal

APA division 35 Journal

Applying to other states for licensure

Art Therapy Newsletter

Association for Death Education and Counseling (ADEC)

Association for Play Therapy (APT)

Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) - state, regional and national level

Association for University and College Counseling Center Directors (AUCCCD)

Association of Black Psychologists (ABPsi)

Association of Counselor Education and Supervision (ACES)

California Association of Marriage and Family Therapy (CAMFT)

California Career Development Association (CCDA)

California Counseling Association (CCA)

Christian Counseling Today a publication of Association of Christian Counselors (ACC)

Employee Assistance Professionals Association (EAPA) Newsletter

Equine Assisted Growth and Learning Association (EAGALA)

Higher Education

Illinois Counseling Association (ICA) Journal

Illinois Mental Health Counselors Association (IMHCA)

International Association of Marriage and Family Counselors (IAMFC)

Kentucky Counseling Association (KCA)

Kentucky Mental Health Counseling Association (KMHCA)

Ladies Professional Golf Association (LPGA)

Continued from page 242

List of Associations where respondents gained knowledge of Professional Advocacy from Journals and Publications

(other than local, state, regional and national ACA and Chi Sigma Iota)

Legislative Institute - Scott Barstow

Licensed Professional Counselors Associations of North Carolina (LPCANC)

Master Addictions Counselor publications (i.e.: Counseling Addiction, American Counseling Association, Counselor Magazine)

Michigan Counseling Association (MCA)

Missouri Association of Marriage and Family Therapy (MOAMFT) - local and state chapters

Nashville Psychotherapy Institute (NPI)

National Association for Alcoholism and Drug Abuse Counselors (NAADAC)

National Association for Social Workers (NASW)

National Board for Certified Counselors (NBCC)

National Career Development Association (NCDA)

National Eating Disorder Association (NEDA)

National Employment Counseling Association (NECA)

National Rehabilitation Association (NRA)

NCB – possibly stands for National Children's Bureau

New York Mental Health Counselors Association (NYMHCA)

New York State School Counselor Association (NYSSCA)

Nonprofit Management

Ohio Counseling Association (OCA)

OPA – possibly Oregon or Ohio Psychological Association

Pennsylvania Counseling Association (PCA)

Pennsylvania Mental Health Counselors Association (PAMHCA)

Phi Delta Kappa

Professional Psychology Research and Practice

Psychologists for Social Responsibility (PsySW)

Psychotherapy Networker

TASH - international association of people with disabilities, their family members, other advocates, and professionals fighting for a society in which inclusion of all people in all aspects of society is the norm.

Texas Association for Marriage and Family Therapists (TAMFT) publications

Texas Counseling Association (TCA)

Texas Education Agency- School Guidance and Counseling (TEA)

Vet Centers (being rejected)

Continued from page 243

List of Associations where respondents gained knowledge of Professional Advocacy from Journals and Publications

(other than local, state, regional and national ACA and Chi Sigma Iota)

Washington School Counseling Association (WSCA)
Web searches
West Central Professional Counselors Association
Wisconsin School Counselor Association (WSCA)

List of Associations where respondents gained knowledge of Professional Advocacy from Websites

(other than local, state, regional and national ACA and Chi Sigma Iota)

Alcohol and Drug Abuse Institute (ADAI)
American Art Therapy Association (AATA) ; www.arttherapy.org
American Association of Christian Counselors (AACC)
American Association of Marriage and Family Therapy (AAMFT)
American Mental Health Counseling Association (AMHCA)
American Psychological Association (APA)
American School Counselor Association (ASCA)
Anxiety Disorders, Obsessive Compulsive Disorders
APA division 35 Journal
Association for Play Therapy (APT)
Employee Assistance Professionals Association (EAPA)
Equine Assisted Growth and Learning Association (EAGALA)
Florida Association of School Psychologists (FASP)
Illinois Counseling Association (ICA)
Illinois Mental Health Counselor Association (IMHCA)
Licensed Professional Counselors Associations of North Carolina (LPCANC)
Michigan or Missouri Mental Health Counselors Association (MMHCA)
National Alliance on Mental Illness (NAMI)
National Association for Alcoholism and Drug Abuse Counselors (NAADAC)
National Association for Social Workers (NASW)
National Association of School Psychologists (NASP)
National Board for Certified Counselors (NBCC)
National Eating Disorder Association (NEDA)
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
National Institute on Drug Abuse (NIDA)
New York Mental Health Counselors Association (NYMHCA)
Northern Virginia Licensed Professional Counselors (NVLPC)
Psychologists for Social Responsibility (PsySW)
SchoolCounselor.org
Substance Abuse and Mental Health Services Association (AMHSA)
Texas Association for Marriage and Family Therapists (TAMFT) publications
Texas Counseling Association (TCA)
Washington School Counseling Association (WSCA)

VITA

Michelle de la Paz earned her Bachelor of Arts degree in English from the University of New Orleans in 1993. Michelle returned to the University of New Orleans and graduated with a master of Education degree in mental health counseling in 1998, and a Ph.D. in counselor education from the University of New Orleans in May of 2011.

Michelle is a licensed professional counselor and approved supervisor (LPC-S), licensed marriage and family therapist (LMFT) and a national certified counselor (NCC). She is a member of the American Counseling Association (ACA), Louisiana Counseling Association (LCA), Association for Counselor Education and Supervision, Southern Association for Counselor Education and Supervision (SACES), Louisiana Association for Counselor Education and Supervision (LACES), and Chi Sigma Iota (CSI). She has held various positions within LCA, LACES, and CSI and has presented and co-presented 17 local, state, regional, and national presentations prior to earning her doctorate degree.

Michelle has been employed in the Greater New Orleans area as a counselor for more than 13 years providing mental health and family counseling to children, adolescents and families. She has worked in non-profit and state associations within agency, community and school settings. Her passion is to assist individuals, families, students and professionals in achieving their full potential through counseling, teaching, supervision and advocacy for the betterment of all.