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Wellness and Discrimination in Counselor Education

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Abstract

Wellness and diversity are cornerstones of professional counseling; however, both have received little attention in terms of counselor educators and their students. The results of a quantitative study ($N = 301$) explored the relationship between wellness and experiences of discrimination for counselor educators, doctoral students, and master's counseling students. Researchers utilized the Five Factor Wellness Inventory, Everyday Discrimination Scale, and a demographic questionnaire to conduct both a hierarchical linear regression and a factorial ANOVA to answer research questions. Results of the study indicated that both perceived discrimination and identity factors significantly impact wellness levels for individuals within counselor education. Implications for the field such as modeling, mindfulness, and individualized wellness for both students and counselor educators are discussed.

Significance to the Public

Wellness and diversity have long been a part of the field of counseling ideologically. Multicultural issues have had a strong stake in the research literature of the field, but only recently has there been an increase in topics around wellness in counselor education. This study aims to explore how the two are related in terms of discrimination experienced within the field. Results show that perceived discrimination has a significant relationship with wellness.

Keywords: discrimination, wellness, counselor education

Both counselor educators and their students are susceptible to stress and burnout (Moate et al., 2016; Thompson et al., 2011) despite the calls for wellness and self-care from professional organizations linked to counselor education (e.g., American Counseling Association [ACA], 2014; Association for Counselor Education and Supervision [ACES], 2016; Council of Accreditation in Counseling and Related Educational Programs [CACREP], 2023). Burnout refers to a state of emotional, physical, and mental exhaustion caused by prolonged stress, overwork, and/or a negative work environment (Maslach, 2003). On the opposite end of the spectrum, wellness has been defined as “both a dynamic process of physical, mental, and spiritual optimization and integration and an outcome of that process” (Myers & Sweeney, 2007, p. 1).

Understanding the importance of one's personal wellness is a vital focus in counselor education programs (Wolf et al., 2014) and it is understood that wellness is a protective measure against stress and eventual burnout for counseling practitioners, students, and educators alike (Lawson & Myers, 2011; Smith et al., 2007).

The wellness of students enrolled in counselor education programs has been examined by numerous researchers (e.g., Gleason & Hays, 2019; Harris et al., 2013; Lambie et al., 2009; Lenz et al., 2012; Meany-Walen et al., 2016; Ohrt et al., 2015; Perepiczka & Balkin, 2010; Pierce & Herlihy, 2013; Roach & Young, 2007). Collectively, these studies have helped the counselor education field expand its knowledge around wellness practices, barriers to wellness, and wellness curriculum pertaining to students. On the other hand, research regarding

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wellness among counselor educators is much more limited (Moate et al., 2016; Shillingford et al., 2013; Soloman & Barden, 2016; Wester et al., 2009). Despite the growing influx of attention toward wellness within the counseling field at the organizational level (ACA, 2014; CACREP, 2023) and within counseling research (Nice et al., 2023), the subject of counselor educator wellness is often neglected from both professional guidelines and professional literature alike. Notwithstanding this lack of information, it has been suggested that counselor educators should model proper wellness in their own lives to students in their program as a means of teaching its importance (Gleason & Hays, 2019; Hill, 2004; Wester et al., 2009) while also juggling many high-pressured tasks within academia (e.g., research, publication, grants; Hill, 2004; Moate et al., 2016). Counselor education programs that prioritize wellness may benefit both their counselor educators and their students, thus also ensuring that future practitioners who graduated from their program will have proper wellness knowledge for themselves and their future clients.

While routine and mindful participation in wellness activities is largely believed to be a defense against the risk of burnout, external factors beyond an individual's control, such as work environment and social interactions, can also influence one's resiliency to burnout (Maslach, 2003). Individuals from marginalized populations are particularly vulnerable, as they are often subject to excess stress and face discrimination regularly (Meyer, 2003). In the simplest terms of the word, discrimination is seen as "the unequal treatment of otherwise similar individuals due to their ascribed membership in a disadvantaged category or group," (Fibbi et al., 2021, p. 13). Perceptions of discrimination and oppression in the workplace can have a significant influence on an individual's overall wellness (Gleason & Hays, 2019; Henfield et al., 2011; Hermann et al., 2014; Shillingford et al., 2013) and, thus, their susceptibility to burnout (Maslach, 2003). Past research on discrimination within counselor education has explored multiple populations with various roles within the field (Brooks & Steen, 2010; Haskins et al., 2013, 2015;

Henfield et al., 2011; Holm et al., 2014; Seward, 2014). Students within marginalized populations have reported feelings of invisibility, exclusion, and a general dissatisfaction to their program's approach to multiculturalism (Haskins et al., 2013; Henfield et al., 2011; Holm et al., 2014; Seward, 2014), while faculty members within marginalized populations reported similar feelings of isolation in their programs based on their identities (Brooks & Steen, 2010; Haskins et al., 2015).

The counselor education field has long strived to support and celebrate diversity through a commitment to social justice while also identifying systems of oppression (ACA, 2014; CACREP, 2023); however, the research shows that both students and faculty of color and of other marginalized populations continue to experience discrimination within counselor education. The 2024 CACREP Standards include a larger focus on wellness and self-care within counselor education curriculum than past editions, expanding from only four curriculum standards pertaining to wellness and/or self-care practices in the 2016 CACREP Standards, to nine in the 2024 update. The renewed focus on wellness within the counselor education field highlights that discrimination and its impact on individual wellness in the profession is a needed area for research, particularly, how wellness and self-care is impacted by positions of power and privilege within counselor education. The purpose of this study is to investigate the relationship between wellness levels and perceived discrimination for individuals enrolled in or employed by counselor education programs.



Method

In order to explore the relationship between wellness and discrimination, the research team chose to employ a hierarchical linear regression and factorial analysis of variance (ANOVA) to answer the following research questions:

1. What is the relationship between experiences of discrimination and levels of overall wellness in counselor education?

2. How do wellness levels vary among diverse groups in counselor education?

Participants and Procedure

Upon approval from the primary researcher's institutional review board, a survey was electronically distributed via email to CACREP accredited program liaisons, the CESNET listserv, and the COUNSGRAD listserv. The CACREP liaisons ($N = 399$) were encouraged to distribute the survey link to faculty and students within their programs. These electronic outlets are appropriate venues to sample the counselor education community as they are typically subscribed to by counselor educators (CESNET) and graduate students in counseling (COUNSGRADS). The survey was presented via Qualtrics and included (a) an informed consent agreement, (b) the demographic questionnaire, (c) the Everyday Discrimination Scale (EDS; Williams et al., 1997), and (d) the Five Factor Wellness Inventory (5F-WEL; Myers & Sweeney, 2005a).

Following six weeks of data collection and two calls for participation, 364 responses were received. After removing 63 incomplete responses, 301 participant responses were utilized in data analysis; with 301 participants, the statistical power in the present study is .87, which exceeds minimum suggested power (.80; Cohen, 1988). Participants ranged in age from 21 to 74 years of age ($M = 33.00$; $SD = 10.73$). Two hundred and thirty-five participants identified as women (78.1%), 58 participants identified as men (19.3%), five participants identified as gender non-binary (1.7%), two participants identified as genderqueer (.7%), and one participant identified as transgender (.3%). Regarding sexual identity, 250 participants identified as heterosexual (83.1%), 19 participants identified as bisexual (6.3%), 10 participants identified as gay (3.3%), eight participants identified as lesbian (2.7%), six participants identified as queer (2.0%), four participants identified as pansexual (1.3%), three participants identified as asexual (1.0%), and one participant identified as questioning (.3%). Ethnoculturally, 206 participants identified as European American or

White (68.4%), 35 participants identified as African American or Black (11.6%), 22 participants identified as multiracial (7.3%), 21 participants identified as Latinx (7.0%), 12 participants identified as Asian (4.0%), three participants identified as Middle Eastern (1.0%), and two participants identified as Native American (.7%).

Participants in the present study are counselor educators ($n = 70$, 23.3%) or counseling students ($n = 231$, 76.7%). Of the 70 participants who identified as counselor educators, 31 identified as assistant professors (10.3%), 12 identified as associate professors (4.3%), 11 identified as professors (3.7%), 11 identified as adjunct/part-time (3.7%), and four identified as non-tenure track full-time faculty members (1.3%). Of the 231 counseling students who participated, 156 identified that they were obtaining their master's degree (51.5%) and 74 identified that they were obtaining their doctoral degree (24.6%). The participants identified that they came from programs focusing in clinical mental health counseling ($n = 94$, 31.2%); doctoral-level counselor education and supervision ($n = 70$, 23.3%); school counseling ($n = 29$, 9.6%); clinical rehabilitation counseling ($n = 22$, 7.3%); marriage, couple, and family counseling ($n = 6$, 2.0%); college counseling and student affairs ($n = 1$, .3%); and career counseling ($n = 1$, .3%). Six participants (2.0%) identified that they were in a program type that was not identified, and two participants (.7%) identified that they were unsure of their program type.

Instrumentation

The present study utilized three instruments, one to measure wellness (The Five Factor Wellness Inventory [5F-WEL]; Myers & Sweeney, 2005a), one to identify experiences of discrimination (The Everyday Discrimination Scale (EDS; Williams et al., 1997), and a demographic questionnaire.

Five Factor Wellness Inventory

The 5F-WEL (Myers & Sweeney, 2005a) is a 98-item, self-report assessment based on the indivisible self wellness (IS-WEL) model. The 5F-WEL is a

holistic measurement of wellness based on exploratory and confirmatory factor analyses of data gathered using its predecessor, the wellness evaluation of lifestyle (WEL; Myers et al., 2004). The 5F-WEL and corresponding IS-WEL are common constructs used to operationalize wellness in counseling scholarship (Shannonhouse et al., 2020). The 5F-WEL has 73 items that are computed to reflect a total wellness score based on the five factors of wellness. These five factors also have corresponding subfactors of wellness. The five factors and corresponding subfactors are: (a) Creative Self (Thinking, Emotions, Control, Work, and Positive Humor), (b) Coping Self (Leisure, Stress Management, Self-Worth, and Realistic Beliefs), (c) Social Self (Friendship and Love), (d) Essential Self (Spirituality, Gender Identity, Cultural Identity, and Self-Care), and (e) Physical Self (Exercise and Nutrition). Total wellness scores and individual scores for each of the five factors of wellness can be computed using this scale. Responses are recorded using a 4-point Likert-type scale from 1 (strongly agree) to 4 (strongly disagree). Some items are reversed scored.

Examples of items from the 5F-WEL include “I know I can get a suitable job when I need one,” “I have at least one person with whom I am close emotionally,” and “My free time activities are an important part of my life.” The 5F-WEL has been validated using structural equation modeling (Myers & Sweeney, 2005a). Alpha coefficients for the 5F-WEL range from .89 to .96 for the five factors and the total wellness score yields an alpha coefficient of .98 (Myers & Sweeney, 2005a). Permission to utilize the A2 version of the 5F-WEL was purchased from Mind Garden. In the present sample, Cronbach’s alpha was .93 for the total wellness scores on the 5F-WEL, demonstrating strong internal consistency (Cohen et al., 2003). The mean for total wellness score was 450.12 ($SD = 72.42$). The range of scores was 279.48 to 672.53.

Everyday Discrimination Scale

The EDS (Williams et al., 1997) is a 9-item, self-report assessment designed to measure the frequency of discrimination experiences in

participants’ day-to-day lives. Some items included on the EDS are: “You are treated with less courtesy than other people are,” “You are treated with less respect than other people are,” and “You are threatened or harassed” (Williams et al., 1997). A 10th question, asked only of those answering “A few times a year” or more frequently to at least one question, was: “What do you think is the main reason for these experiences? (Select all that apply).” Participants had 14 options to select from (including a fill in “other” option) including: your ancestry or national origins, your gender, your race, your age, your religion, your height, your weight, some other aspect of your physical appearance, your sexual identity, your education or income level, a physical disability, your shade of skin color, your tribe, and other (please specify). The alpha coefficient for the EDS is .88 in previous studies (Williams et al., 1997). In the present sample, $\alpha = .86$, demonstrating sufficient internal consistency (Cohen et al., 2003). The mean for total EDS scores was 4.23, the median was 4.25 ($SD = .85$), and the range was 1.88 to 6.00.

Demographic Questionnaire

Participants reported their age, race/ethnicity, gender identity, sexual identity, ACES region (NCACES, NARACES, RMACES, SACES, WACES, other, or unsure), faculty status (professor, associate professor, assistant professor, non-tenure track [full-time], adjunct/part-time, or other), student status (master’s or doctoral), CACREP accreditation status of their institution (yes, no, or unsure), degree/program type (career counseling; clinical mental health counseling; clinical rehabilitation counseling; college counseling and student affairs; marriage, couples, and family counseling; school counseling; counselor education and supervision; unsure; or other). Identity variables were write-in items to allow participants to have the ability to describe their identity factors. We chose to collect these demographic variables to (a) describe our sample and (b) to control for factors in our statistical model (age, gender, sexual identity, ethnocultural identity, status in counselor education).

Data Cleaning and Analysis

Before data were analyzed, they were entered into the Statistical Package for the Social Sciences (SPSS) 25 for cleaning. Data cleaning included removing any cases that were not fully complete as all participant information and scores (demographic data, 5F-WEL scores, and EDS scores) were needed for analysis. Research questions were answered using a hierarchical linear regression (research question 1) and a factorial analysis of variance (ANOVA; research question 2). To complete data cleaning, assumptions of these tests were checked. The assumptions of hierarchical linear regression are linearity, homoscedasticity, multicollinearity, the absence of outliers, and normality. Linearity and homoscedasticity of the data were checked using scatterplots; these scatterplots indicated a linear relationship between variables of interest (5F-WEL and EDS scores) and the residuals were evenly spread. Pearson product moment correlations (*r*) were used to assess multicollinearity. The independent variable correlations do not exceed .7 (see Table 1), indicating this assumption is met in the present sample (Tabachnick & Fidell, 2013). There were no significant outliers within this sample (assessed by scatterplot). All continuous variables were distributed normally (skew and kurtosis within ±2) and met assumptions of regression (Tabachnick & Fidell, 2013).

Independence, the absence of outliers, normality, homogeneity of variance, multicollinearity, linearity, continuous dependent variable (5F-WEL scores), and categorical independent variables are the assumptions of factorial ANOVA. Participants were not in multiple groups, and outliers, normality, multicollinearity, and linearity were addressed in the assumption testing for regressions as outlined previously, meeting the assumptions of factorial ANOVA. Homogeneity of variances was assessed using a Levene’s test of equality of variances ($F = 1.51, p = .068$), indicating the assumption is met in the present sample.

The final step of data cleaning was dummy coding the factors used to answer research question 1. The 5F-WEL, EDS, and age variables are continuous and did not require dummy coding. The gender, sexual identity, ethnocultural identity, and status within counselor education were dummy-coded as dichotomous variables for use in the regression model. Gender identity was coded *non-cisgender* (0) and *cisgender* (1). Sexual identity was coded *non-heterosexual* (0) and *heterosexual* (1). Ethnocultural identity was coded as *Non-White* (0) and *White* (1). Status within counselor education was coded as *student* (0) or *faculty* (1). These coding decisions were made to reflect experiences of privilege and oppression, and possible exposure to discriminatory experiences based on proximity to power.

Table 1

Correlations Between Variables of Interest

	1. 5-F WEL Total	2. EDS Total	3. Ethnocultural Identity	4. Sexual Identity	5. Gender	6. Counselor Education Status	7. Age
1	---	-.150**	.063	-.051	-.034	-.177**	-.209***
2	---	---	.184***	.131***	.048	-.006	.162**
3	---	---	---	-.021	.049	.069	.017
4	---	---	---	---	-.049	.060	.094
5	---	---	---	---	---	.210***	.228***
6	---	---	---	---	---	---	.457***

Note: * indicates significance at the $p < .05$ level, ** indicates significance at the $p < .01$ level, *** indicates significance at the $p < .001$; 5F-WEL = Five Factor Wellness Inventory; EDS = Everyday Discrimination Scale.

To answer research question 1, a hierarchical linear regression was conducted to test the relationship between (a) experiences of discrimination (EDS scores) and (b) wellness (5F-WEL scores) in counselor education. The variables were entered into the regression step-wise to reflect causal priority (Petrocelli, 2003). EDS scores were entered as the independent variable; the first step included participants' age, ethnocultural identity, sexual identity, and gender; the second step included participants' status in counselor education (student or faculty); and the third and final step included participants' 5F-WEL scores. To answer research question 2, which explored the relationship between participants' identity factors (ethnocultural identity, sexual identity, gender, age, and status within counselor education [faculty or student]) and wellness (as measured by the 5F-WEL), a factorial ANOVA was conducted. A Bonferroni correction was used to limit family-wise error.

Results

Discrimination, along with identity factors, significantly predict wellness levels in the present sample (see Table 2). Models one (age, ethnocultural identity, sexual identity, and gender), two (status in counselor education), and three (discrimination experiences) were all significant ($p = .005$, $p = .003$, and $p < .001$, respectively). The first model was significant, with an R^2 of .049 $F(4, 293) = 3.79$, $p = .005$, adjusted $R^2 = .036$, indicating a small effect size (Cohen, 1988). The second model led to a significant increase in R^2 of .01 $F(1, 292) = 3.059$, $p = .003$, adjusted $R^2 = .043$, indicating a small effect size (Cohen, 1988). The

third model led to a significant increase in R^2 of .02 $F(1, 291) = 6.292$, $p = .001$, adjusted $R^2 = .06$, indicating a small effect size (Cohen, 1988).

With significance at every step in this model, it is important to examine the beta (β) weights of each individual variable in each step. The first step of the model explored the relationship between wellness and participants' ethnocultural identity, sexual identity, gender, and age. Within in this step, only age had a significant ($p \leq .001$) beta of $-.211$. The second step, which included participants' ethnocultural identity, sexual identity, gender, age, and status within counselor education (faculty or student), age was again the only significant variable ($p = .012$), $\beta = -.163$. The final step included participants' ethnocultural identity, sexual identity, gender, age, status within counselor education (faculty or student), and EDS scores. In this step, age ($p = .038$; $\beta = -.136$), status in counselor education ($p = .046$, $\beta = -.129$), and EDS scores ($p = .013$, $\beta = -.147$) were all significant.

Wellness and Identity Factors

The differences in wellness levels across sample identity factors was assessed using a factorial ANOVA. The factorial ANOVA results indicated that of the identity factors included, only sexual identity and age showed significant differences in wellness levels; sexual identity: $F(7, 51) = 2.28$, $p = .029$; age: $F(1, 51) = 1.801$, $p = .003$. No statistical differences in wellness were found between participants' ethnocultural identity, $F(6, 51) = 1.27$, $p = .273$; gender, $F(4, 51) = 2.14$, $p = .076$; status in counselor education, $F(1, 51) = 2.71$, $p = .101$.

Table 2

Summary of Hierarchical Linear Regression for Variables Predicting Levels of Wellness in Counselor Education

Model	R	R^2	Adj. R^2	SE	$\otimes R^2$	$\otimes F$	df	Sig $\otimes F$	Sig.
1	.222	.049	.036	71.105	.049	3.79	(4, 293)	.005	.005
2	.243	.059	.043	70.857	.010	3.059	(1, 292)	.081	.003
3	.281	.079	.060	70.223	.020	6.292	(1, 291)	.013	.001

Discussion

These data provide an opportunity to explore the experiences of wellness and discrimination of diverse groups within counselor education in a way that has yet to be established in the counseling literature. Both research question 1, exploring the relationship between wellness and discrimination in counselor education, and research question 2, exploring wellness levels in diverse groups in counselor education, yielded significant results in the present sample. These data can help counselor educators understand wellness levels and the experiences of diverse students and faculty as related to experiences of discrimination. However, the effect size in the present sample is small, where only 6% of variance is explained by the variables examined. This small effect size may be attributed to the unique intersection of these identities, and how an individual can be simultaneously privileged or marginalized depending on the setting, the context, and individual experience within unique systems (Slaughter-Acey et al., 2023). While the effect size was small, using beta weights, researchers were able to further identify which identities were most specifically impacted.

In summary, our results of research question 1 indicate that experiences of discrimination significantly impact wellness levels in counselor education faculty and students when controlling for age, ethnocultural identity, sexual identity, gender, and status in counselor education in the present sample. These results are theoretically consistent (Brooks & Steen, 2010; Haskins et al., 2013; Henfield et al., 2011; Kidd & Veltman, 2011), in that increased discriminatory experiences decrease levels of overall wellness both inside and outside counselor education communities.

In this study, three variables — age, status in counselor education (faculty or student), and experiences of discrimination — emerged as significant predictors of wellness in students and faculty. Hierarchical regression analysis revealed that age consistently had a significant impact on wellness across different models, suggesting that

increased age, being a faculty member, and experiencing discrimination are associated with lower levels of wellness in the sample. This suggests that increased age, faculty status, and higher experiences of discrimination may contribute to lower overall wellness levels, as established by correlations within the present sample (see Table 1).

The lower wellness scores correlating with age are partially supported in the literature (Fullen, 2019). The understanding of wellness as it pertains specifically to older adults is very limited and there is a need for further research that tailors wellness to individual needs of older adults (Fullen, 2019; Myers & Sweeney, 2005b). Relatedly, status as a faculty member and lower wellness is also reinforced within the literature as well (Shillingford et al., 2013; Wester et al., 2009). While Wester et al. (2009) did not find a significant difference in overall wellness between professor ranks, a significant difference between assistant and full professors was noted in the realistic beliefs scale, a third-order factor scale. Shillingford et al. (2013) found that untenured faculty reported an overwhelming workload with activities that they felt endangered their pursuit of tenure, coinciding with reports of higher levels of anxiety and stress-related health concerns among this group (Hill, 2004).

In addition to faculty reporting an overwhelming workload, Shillingford et al. (2013) also found common feelings of alienation and lack of support for faculty women of color, which could explain the lower wellness scores in relation to increased experiences of discrimination. Brooks and Steen (2010) found that participants in their study reported feelings of frustration with the lack of representation for African Americans in counselor education resulting in people of color feeling overworked with obligations of multicultural courses and committee representation. This added pressure could help to explain the lower wellness scores for individuals who report experiencing discrimination.

Researchers also explored how wellness levels varied among diverse groups in counselor education (by age, sexual identity, gender identity, and status in counselor education). Wellness levels

significantly varied among different ages (congruent with research question 1) and sexual identities. While ANOVA does not provide directional or relational information, in the present sample participants' ages and sexual identities significantly impacted their level of wellness in a distinct way. This coincides with research that has shown sexual identity, and the resulting discrimination and/or support that one faces, can have a profound impact on mental health and overall well-being (Dew et al., 2006; Freitas et al., 2016; Kidd & Legate et al., 2011; Veltman, 2011).

Implications

Results indicate that experiences of discrimination, whether within or outside counselor education, may have a detrimental impact on the wellness of counseling students and faculty, highlighting critical issues that counselor educators, supervisors, and students should be aware of. For students, counselor education programs should adopt proactive measures to address their unique wellness needs and evaluate how the program culture influences their overall wellness. Incorporating a wellness assessment such as the 5F-WEL (Myers & Sweeney, 2005a) could help to identify individual wellness needs, which has been shown to be a desire for counselor education students (Gleason & Hays, 2019). Faculty–student mentorships should prioritize discussions on personal wellness, enabling students to have a deeper understanding of their wellness and self-care needs, as well as providing opportunities for the faculty member to model proper wellness. In addition, implementing tools such as the EDS (Williams et al., 1997) can help identify discriminatory attitudes that students may be encountering, whether in the academy or while in an outside location, such as a practicum or internship site.

For counselor educators, supporting faculty members in balancing work expectations and well-being is vital. Trainings could help clarify expectations and introduce effective strategies to manage academic work–life balance. Programs

should also ensure that faculty are aware of the proper protocols for reporting discriminatory behaviors.

Understanding personal biases and methods for counteracting them is essential for future counseling practitioners and counselor educators, as implicit bias can have a detrimental impact on the learning experience (Boysen, 2010). Further research regarding discrimination in counselor education programs may help to expose some weaknesses in the field and identify protective factors to help mitigate discrimination. Furthermore, there is a call for more wellness-focused support tailored to faculty and students from underrepresented populations. Specialized mentoring and support groups in counselor education programs could help to promote well-being across diverse populations.

Limitations

This study faced several limitations. First, there are limitations in the instrumentation used to collect this data. Both the 5F-WEL and the EDS are self-report assessments (Myers & Sweeney, 2005a; Williams et al., 1997) and thus subject to validity threats (e.g., participant mood, environment, etc.). Another limitation is the sampling method used to distribute the survey. While the CESNET listserv was utilized, the surveys received a larger response after deploying targeted emails to CACREP university liaisons. A total of 15 individuals reported either that they were not enrolled in a CACREP program or were unsure about their program's accreditation status (<5%). This study only looked at individuals in CACREP-accredited programs. It is possible that data from this survey would have been reflected differently had more individuals in non-CACREP-accredited programs participated. In addition to the distribution, there could be a limitation in the amount of time the survey took to complete. With 122 total questions, it is possible that individuals with limited free time were unable to complete the survey. Those individuals could have perhaps provided data to change the outcome of the findings.

The sample in and of itself could be considered a limitation as well. Women comprised 78.1% of the participants for this study, heterosexuals represented 83.1%, and individuals identifying as European American or White made up 68.4% of the participants. In addition, 76.7% of the participants were counseling students. While counseling as a profession is often overwhelmingly White and female (CACREP, 2018), a more diverse demographic may have reflected different results. These limitations could restrict the generalizability of the findings and further research is needed to be more inclusive of the entirety of the counselor education field, to include different or additional identity variables (e.g., social class, immigration status, and others).

Conclusion

Counselor education programs should consider the impact that discrimination can have on an individual's overall wellness and work to mitigate these negative experiences for both counselor educators and students. Ensuring that students and faculty are aware of proper procedures in reporting discrimination is critical; however, the discrimination that individuals face can often be "silent," such as not receiving enough support or feeling isolated. To help, programs should consider ways to empower both students and faculty in underrepresented populations so that their voices are more clearly heard. In addition to perceived discrimination, counselor education programs should understand that age and faculty status can also have an impact on overall wellness. Protecting individuals from taking on too much service, encouraging variety in professional obligations, and allowing for greater autonomy may help to alleviate the pressures that are often faced in academia.

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