Journal of Counselor Preparation and Supervision

Volume 14 | Number 4 Article 7

2021

Counselor Educators Experiences and Techniques Teaching about Social-Health Inequities

Kaprea Johnson
johnsonkf@vcu.edu

Lauren B. Robins
Regent University, laurmah@mail.regent.edu

Counselor Educators Experiences and Techniques Teaching about Social-Health Inequities

Abstract

Social Determinants of Health (SDOH) are social-health inequities which cause wellness disparities amongst the population. This phenomenological investigation explored counselor educators' (N=12) methods for teaching about SDOH. Two structural themes (pedagogic strategies and instructor context) and seven textural themes were identified, displaying the comprehensive coverage of SDOH in counseling courses. Implications for refinement of SDOH coverage are included.

Keywords

social determinants of health, equity, social justice, counselor educators, descriptive phenomenology

Author's Notes

The Virtual Equity Lab at Virginia Commonwealth University.

Counselor Educators Experiences and Techniques Teaching about Social-Health Inequities

As a field, counselor education has long focused on addressing advocacy, multicultural competency, equity, and social justice in counselor training (Constantine et al., 2007). In recent years, the focus on human rights, equity, and justice has increased (Gazzola et al., 2018; Singh et al., 2020). An equity and human rights issue that needs more attention in counselor training is social determinants of health (SDOH). The World Health Organization (WHO) defines SDOH as the conditions in which people are born, grow, work, and live and the broader set of forces and systems that shape the conditions of daily life (WHO, 2012). Due to the unequal distribution of resources and power, the conditions of daily life for some portions of society decrease their chances at health equity, a basic human right (Bailey et al., 2017; Wilkinson & Pickett, 2020). In addition to such human rights violations, SDOH also creates, maintains, and increases mental health inequities, such as access to and quality of mental health care (Plamondon et al., 2018). The impact of SDOH are seen in every sector of healthcare causing a renewed focus on the roles and responsibilities of mental health care in addressing SDOH in practice and pedagogy (Artiga & Hinton, 2019). Focusing on pedagogy, the purpose of the current phenomenological investigation was to explore counselor educators' experiences with teaching SDOH in graduate counseling classes.

Teaching Social Determinants of Health

Social determinants of health (SDOH) refer to any nonmedical factor which influences health and wellness, including health literacy, attitudes, beliefs, and behaviors (WHO, 2012). Historically, SDOH have focused on racial and ethnic differences in health and health care outcomes (WHO, 2012). Researchers have critiqued this focus on racial and ethnic differences, often centering individuals as the problem, instead of systems (i.e., healthcare, education,

politics, etc.) that cause inequities (Artiga & Hinton, 2019; Marmot & Allen, 2014). The focus shifts from problematizing the person and illness to problematizing the system that perpetuates, maintains, and increases inequity in health and wellness outcomes (Artiga et al., 2019; Bailey et al., 2017; Marmot et al., 2014). The framework for teaching SDOH provides five concrete domains in which systems operate and fail. The persistent failure within these domains causes human rights violations due to inequitable distribution of power and privilege (WHO, 2012). The five SDOH domains include: (1) environment, (2) health and healthcare, (3) social and community context, (4) education, and (5) economic stability, are responsible for significant disparities in mental and physical health outcomes and are key areas of investigation in courses that address SDOH inequities (Andermann, 2016; Marmot & Allen, 2014; WHO, 2012).

Content in SDOH Courses

The research on SDOH courses primarily comes from medical education and allied health science fields, such as nursing and dental hygiene (Choskshi et al., 2010; Doobay-Persaud et al., 2019; Klein et al., 2011). The content covered most frequently and cited as important in SDOH courses are access to health care, access to primary care, health literacy, poverty, employment, access to food, environmental conditions, social cohesion, and income instability (Klein et al., 2011; Sharma et al., 2018; Siegel et al., 2018; WHO, 2012). This approach of covering a list of important constructs is often noted as an essential first step of developing awareness about SDOH and the outside influences that might impact client health and wellbeing (Klein et al., 2011). The most important next step is increasing skills for assessing and addressing SDOH in practice (Sisler et al., 2019).

Similar to medicine and allied health, counselor education has courses that include a laundry list of important key constructs. Some of the more important SDOH constructs covered

in medical education are also mirrored in the counselor education curriculum, although not termed SDOH. These are frequently addressed in social and diversity courses because of the emphasis on power, privilege, and isms (CACREP, 2015). However, researchers caution that piecemealing together a laundry list of SDOH adjacent topics is insufficient without the grounding of a SDOH framework (Sharma et al., 2018). This creates challenges within counselor education, as these pieces of SDOH are not properly or fully explored, creating gaps in awareness and application. The SDOH framework centers the interconnectedness of nonmedical factors and the influence on health and wellness outcomes and provides a foundation to explore techniques and evidence-based approaches for addressing social inequities (Klein et al., 2011; WHO, 2012).

Techniques

Techniques for teaching SDOH within the medical field include recommendations on course type, activities to encourage learning and adaptation of SDOH content, and theoretical approaches (Martinez et al., 2015; Mu et al., 2011; Sisler et al., 2019). No approach is touted as superior; however, didactic courses in the medical field with an experiential component allow students to translate their knowledge within the confines of a safe supervised environment (Martinez et al., 2015). Similar research in counselor education supports the positive influence on learning when didactic and experiential learning is blended (Furr & Barret, 2011; Osborn & Dames, 2013). In terms of course delivery, SDOH content and courses have been successfully delivered in face to face, web enhanced, and completely online formats, often attached with experiential activities or exercises. Counselor education has a long successful past of delivering courses and content from a distance using online or hybrid options (Snow & Coker, 2020) and are uniquely prepared to deliver SDOH course content using any of the best practices noted

above, in any delivery format. In counselor education, we are well equipped and already engaged in some of these best practice techniques. This is not necessarily in the context of teaching SDOH, but in teaching related topics such as social justice, advocacy, and diversity (Odegard & Vereen, 2011).

In terms of specific techniques to teach SDOH, Martinez and colleagues (2015) noted the following relevant tips: define key terms, guide students in self-reflection, use raw data, provide a history lesson (addressing discrimination and racism, discussions about race and outcomes, include service learning, utilize exercises (i.e., opportunity to apply what you learn), include authentic assessments, and aim for cultural humility. In comparing the techniques used to teach SDOH and those that counselors are uniquely equipped with, there is significant overlap. The missing piece for counselor educators is highlighting the need for a unified SDOH theoretical framework that would provide the foundation to connect SDOH to health outcomes, standardization of techniques, and comprehensive approaches to foster action-oriented counselors prepared to address SDOH in practice.

Rationale

Counselors, along with all healthcare professionals, must be knowledgeable and prepared to address SDOH in practice, as this is imperative for health and wellness equity (Klein et al., 2011; WHO, 2012). From our review of the literature, it is evident that teaching SDOH content and techniques overlap with counselor education; however, there are no qualitative or quantitative research studies related to teaching SDOH specifically or techniques utilized in counselor education. The purpose of the current study is to explore counselor educators' experiences with teaching SDOH. A phenomenological approach with a social constructivist paradigm was utilized to explore two research questions: (1) what are your experiences teaching

social determinants of health? and (2) what techniques do you use to teach social determinants of health?

Methods

In line with descriptive methodology, the lived experiences of participants were understood from a lifeworld approach (Dahlberg et al., 2008). The ontological and epistemological foundation of this approach centers the importance of understanding our bodily being in the world and how we interact with others, requiring less interpretation of responses and freedom for participants to socially construct their experiences (Dahlber et al., 2008). This methodology is favorable for research that elicits rich descriptions.

Participants and Procedures

The institutional human subjects review board of the first author's university approved this study in the Fall of 2019; and recruitment began shortly after. Criterion and snowball sampling (Patton, 2014) were used to recruit diverse counselor educators who met the following predetermined criterion: (a) at least one year of experience teaching in a CACREP accredited counselor education program, (b) counselor educator identity, (c) experience teaching in one of the eight core counselor education core curriculum areas, and (d) experience with infusing multicultural competence into counseling curriculum. This means of sampling is appropriate for phenomenological research, as a specific population was necessary (Patton, 2014).

The research team independently reached out to contacts in counselor education at universities in 12 states across the United States. The first author constructed the recruitment materials and asked that all research team members send the materials via email to universities and counselor educators they are affiliated with in the United States. There were 26 emails sent to potential participants; 16 responded initially, but only 12 completed the demographic form and

the interview. See Table 1 for detailed participant information. The participant group was diverse in terms of racial ethnic makeup: four African Americans, one Latinx, and seven White; representation of both genders: with seven men, five women; Ages ranged: five people being 55+, three in their 40s (i.e., range 40-49), and four in their 30s (i.e., range 30-39). Lastly, mental health, college, and school counseling specialty areas were represented along with a range of ranks and types of institutions (R1-R3).

Table 1
Participant demographics and related characteristics

Person	Race	Sex	Yrs Exp	Rank	CE Specialty	School Demographics (Research intensity, size of college, geographic location, % of staff URM; % of students URM)
1	Latinx	Male	2	ASP	MH	R1; 15,000 or more students; Suburban; 22%; 25%
2	Black	Female	1.5	ASP	MH	R3; 5,000 of fewer students; Urban; 1 staff member; less than 15%; 40%
3	White	Female	6	Clin	MH	R1; 15,000 or more students; Urban; 20%; 35%
4	Black	Female	5	ASP	MH	R2; 5,000 to 15,000 students; Suburban; 25%; 30%
5	White	Male	5	ASP	MH, SCH, CSC	R3; 15,000 or more; Suburban; 30%; 25%
6	Black	Male	6	ASP	CSC	R3; 5,000 to 15,000 students; Suburban; 30%; 25%
7	Black	Male	6	Clin	MH	R1; 15,000 or more students; Urban; 43%; 45%
8	White	Male		Full	MH	R3; 15,000 or more students; Suburban; 30%; 25%
9	White	Female	13	Clin	SCH	R1; 15,000 or more students; Urban; 14%; 30%

10	White	Female		Full	MH	R2; 15,000 or more students; Suburban; 30%; 25%
11	White	Male		Assoc	MH, SCH, CSC	R2; 5,000 to 15,000; Suburban; 20%; 15%
12	White	Male	31	Full	MH	R1; 15,000 or more students; Urban; 20%; 35%

Note: Full = Full Professor, Assoc = Associate Professor; ASP = Assistant Professor; Clin = Clinical Assistant Professor; MH=Mental Health; SCH=School Counseling; CSC=College; URM = underrepresented minority; Yrs Exp = years of experience as a counselor educator

A semi-structured interview was conducted as the primary data collection method. This approach is appropriate, as well as recommended, for qualitative research studies (Creswell, 2007). The interviews for this study included open-ended questions pertaining to teaching SDOH in counseling courses. Example questions include: (1) “When you hear the term social determinants of health, abbreviated as SDOH, what comes to mind for you?”; (2) “What specific skills do you teach counseling students for addressing SDOH in practice?”; and (3) “What barriers exist in teaching about SDOH in Counselor Education? What are the benefits?” Both of the authors completed the interviews, which lasted approximately 45-86 minutes, and occurred via video conferencing software (e.g., Zoom). The audio files were transcribed using an online transcription service (i.e., TEMI) and later checked for accuracy in audio-to- text transcription. The secondary data collection method included a review of written responses to clarifying questions after the initial interview, and artifacts provided by participants.

Research Team

The primary research team consisted of two women: a counselor educator, who has experience with designing and completing qualitative studies and has an expertise in health disparities, school counseling, and interprofessional collaboration and one advanced doctoral student who has completed qualitative research studies independent of a class assignment and

has experience working with vulnerable populations in schools and in community-based mental health counseling. The researchers acknowledged how their preconceived notions of the topic can influence the data analysis and interpretation. The researchers used reflexive journaling to bracket biases and assumptions. In addition, for consistency, both authors were the primary interviewers. Finally, a male advanced doctoral student who has experience working with vulnerable populations served as the peer debriefer.

Trustworthiness

Several methodological processes in line with descriptive phenomenology were engaged to increase trustworthiness of the findings. In line with descriptive phenomenology, we focused on maintaining openness and questioning pre-understandings and conceptions (Dhalberg et al., 2008). The research team engaged in reflexive journaling and orally self-disclosed biases, beliefs, and assumptions in every research team meeting during the course of the research study (Creswell & Poth, 2018). This approach to researcher reflexivity assisted the researchers in understanding how their preconceived notions can shape the qualitative inquiry and invited researchers to highlight when they believed researcher-specific biases were emerging within the process (Creswell et al., 2018). The research team was also encouraged to memo, which formed a history of the research team's thoughts during data collection analysis, and throughout the conclusion of the study (Creswell et al., 2018). A peer debriefer, was engaged to review and assess transcripts, memos, categories and final themes (Creswell, 2007). The peer debriefer was in agreement with the final categories and themes and did not suggest further discussion. Triangulation of data sources was utilized through the diverse experiences of participants and triangulation of interpretation and findings was accomplished because of the collaboration of a diverse research team and peer debriefer. Lastly, member checking was also conducted

(Creswell, 2007). Participants received a request five to eight days after their interview to review the transcript for accuracy and to denote “no points of clarity needed” or “with points of clarity” indicated on their transcript. All participants completed member checking with some answering the additional request to send artifacts that are related to their experience teaching about social inequalities.

Data Analysis

Descriptive phenomenological methods were used by the research team to analyze the empirical data from transcribed participant interviews (Moustakas, 1994; Creswell, 2007). Prior to data collection and analysis, the research team developed and maintained a phenomenological attitude (Husserl, 2008), which allows for bracketing and putting aside presuppositions. Next, research team members independently read the entire “naive descriptions” provided by participants to familiarize themselves with participant experiences (Moustakas, 1994; Giorgi, 2009). Each member of the research team read the entire transcript until they felt familiar with the tone and nature of responses (Creswell, 2007).

Next, meaningful statements were generated which fit under five major themes (Creswell, 2007). The research team then used the significant statements and demarcated invariant meaning units using horizontalization (Creswell, 2007; Giorgi, 2009). For the current study, horizontalization included identifying phrases and parts of the passages that related to the participants experience or description of teaching about SDOH in counselor education. Moustakas (1994, p. 95) describes the horizon as “the grounding or condition of the phenomenon that gives it a distinct character.” As we think about each horizon and its textural qualities, we begin to understand the experiences through our own self-awareness and reflection.

Next, the research team focused on formulating meaning from each of the themes identified from the data, developing a textural description of the phenomena (Creswell, 2007; Moustakas, 1994); in the current study the phenomenon is *teaching SDOH.* After coding was complete, the research team identified structural descriptions of the phenomenon. In the final phenomenological analysis step the research team created a composite description of the phenomenon that incorporated the textural and structural descriptions into an exhaustive description of the research team's interpretation of the essence of the phenomenon of teaching SDOH in a graduate counseling course (Creswell, 2007; Moustakas, 1994).

Findings

The research team identified *how and in what setting* DOH were taught by counselor educators in two structural themes. Numerous textural descriptions delineated *what* happened, specifically the content taught and techniques. The frequency of endorsement for structural and textural themes is included in parentheses, along with a thematic description and participant thick rich descriptions of their experiences. Additionally, excerpts from the literature reviewed are used here to elucidate the terminology used by the participants.

Instructor Context

The first structural theme, *instructor context* (*n* = 12) is referring to the lens from which participants conceptualized SDOH. The textural themes included: (a) *theory and models* (*n* = 12), which described the theoretical lens they used to conceptualize and the course and content delivery; (b) *instructor dispositions* (*n* = 9), were reflections from participants on their nature, temperament, and positioning when teaching SDOH content; (c) *course and content* (*n* = 12), were the courses and information mentioned that they cover when teaching SDOH; and (d)

purpose and outcome (*n* = 12), were the experiences of what participants wanted students to get from the class. There are several subcategories to the textural themes, presented in table two.

Table 2
Structural Theme 1: Instructor Context

Textural Theme & Subcategory	Participant Quote	n
Theory and Models		12
Ecological systems Theory	Participant 1: "I'm always talking about different aspects of social support ...I try to talk about social support in a larger context and what that looks like for different communities." Participant 2: "The ecological systems theory that is probably the only piece that I use with them and helping them see the bigger picture." Participant 7: "It helps students and it also helps clients to see their presenting problems from a larger perspective."	6
Inter-sectionality	Participant 4: "So on the outset, maybe gender identity doesn't seem initially like a social determinant of health, but it definitely impacts..., where a person lives, what kind of employment they're able to obtain and that's directly connected to, you know, air quality. It's connected to where you live. It's connected to if you presumably live in a food desert or not, it's connected to the amount of crime that is in your neighborhood or are you able to obtain higher education and what resources you have." Participant 12: "being aware of, intersectional identities and the identities that people bring into the classroom, the voices that people are bringing into the classroom."	7
Social Justice Multicultural Counseling Theory	Participant 6: "I have a foundation that is based in our multicultural and social justice counseling competencies" Participant 4: "We talk about how those things impact a person's lived experience or what they have access to and what they don't."	9
Counseling Models & related theory	Participant 7: "We use evidence-based models that address culture. We also use the broaching model for skills...Racial Identity development model" Participant 9: "starting even with a thing of like Maslow's hierarchy of needs" Participant 3: "Psychology of working, the three main areas, he looks at his work as a means of survival and power, work as a means of social connection, and then work as a means of self-determinations."	12
Instructor Disposition		9
Gentle	Participant 2: "in being mindful about student feelings discussing SDOH… If I'm	5

Approach	pushing someone to change who truly isn't ready, presenting information that is heavy information and they're not ready, I could cause more damage than good and leave the educational space altogether for that individual student." Participant 4: "So it's new for a lot of these students and so I'm trying to like decrease that discomfort, getting the conversation going"	
Direct	Participant 6: "I don't sugar coat anything." Participant 1: "They're allowed to make mistakes. They're allowed to not know things, they're allowed to struggle and stumble, stumble through the material on the semester. But at the same time, I expect them to work hard and I have standards. And so I share my own personal experience in that way and I'm very transparent. I allow them to ask me questions and if there is anything that I don't feel comfortable discussing, then I will draw a boundary."	9
Course and Content Covered		12
Ethics	Participant 8: "Ethical and multicultural issues arise in the course of ethics Participant 10: "I mostly teach ethics courses and so there's a module or a section where we're talking about multicultural issues….self-analysis is in the ethical part where they're looking at the differences between me and the individual, especially if they're coming from a different background and how that may impact them in counseling."	9
Internship & Practicum	Participant 5: "Dialogue around the case if it's an internship." Participant 9: "Engaging conversations with this usually comes at practicum and internship because that's when they actually really see it." Participant 2: "it really comes all together in internship because they're at their sites and we're able to make it super practical."	10
Diversity/ SJ	Participant 6: "We talk about social class, power and privilege, race and ethnicity." Participant 8: "but as they look at the culture and advocacy, they are certainly going to be more acquainted with it, but we cover that in an advocacy course. Participant 7: "diversity courses & we integrate diversity into all of our courses."	8
Human Sexuality	Participant 3: "...social determinants really impact that, you know, makes higher risk for STI or is higher risk for HIV cause you don't have access to the resources, unintended pregnancies. Participant 8: "human sexuality, it's highly relevant obviously. Um, because of all the differences between individuals, cultures, involvement in, their sexual scripts and their values	3
Purpose and Outcome		12
Application	Participant 3: "So I try to incorporate different things that are new and fun and what skills can they develop and take with them as well." Participant 2: "collaboration in that sense there, but then also making sure they	12

	know when it is truly appropriate to refer out. Participant 10: “doing assessments, referrals, prognosis, …” Participant 1: “have discussions, about how to ask questions and how to respond to elicit more information or to be able to explore more aspects of the person.”	
Empathy	Participant 5: “So, you know, having them really start thinking about that in a conceptual way that incorporates that is essential for them to grow and understand and empathize.” Also noted, “I don’t know if, if I use as much of a pedagogy than just the encouragement of empathy” Participant 10: “Then we're doing another workshop on empathy.”	6
Critical thinking	Participant 5: “to understand cultures is a multifaceted thing. And we can’t just assume” Participant 1: “And I want students to understand the complexities of the relationships between social determinants of health and physical and mental health.”	6
Understand Interconnectedness	Participant 1: “we want our students to understand that mental health and physical wellbeing are not two separate things. That they are very much tied together and that they both affect each other so if somebody is not healthy mentally and psychologically it’s going to affect their physical wellbeing and their physical health. Whereas if their physical health and wellbeing is also not in a good place, it’s due to numerous, social determinants of health, then their mental health is also going to be impacted.” Participant 2: “we’re putting together a big picture of human behavior”	7

Pedagogic Strategies

Pedagogic strategies (*n* = 12) identifies how participants conceptualized their role in the process of teaching SDOH within counseling courses. There were three textural themes and a number of subcategories for each. The first textural theme, *Instructional approach (n* =12), identifies how instructional material was presented based on an underlining pedagogical theory. Subcategories include: (a) *Phenomenon Based Learning*, defined as approaching SDOH holistically, including both topical and theme-based learning; (b) *Anchored instruction*, uses context, through case examples, to situate learning and application of knowledge in real world contexts; and (c) *experiential learning* is learning through experience, and for SDOH it also includes learning through reflection on “doing”. The second textural theme, *teaching methodology (n* =12), refers to the method of instruction, with three subcategories. The third

textural theme, *strategic assignments* (*n* = 12), described assignments for growth and reflection that were split into two subcategories: *self-awareness* and *social awareness*. Table three includes example participant quotes.

Table 3
Structural Theme 2: Pedagogic Strategies

Textural Theme & Subcategory	Participant Quote	n
Instructional Approach		12
Phenomenon Based Learning	Participant 4: "And one like very general topic that connects to a lot of those different social determinants of health is privilege. So that's a way that I can kind of like ease into that."	9
Anchored instruction	Participant 1: "Another way I think is to make sure that students are aware of what's happening in the world. So by keeping things relevant...Another way is by which I've said a few times is the case examples." Participant 2: "So the resource activity that I have them do ..Start looking for resources and creating that list. and then having the students calling some of those places, finding out what is all included cause websites are nice, but what's the real experience of people coming through?"	9
Experiential Learning	Participant 4: "I like very hands-on experiential activities that allow for students to experience something and then process, debrief and have a conversation about what actually took place there" Participant 7: "A lot of experiential learning. Uh, sometimes we would have students to form families ...They will have to assess these families according to SES, according to race, sexual orientation and those different issues. And they would write conceptualizations about these families and employ the skills that they're learning in class from the theories."	7
Teaching Methodology		12
Discussion	Participant 7: "We start that conversation in the first semester for students discussing diversity, discussing SDOH and talking about how SDOH impacts the presenting problem and what kind of counselor you want to be in utilizing those skills."	12
Repetition	Participant 1: "it doesn't matter what class it is, if it's research, if it's the basic skills class, if it's, the diversity class or if it's like theories really don't care what it is, somehow I'm going to bring in issues of race and how all of these social determinants of health are politicized."	10

	Participant 11: “It's [social justice] really infused in all of our courses and so it's, I tend to not be a person that we're just going to have a unit on this. I try to infuse it into everything that we're talking about.”	
Media and Technology	Participant 1: “Introducing different examples from media, whether it’s, um, something that’s happening on social media that’s become popularized or something that’s been.” Participant 3: “I try to incorporate a lot of just media, um, podcast, Ted talks, YouTube videos. When I see news articles that are relevant, like I post a lot of resources like media related resources... I'm like, yes, but it's still getting the same concept that I want them to take home.”	11
Strategic Assignments		12
Self awareness	Participant 6: “Something to really dive deep into their own cultural backgrounds. I would say cultural biography with the genogram.” Participant 4: “I had a privilege activity. I put them in groups. Each group had a certain amount of money and there was a list of privileges on a piece of paper and they had to buy which ones that they thought were most pertinent … So doing activities like that and allowing students an opportunity to just for one second kind of get out of themselves Participant 1: “We should always be self-critical and have, moments of reflection.”	9
Social awareness	Participant 5: “immersion project... so encouraging real deep, rich experiences in that project is essential to really be able to get a good understanding of what folks go through.” Participant 6: “Immersion activity where students are made to feel uncomfortable” Participant 9: “advocacy day of the general assembly, they go and advocate. They tend to soak it up and to bring more to the table, bring more ideas of what, what they've read, what they've heard, what they're learning, what people are saying out there, what they're finding.”	7

In summary, the findings represent the structural and textural description of the experiences of counselor educators teaching SDOH. The first research question asked, “What are your experiences teaching social determinants of health?” which was addressed in the first structural theme. The second research question asked, “What techniques do you use to teach SDOH?” which was addressed in the second structural theme. The discussion section explores

the structural themes and broadly discusses some of the textural themes, within the context of previous literature.

Discussion

The findings from the current study are unique in that no other study in counselor education has been conducted on the experiences of counselor educators teaching SDOH. While there have been a number of studies on medical educators and other allied health professionals experience teaching SDOH, this study is the first of its kind for counselor education. There are similarities between the content and techniques used to teach SDOH to medical students and counselors as reflected in the experiences presented here and in the previous literature on medical educators (Andermann, 2016; Doobay-Persaud et al., 2019). A unique difference in our study was the motivation to teach SDOH. In medical education, it is a specific competency and knowledge base that has to be covered within their co-curricular experience; however, in counselor education, the curriculum is not as specific and does not list SDOH in any standards or competencies (Siegel et al., 2018). Based on the participant transcripts, the motivation to cover SDOH topics was clearly driven by their personal experiences, interests, and values. While this presents an optimal experience for counselor educator students, it calls into question what is taking place across programs. This variability in what content is taught based on the counselor educators' personal context is also in line with findings related to teaching multicultural counseling (Milan & Bridges, 2019; Trahan & Keim, 2019). To remedy the variation in what is taught in relation to SDOH, CACREP and faculty member input can determine if the SDOH framework (WHO, 2012) is a reasonable and plausible competency to add to the current standards.

A major difference between the current study and previous studies in medical education, is the use of a SDOH framework (Andermann, 2016). The framework is imperative, as it provides direction and guides the course objectives, goals, and expected outcomes (National Academies of Science, Engineering, and Medicine [NASEM], 2016). If a solid SDOH framework to guide an SDOH course is not utilized, it poses the problem of providing inadequate teaching that lacks information and minimizes the use of evidence-based practices (Klein et al., 2011). Additionally, a significant limitation that arises when failing to correctly address SDOH is the missed opportunity of creating lifelong learning. The creation of lifelong learning is one of the primary goals of SDOH education, as the world and conditions that people live, learn, work and play change so rapidly (NASEM, 2016).

The results from the first research question (i.e., counselor educators experience teaching SDOH), answered by the first structural theme, *Instructor Context*, were increasingly reflective. The responses varied, as some participants reflected on hearing the new term (SDOH) for the first time. Others reflected after hearing our definition of SDOH, realizing that they had been thoroughly covering SDOH without being aware of the term or associated frameworks. SDOH specifically is not a competency that graduate counseling students have to be attuned to, according to CACREP standards (CACREP, 2015). Although, there are SDOH adjacent topics that are primarily listed in the 'social and cultural diversity' course (CACREP, 2015), SDOH has not been specifically included. Although SDOH language and frameworks are absent within counseling curriculum and competencies, this study has uncovered that counselors are covering SDOH topics in various classes. Participants in the current study noted covering SDOH topics in ethics, human sexuality, multicultural social justice, advocacy, internship, practicum, and theories. Additionally, a few participants mentioned that they cover SDOH topics in all of their

classes and across the entire program. This finding is unique in counselor education and in medical education where the push is to cover SDOH throughout the entire educational experience. SDOH is inextricably linked to multicultural social justice (MSJCC), and the findings are in line with recommendations to cover MSJCC topics across the curriculum (Crumb et al., 2019; Ratts et al., 2016). The MSJCC provides a broader more conceptual framework of who we should be and what we should do (i.e., advocate) and the SDOH framework shows us the direction for the largest impact on eradicating inequities that cause wellness disparities.

Another new finding related to structural theme of *Instructor Context* is the instructor disposition, purpose for teaching SDOH and the subsequent intended outcome. Although instructor disposition and related course content has been investigated, our study is an extension of that research due to the type and context of the dispositions. The disposition and purpose were widespread, as some participants noted the importance of "keeping it real" and being transparent when teaching SDOH, while others noted the importance of "easing" into the content; and lastly, one person noted being "steadfast" in their pursuit of teaching SDOH, indiscriminate of any barriers or challenges. These dispositions were directly linked to the content that was covered in the course, their purpose for teaching SDOH content (i.e., the value, importance, and significance for counselors) and their goals for students (i.e., increase knowledge, awareness, and skills). All participants noted the purpose of teaching SDOH (i.e., the intended outcome) was to develop skills of the counselor trainee. In SDOH education, skill development is a primary focus (Sisler et al., 2019), with strategic initiatives to build skills (i.e., simulation activity, service learning, residency, etc.). The counselor educators in the current study all noted the importance of skill development to collaborate, consult, refer, and assess but how they were developing those skills was not fully fleshed out.

Structural theme two, *Pedagogic Strategies,* is directly related to research question two (i.e., techniques used to teach SDOH). The reflections and descriptions echoed with their belief of how students learn which is reflected in their approach and method to teaching the content as well as assignments they thought were particularly useful in improving knowledge and awareness. Similar to the 'social and cultural' course in counseling, many use the foundation of knowledge, skills, and awareness to ensure coverage of the information they deem necessary (Killan & Floren, 2020). The strategies listed learning approaches, teaching methodologies, and strategic assignments participants found valuable for increasing knowledge and skill development. Different types of learning approaches and strategic assignments were uncovered in this study, presenting enlightening findings and departing from the medical education literature. This study found that strategic assignments could potentially be grouped into two distinct areas: building self-awareness and social awareness. This is a new finding for the SDOH medical education literature and a unique finding for counselor educators teaching SDOH, as previous studies have typically focused solely on self-awareness (Springer, 2019; Thorton & Persaud, 2018). Many educators focused on both the importance of having assignments that created space for self-reflection and cultural immersion; however, equally important was understanding others, building empathy, and skills to serve. Some of the assignments mentioned, such as, cultural genograms, cultural immersion, are not mentioned in most medical education studies on teaching SDOH (Sharma et al., 2018), but hold importance in counselor education as it relates to multicultural competencies. These findings are new for counselor education but not surprising, as counselor education training emphasizes reflecting on who you are as a person and a counselor; while holding the expectation for multicultural consideration and competency (Melamed et al., 2020; Merrell-James et al., 2019).

Limitations

The findings should be reviewed in light of a few limitations. While there was a diverse range of participants, the university location in which they work, could either maximize or limit their exposure to SDOH, impacting their awareness of SDOH and inclusion of it in their courses. As this topic is fairly new in the counseling profession, the lack of a general understanding of terminology, knowledge, and awareness of SDOH could have impacted the participants' thoughts and responses. In regard to the interviews, the online format and order of questions, could have potentially affected the responses, and reporter bias. Additionally, researcher bias may also have affected data analysis; however, reflexive journaling and a peer debriefer was utilized. Additionally, limitations of descriptive phenomenology include subjectivity, bias, bracketing, and presentation.

Implications and Future Research for Counselor Education

Counselors overwhelmingly were including SDOH adjacent topics in their counseling courses however no participants mentioned the use of an evidence based SDOH framework. There was also variation amongst participants in what was covered in the discussions on SDOH (i.e., race, income, housing, food, etc). Sisler and colleagues (2019) note the importance of an evidence based SDOH framework when teaching SDOH to students because it provides the tools, structured plan, standards, and necessary competencies to deliver instruction on the topic. The findings from the current study imply the need for counselor educators to use a SDOH framework, which will help minimize variation, and provide structured content and strategies. The use of an SDOH framework also grounds the work of counselors within the five domains outlined by the World Health Organization that cause inequities in health, education, and wellness (WHO, 2012). Future research, should investigate the use of an SDOH framework in

counseling courses for instruction on SDOH topics, assessing feasibility and student learning outcomes. In addition, there are many SDOH frameworks, future research should investigate which framework is appropriate or useful for counselors in training. Our study findings also necessitate the need for SDOH continuing education for counselor educators. All participants requested to have access to the free continuing education module on SDOH that we created as a part of this project, because they recognized gaps in their current knowledge. Continuing education as it relates to SDOH is a recommendation for all educators and healthcare providers because the needs of people and systems that create and maintain inequities are always evolving (NASEM, 2016). Future research should investigate SDOH continuing education interventions for counselor educator's, focusing on dosage and type of education that yields the best results in terms of improving SDOH knowledge, awareness, and skills.

Conclusion

Counselor education is a key area to investigate because it is responsible for equipping the next generation of counselors trained and prepared to address social inequities within their spheres of influence and with clients. The findings in the current study expand what is currently known about teaching SDOH and is beneficial for counselor educators who seek to incorporate a framework for reflecting and teaching about SDOH. Additionally, the study findings are important for counselor educators who want to learn more about SDOH, as one of the values in teaching about SDOH is to create lifelong learners (NASEM, 2016). It is our hope that this study is the first of many that spark interest in counselor educators to continue teaching, learning, and researching about SDOH.

References

Andermann, A. (2016). Taking action on the social determinants of health in clinical practice: a framework for health professionals. *Canadian medical association journal*, *188*(17-18), E474-E483. https://doi.org/10.1503/cmaj.160177

Artiga, S., & Hinton, E. (2019). Beyond health care: the role of social determinants in promoting health and health equity. *Health*, *20*(10), 1-13. http://resource.nlm.nih.gov/101740257

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. *The Lancet*, *389*(10077), 1453-1463. https://doi.org/10.1016/S0140-6736(17)30569-X.

Constantine, M. G., Hage, S. M., Kindaichi, M. M., & Bryant, R. M. (2007). Social justice and multicultural issues: Implications for the practice and training of counselors and counseling psychologists. *Journal of Counseling & Development*, *85*(1), 24-29. https://doi.org/10.1002/j.1556-6678.2007.tb00440.x

Council for Accreditation of Counseling and Related Educational Programs. (2015). https://www.cacrep.org/for-programs/2016-cacrep-standards/

Crumb, L., Haskins, N., & Brown, S. (2019). Integrating social justice advocacy into mental health counseling in rural, impoverished American communities. *Professional Counselor*, *9*(1), 20-34. https://doi.org/10.15241/lc.9.1.20

Dahlberg, K., Dahlberg, H., & Nyström, M. (2008). Reflective lifeworld research. Lund, Sweden: Studentlitteratur. https://www.researchgate.net/publication/265657817_Reflective_Life-World_Research

Doobay-Persaud, A., Adler, M. D., Bartell, T. R., Sheneman, N. E., Martinez, M. D., Mangold, K. A., ... & Sheehan, K. M. (2019). Teaching the social determinants of health in undergraduate medical education: a scoping review. *Journal of general internal medicine*, *34*(5), 720-730. https://doi.org/10.1007/s11606-019-04876-0.

Gazzola, N., LaMarre, A., & Smoliak, O. (2018). Social justice and advocacy: Critical issues in counselor education. In C. Audet & D. Paré (Eds.), Social justice and counseling: Discourse in practice (p. 43–56). Routledge/Taylor & Francis Group. https://doi.org/10.4324/9781315753751.

Hays, D. G., & Singh, A. A. (2011). *Qualitative inquiry in clinical and educational settings*. Guilford Press.

Klein, M. D., Kahn, R. S., Baker, R. C., Fink, E. E., Parrish, D. S., & White, D. C. (2011). Training in social determinants of health in primary care: does it change resident behavior?. *Academic Pediatrics*, *11*(5), 387-393. https://doi.org/10.1016/j.acap.2011.04.004

Martinez, I. L., Artze-Vega, I., Wells, A. L., Mora, J. C., & Gillis, M. (2015). Twelve tips for teaching social determinants of health in medicine. *Medical teacher*, *37*(7), 647-652. https://doi.org/10.3109/0142159X.2014.975191.

Melamed, L., Casado Pérez, J. F., & Hunt, B. (2020). Teaching Strategies for Incorporating the Multicultural and Social Justice Counseling Competencies. *The Journal of Counselor Preparation and Supervision*, *13*(2), 2. http://dx.doi.org/10.7729/42.1350

Merrell-James, R. H., Douglass, M. J., & Shupp, M. R. (2019). Promoting Awareness of Self: Cultural Immersion and Service-Learning Experiences of Counselors-in-Training. *The Journal of Counselor Preparation and Supervision, 12*(2), 1. Retrieved from https://repository.wcsu.edu/jcps/vol12/iss2/1

Milan, M. J., & Bridges, C. W. (2019). Conflict in the Multicultural Counseling Classroom: Counselor Educators' Experiences. *Journal of Educational Research and Practice, 9*(1), 18. https://doi.org/10.5590/JERAP.2019.09.1.17

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.

Mu, L., Shroff, F., & Dharamsi, S. (2011). Inspiring health advocacy in family medicine: a qualitative study. *Education for Health, 24*(1), 534. http://www.educationforhealth.net/text.asp?2011/24/1/534/101455

National Academies of Sciences, Engineering, and Medicine [NASEM]. (2016). A framework for educating health professionals to address the social determinants of health. National Academies Press. https://doi.org/10.17226/21923

Plamondon, K. M., Bottorff, J. L., Caxaj, C. S., & Graham, I. D. (2018). The integration of evidence from the commission on social determinants of health in the field of health equity: a scoping review. *Critical Public Health*, 1-14. https://doi.org/10.1080/09581596.2018.1551613

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28-48. https://doi.org/10.1002/jmcd.12035

Sharma, M., Pinto, A. D., & Kumagai, A. K. (2018). Teaching the social determinants of health: a path to equity or a road to nowhere?. *Academic medicine, 93*(1), 25-30. https://doi.org/10.1097/ACM.0000000000001689.

Siegel, J., Coleman, D. L., & James, T. (2018). Integrating social determinants of health into graduate medical education: a call for action. *Academic Medicine*, 93(2), 159-162. https://doi.org/10.1097/ACM.0000000000002054

Singh, A. A., Nassar, S. C., Arredondo, P., & Toporek, R. (2020). The past guides the future: Implementing the multicultural and social justice counseling competencies. *Journal of Counseling & Development*, *98*(3), 238-252. https://doi.org/10.1002/jcad.12319

Snow, W. H., & Coker, J. K. (2020). Distance Counselor Education: Past, Present, Future. Professional Counselor, 10(1), 40-56. https://doi.org/10.15241/dss.10.1.133

Thornton, M., & Persaud, S. (2018). Preparing today's nurses: Social determinants of health and nursing education. *The Online Journal of Issues in Nursing*, 23(3). https://doi.org/10.3912/OJIN.Vol23No03Man05

Trahan Jr, D. P., & Keim, J. (2019). Counselor Educators' Teaching Practices in Contemporary Society. *The Journal of Counselor Preparation and Supervision, 12*(3), 1. Retrieved from https://repository.wcsu.edu/jcps/vol12/iss3/1

Watt, D. (2007). On becoming a qualitative researcher: the value of reflexivity. *Qualitative Report*, *12*(1), 82-101. Retrieved from https://nsuworks.nova.edu/tqr/vol12/iss1/5

Wilkinson, R., & Pickett, K. (2020). The inner level: how more equal societies reduce stress, restore sanity and improve everyone's well-being. New York, NY: Penguin Books

WHO (World Health Organization). (2012). What are the social determinants of health? Retrieved from http://www.who.int/social_determinants/sdh_definition/en/