Vicarious Trauma, Subthreshold PTSD, and Resilience in Professional Counselors Working with Traumatized Populations

by

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Abstract

As counselors empathically listen to their clients' traumatic experiences on a regular basis, there is a potential for counselors to be negatively impacted and become impaired (Abassary & Goodrich, 2014). Without effective protective factors in place, counselors are at risk of experiencing vicarious trauma and subthreshold PTSD from exposure to clients' traumatic events (Nelson, 2016). The purpose of this study was to develop an understanding of the vicarious trauma and subthreshold PTSD symptoms experienced by professional counselors and the factors related to resiliency that protect counselors from developing these symptoms, such as years of professional counseling experience, the amount of one's trauma caseload, and a personal experience of trauma. Participants for this study were a national sample of 211 professional counselors recruited through various counseling list-serves. This research study established an understanding of the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms experienced by professional counselors and the relationship between these symptoms and resilience. Furthermore, this study determined that years of professional experience decreased arousal symptoms of vicarious trauma and increased level of resilience in professional counselors, and that having a history of personal trauma increases one's arousal vicarious trauma symptoms. Implications for professional counselors and counselor educators to mitigate and lessen the symptoms of vicarious trauma and subthreshold PTSD and maximize resiliency in professional counselors are discussed.

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Table of Contents

Abstract ii

Acknowledgments iii

List of Tables vi

Chapter 1 1

Chapter 2 16

Chapter 3 24

Chapter 4 39

Chapter 5 51

References 73

Appendix 1 84

Appendix 2 86

Appendix 3 88

Appendix 4 90

Appendix 5 91

Appendix 6 92

List of Tables

Table 1 …….. 26

Table 2 …….. 27

Table 3 …….. 29

Table 4 …….. 30

Table 5 …….. 32

Table 6 …….. 34

Table 7 …….. 36

Table 8 …….. 38

Table 9 …….. 38

Chapter 1

Introduction and Background of the Problem

Counselors in all clinical settings work with clients who have experienced trauma to some extent in their lifetime. According to the U.S. Department of Veteran Affairs National Center of PTSD (2015), trauma is prevalent in today's society, with about six out of ten men and about five out of ten women experiencing at least one trauma during their lives. PTSD United (2015) estimates as many as 70% of adults in the United States have experienced at least one traumatic event in their lives, and up to 20% of those individuals develop a diagnosis of Post-Traumatic Stress Disorder. Traumatic events also occur at an alarmingly high rate in children and adolescents as well. The National Child Traumatic Stress Network (2011) states that at least ten million children experience a traumatic event per year. Trauma can be defined generally as any exposure to an event or situation in which an individual is confronted with an incident that involves perceived, actual, or threatened death or serious injury to self or others' well-being (American Psychiatric Association, 2013). Traumatic events are broad in scope and have a wide range of intensity. Exposure to traumatic events, whether direct exposure or indirect exposure, ranges from 40% to 81% of the United States' population (Bride, 2007). Frequent traumas that clients experience include domestic violence, school or work-related violence, sexual assault, physical assault, grief, community-based trauma, natural and human-made disasters and childhood sexual abuse (National Child Traumatic Stress Network, 2011).

Clients' responses to these various traumas may be psychological, emotional, and/or physiological and typically include symptoms such as hyper-arousal, severe anxiety and fear, and a sense of helplessness that was not present before experiencing the trauma (American Psychiatric Association, 2013). When individuals who have experienced trauma seek counseling

services, counselors are exposed to and empathically listen to their clients' traumatic experiences. This increased exposure in turn increases the counselors' vulnerability of taking on their clients' traumatic events (Finklestein, Stein, Green, Bronstein, & Solomon, 2015) and increases the likelihood that counselors will experience their clients' traumatic experiences indirectly. Studies indicate that as many as 50% of counselors are at risk of developing vicarious trauma (National Child Traumatic Stress Network, 2011).

Vicarious Trauma (VCT)

The term vicarious trauma (VCT) has been used to describe counselors' reactions to directly working with clients who have experienced trauma (McCann & Pearlman, 1990). This definition of VCT includes secondary symptoms that are the result of exposure to clients' traumatic experiences (McCann & Pearlman, 1990). Pearlman and Saakvitne (1995b) described the construct of VCT as the negative inner transformation that occurs within therapists who engage and empathize with clients' traumatic narratives. This transformation can cause profound changes in the core traits of how the therapist views themselves, others, and the world (Pearlman & Saavkvitne, 1995b).

Such changes can manifest in the counselors' feelings, relationships, and quality of life (Helm, 2016). It is imperative that counselors be knowledgeable about the signs and symptoms of VCT. Saakvitne and Pearlman (1996) noted several symptoms that may have a significant impact on a counselor. For example, the memories of practitioners affected by VCT often become fragmented such that they can recall clients' trauma narratives without also recalling the client's emotional responses to the trauma. Counselors may also experience images (e.g. flashbacks) of their clients' trauma as if they themselves experienced the trauma firsthand (Pearlman & Saavkvitne, 1995b; Saakvitne and Pearlman, 1996). They may also have increasing

feelings of cynicism and despair and have recurring and ongoing nightmares (Briere & Scott, 2015; Elwood, Mott, Lohr, & Galovshi, 2011; Saakvitne and Pearlman, 1996). Counselors affected by VCT may also experience negative changes in identity, worldview, spiritual beliefs, self-esteem, resources, and cognitive schemas (Elwood et al., 2011; Helm, 2016; Pearlman & Saavkvitne, 1995b; Saakvitne and Pearlman, 1996). VCT can also cause negative mental health effects such as problems with trauma-related memory, perception, dissociation, intrusive imagery, and depersonalization (Elwood et al., 2011; Helm, 2016; Pearlman, 1999).

This negative shift can compromise the counselor's well-being and effectiveness in professional practice, as these symptoms can negatively influence the therapist's capacity for empathy and the ability to appropriately respond to the client (Briere & Scott, 2015; Trippany, White Kress, & Wilcoxon, 2004). Counselors who are exposed to several client trauma experiences may experience adverse changes in their beliefs about safety, power, independence, and intimacy, which may influence their ability to help clients (Elwood et al., 2011). Counselors with high caseloads that consist of a majority of intense trauma cases and counselors with little professional counseling experience have been found to be risk factors for developing VCT (Meichenbaum, 2007; Michalopoulos & Aparicio, 2012). Additionally, counselors with unresolved personal traumatic experiences has been found to be a risk factor for developing VCT (Baird & Kracen, 2006). Should these symptoms of VCT remain untreated, they could negatively affect counselors' ability to provide the client with effective treatment (ACA, 2017; Helm, 2016; Lonn & Haiyasoso, 2016).

Symptoms of VCT closely align with those of post-traumatic stress disorder (PTSD) (Briere & Scott, 2015; Keim, Olguin, Marley, & Thieman, 2008) Research has found that individuals who experience symptoms of VCT meet criteria for subthreshold PTSD, as the

symptoms are similar to one another (Adams & Riggs, 2008; Briere & Scott, 2015; Jordan, 2010; Keim et al., 2008; Neumann & Gamble, 1995). Symptoms include recurring nightmares, recalling images of clients' traumas, feeling disconnected and isolated from loved ones, become socially withdrawn from friends and family members, feeling no energy, being more sensitive to loss and to trauma, emotional numbing and flooding (Lonn & Haiyasoso, 2016; Neumann & Gamble, 1995; Saakvitne & Pearlman, 1996). Furthermore, symptoms of VCT that are highly correlated with symptoms of PTSD include recurring and distressing thoughts about work or a specific client's trauma, emotional numbing and flooding, dissociative responses to clients' trauma experiences, triggering previous traumatic experiences; increased feelings of vulnerability, increased reactivity or hypervigilance, feelings of guilt or irritability, and decreased compassion and empathy (Adams & Riggs, 2008; Briere & Scott, 2015; Cukor, Wyka, Jaysinghe, & Difede, 2010; Helm, 2016; Jordan, 2010; Keim et al., 2008; Lonn & Haiyasoso, 2016; Nelson, 2016; Neumann & Gamble, 1995).

Subthreshold PTSD

Post-traumatic Stress Disorder (PTSD) was first included in 1980 in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and is still included in the current edition of the DSM, the DSM-V. The National Institute of Mental Health (n.d.) describes PTSD as a disorder that develops in some individuals who have experienced a dangerous, scary, or shocking event. In the DSM-V, PTSD is classified within the Trauma and Stress-Related Disorders and includes eight criteria to meet the diagnosis of PTSD.

Criterion A is classified as exposure to death or threatened death, actual or threatened serious injury, or actual or threatened sexual violence in the following way(s): direct exposure, witnessing the trauma, learning that a relative or close friend was exposed to a trauma, or indirect

exposure to aversive details of the trauma, typical in professional capacities (American Psychiatric Association, 2013). Criterion B states that the traumatic event is persistently re-experienced in the following ways: intrusive thoughts, nightmares, flashbacks, emotional distress after exposure to traumatic reminders, and/or physical reactivity after exposure to traumatic reminders (American Psychiatric Association, 2013). Criterion C is classified by avoidance of trauma-related stimuli after the trauma in the following ways: trauma-related thoughts or feelings, and/or trauma-related reminders (American Psychiatric Association, 2013). Criterion D involves negative thoughts or feelings that began or worsened after the trauma in the following way(s): inability to recall key features of the trauma, overly negative thoughts and assumptions about oneself or the world, exaggerated blame of self or others for causing the trauma, negative affect, decreased interest in activities, feeling isolated, and/or difficulty experiencing positive affect (American Psychiatric Association, 2013). Criterion E includes trauma-related arousal and reactivity that began or worsened after the trauma in the following way(s): irritability or aggression, risky or destructive behavior, hypervigilance, heightened startle reaction, difficulty concentrating, and/or difficulty sleeping (American Psychiatric Association, 2013). Criterion F states that the symptoms last for more than one month, Criterion G requires that the symptoms create distress or functional impairment, and finally, Criterion H states that symptoms are not a result of medication, substance use, or any other illness (American Psychiatric Association, 2013).

The U.S. Department of Veteran Affairs National Center of PTSD (2015) states that about seven or eight out of every 100 people (7-8% of the U.S. population) will have PTSD at some point in their lives. Furthermore, an estimated 8 million adults are diagnosed with PTSD per year, which is only a small portion of individuals who have gone through a trauma (U.S.

Department of Veteran Affairs National Center of PTSD, 2015). Considering the prevalence of PTSD, the symptoms of most individuals suffering from PTSD related symptoms do not meet the full criteria for a PTSD diagnosis, which is known as subthreshold PTSD (Bergman, Kline, Feeny, & Zoellner, 2015). More specifically, subthreshold PTSD refers to the experiencing of PTSD symptoms, but not enough symptoms to meet the criteria for a full diagnosis of PTSD (Bergman et al., 2015; McLaughlin et al., 2015).

Subthreshold PTSD has been defined as the presence of clinically significant PTSD symptoms that do not meet the full *Diagnostic and Statistical Manual of Mental Disorders* PTSD diagnostic criteria (Bergman et al., 2015). More specifically, subthreshold PTSD is defined as meeting two or three of the PTSD Criteria B-E (McLaughlin et al., 2015). The prevalence rate of subthreshold PTSD appears to be consistent with that of full PTSD (Brancu et al., 2016; Cukor, Wyka, Jayasinghe, Difede, 2010; McLaughlin et al., 2015; Muller et al., 2014; Zlotnick, Franklin & Zimmerman; 2002). However, due to a lack of reporting and inconsistency in terminology and methodology when researching subthreshold PTSD, it is challenging to obtain an accurate percentage of individuals who would meet the criteria of subthreshold PTSD (Brancu et al., 2016). Brancu et al. (2016) conducted a meta-analysis of the subthreshold PTSD literature and found that behavioral and psychological symptoms among individuals who identified meeting criteria for subthreshold PTSD were higher than individuals who did not identify having PTSD symptoms, but lower than those who identified as having full PTSD. Additionally, Brancu et al. (2016) found that the average prevalence rate of subthreshold PTSD among their participants, across studies, was 14.7%. Overall, the results from this research suggest that individuals who experience symptoms of subthreshold PTSD are at risk for the same negative concerns as those individuals who meet criteria for full PTSD (Brancu et al., 2016).

In addition to the clinical significance of subthreshold PTSD, research indicates that subthreshold PTSD symptoms may be longstanding (Cukor et al., 2010; McLaughlin et al., 2015; Muller et al., 2014; Zlotnick, Franklin & Zimmerman; 2002). Cukor et al. (2010) studied the long-term effects of subthreshold PTSD symptoms and found that of individuals with subthreshold PTSD studied, 30% met criteria for subthreshold PTSD or full PTSD one year later, and 25% still met the diagnostic criteria two years later. Research indicates that subthreshold PTSD is not simply a normative reaction to a traumatic event, as it can cause significant impairment if untreated (Cukor et al., 2010; McLaughlin et al., 2015; Muller et al., 2014; Zlotnick, Franklin & Zimmerman; 2002). While understanding the potential presence and severity of subthreshold PTSD is important, it is equally as important to examine what keeps experienced professional counselors who are exposed to trauma content in their work from developing these symptoms.

Resilience

Resilience first received attention in the developmental literature in investigations of children's adaptation to chronic adversity, including traumatic experiences (Bonnano, 2012; Masten, 2001; Wagnild, 2009). Developmentally speaking, one's capacity for resilience increases over time and into adulthood, often as a consequence of coping with adverse experiences (Wagnild & Collins, 2009). Research suggests that both genetic and environmental factors influence the developmental and expression of resilience (Cicchetti & Blender, 2006; Feder, Nestler & Charney, 2009; Haglund, Nestadt, Cooper, Southwick & Charney, 2007; Herrman, Stewart, Diaz-Granados, Berger, Jackson & Yuen, 2011). Therefore, one may be born with a predisposition for a level of resiliency and environmental factors may also determine the extent to which this capacity of resiliency is expressed (Pantelis & Bartholomeusz, 2014).

Resilience refers to one's ability to "bounce back" from unfavorable experiences and refers to one's inner strength, competence, optimism, and flexibility (Wagnild & Collins, 2009). Resilience has also been described as the successful adaptation to stressful circumstances (Cohen, Ferguson, Harms, Pooley, & Tomlinson, 2011; Masten, Best, & Garmezy, 1991; Smith, Tooley, Christopher & Kay, 2010). Resilience reflects one's ability to utilize internal and external resources to cope effectively with adverse circumstances (Wagnild & Young, 1993). It is not regarded as a fixed characteristic, but rather as a quality of one's adaptive trajectory (Luthar & Zelazo, 2003; Smith et al., 2010). Resilience is a flexible and adaptive ability that can be highly dependent on life's stressors and other environmental factors (Smith et al., 2010; Wagnild & Collins, 2009). Despite a multitude of definitions across several fields of research, there are common themes across definitions including adaptability, competence, determination, and acceptance (Wagnild, 2009). For the purposes of this study, resilience is defined as a personal characteristic that moderates the negative effects of stress and other negative factors and promotes adaptation (Wagnild & Young, 1993).

The topic of resilience has been widely researched concerning how individuals respond following traumatic events (Bartelt, 1994; Masten et al., 1991; McCord, 1994; Ryff, Singer, Love, Essex, 1998**;** Paton, Violanti, Smith, 2003; Smith, Lenz, Strohmer, 2016). According to Paton et al. (2003) the notion of resilience is the idea that individuals can and often do return to prior levels of functioning after a traumatic experience and in turn, are able adapt to adversity more effectively. There is an intrinsic quality that makes individual's responses to stress or negative symptoms more adaptive than others who have not experienced an event of trauma (Paton et al., 2003; Smith et al., 2010). Furthermore, individuals with high levels of resilience are

often more resistant to the adverse effects of various life stressors and can cope effectively despite adversity (Bartone, 2003).

According to the literature, resilience has been shown to be associated with positive mental health outcomes including reduced depression and anxiety (Humphreys, 2003; Rew, Taylor-Seehafer, Thomas, & Yockey, 2001; Wagnild, 2009). Also, resilience has been shown to correlate positively with an increased sense of purpose in one's life and in one's belief that his or her life has meaning (Nygren, Alex, Jonsen, Gustafson, Norberg, & Lundman, 2005). Through different qualitative studies, Wagnild and Young (1988; 1990) identified a theory and a measure of resilience that is commonly used to examine resilience. The five main components of their qualitative work comprise the conceptual foundation for the construct of resilience and the resiliency measure, *The Resilience Scale*. The components include purpose, perseverance, equanimity, self-reliance, and existential aloneness (Wagnild & Young, 1990; Wagnild & Young, 1993). Purpose can be understood as one's belief that life has meaning and valuing one's contribution to this meaning (Wagnild, 2009). Perseverance is defined as the act of persistence despite adversity or discouragement, indicating a willingness and drive to continue the struggle to reconstruct one's life and remain committed to this construction despite adversity (Wagnild, 2009). Equanimity can be understood as one's ability to maintain a balanced perspective of life and may be thought of as taking what comes in life and influences one's response to adversity (Wagnild, 2009). Self-reliance is defined as believing in one's self and one's abilities by recognizing one's strengths and limitations (Wagnild, 2009). Lastly, existential aloneness is also known as authenticity and is defined as the realization that each person has a unique path in life (Wagnild, 2009). Meaning, while some life experiences will be shared, many others will be faced

alone. Existential aloneness encompasses both uniqueness as well as a sense of freedom (Wagnild, 2009; Wagnild & Young, 1990).

More recently, studies have explored the relationship between resilience characteristics and clinical experiences in helping professionals. Lambert and Lawson (2013) explored mental health, self-care, burnout, resilience, and VCT in professional counselors who worked with individuals affected by Hurricanes Katrina and Rita, and they found that resiliency may serve to buffer the negative effects of adverse life experiences. Similarly, a qualitative study explored the resilience of mental health professionals in crisis care community mental health in Australia (Edward, 2005). In this study, resilience was defined as the ability to bounce back from adversity and to persevere through adversity, returning to a state of internal balance (Edward, 2005). The findings from this study suggested that there is a relationship between resilience and level of clinical experience in mental health professionals in that the theme of resilience was present within the participants with more professional experience. Additionally, another qualitative study of 22 trauma therapists identified a theme of personal and professional resilience among its participants (Pack, 2014).

In a recent comprehensive review of the literature, Hernandez-Wolfe (2018) emphasizes the paucity of quantitative research exploring the relationship between levels of resilience and mental health professionals working with trauma. However, research has documented the relationship between resilience and years of experience within the medical helping profession. One quantitative study of helping professionals such as nurses and medical personnel found that years of professional experiences predicted resilience using regression analyses as evidenced by a β-coefficient of 0.126 ($p=0.017$), and they also found a statistically significant correlation between resilience and years of professional experience ($p<0.0001$) (Gillespie, Chaboyer, Wallis,

& Grimbeek, 2009). A similar quantitative study of 13,000 nurses indicated one of the strongest predictors of professional resilience in nurses was years of employment and professional experience ($p<0.001$). Further quantitative research on resilience is needed regarding the mental health field, specifically studies that explore the relationship between resilience and mental health professionals who work with traumatized populations.

Counselor Educator Implications

It is essential that counselor educators and professional counselors be knowledgeable about the harmful effects of VCT and subthreshold PTSD. According to the American Counseling Association's Code of Ethics, professional counselors have an ethical responsibility to monitor their effectiveness and any impairment that could affect their ability to provide optimal counseling services (ACA, 2014). Regarding counselor education, it is the ethical responsibility of counselor educators to educate future counselors on the professional and ethical standards and legal responsibilities as well as monitor for any counseling student impairment (ACA, 2014). Also, CACREP (2014) mandates that accredited counselor programs educate counseling students on trauma related counseling skills and to adequately take care of themselves to avoid developing VCT and subthreshold PTSD symptoms. In a study that examined counselors-in-training and VCT, it was found that 12% of current counselors-in-training at a CACREP accredited counseling program met the criteria for a PTSD diagnosis (Keim et al., 2008). Furthermore, of those same participants, 12.5% stated that they had worked with at least one client who caused them personal traumatic stress based on the client's traumatic experiences (Keim et al., 2008). In order to thoroughly prepare future counselors, counselor educators must educate counseling students on VCT and subthreshold PTSD and their detrimental effects (Sommer, 2008). However, in order to effectively educate counseling students, counselor

educators must first fully understand these symptoms and the causes of VCT and subthreshold PTSD (Keim et al., 2008).

When the counselor-in-training transitions to a professional counselor, they must continue to navigate these challenges on a daily basis. Practicing professional counselors who experience symptoms of VCT or subthreshold PTSD may leave the profession prematurely, and may also experience emotional or physical disorders, strained relationships, increased rates of professional burnout, suicidal ideation, and substance abuse (Berman et al., 2015; Keim et al., 2008). Also, subthreshold PTSD increases counselors' potential for clinical error when continuing to practice counseling clients when symptoms of VCT or subthreshold PTSD are present (ACA, 2017; Trippany et al., 2004). Numerous factors contribute to the vulnerability of professional counselors developing these symptoms, and counselor educators should be aware of these factors to best educate and train beginning counselors. This also includes educating and training beginning counselors in how to maximize resilience, in turn, minimizing the risk of developing VCT or subthreshold PTSD. However, counselor educators must first fully understand these contributing factors in order to best educate and train future professional counselors.

Statement of the Problem

VCT and subthreshold PTSD can be detrimental to both the professional counselor and the client, and these symptoms can be viewed as an occupational hazard for the employee, the workplace, and the client (Bercier & Maynard, 2015; Howlett & Collins, 2014). VCT commonly occurs when counselors work directly with clients who have experienced a traumatic event (Lonn & Haiyasoso, 2016). Practicing counseling while experiencing symptoms of VCT or subthreshold PTSD can negatively influence the counselor's judgment, increase the risk for re-

traumatization, and harm the client (ACA, 2017; Helm, 2016; Trippany et al., 2004). While it is essential to understand the negative symptoms that a counselor might encounter, it is equally as important to understand factors such as resilience that protect and motivate counselors in their clinical work when working with traumatized populations.

Significance of the Study

As many as 50% of professional counselors are at risk for developing VCT symptoms, and the estimated prevalence rate of VCT among counselors is 45.9% (Dunkley & Whelan, 2006; National Child Traumatic Stress Network, 2011). Several studies have documented the full range of risks associated with working directly with traumatized individuals on a regular basis, including recurring and distressing thoughts about work or a specific client's trauma, emotional numbing and flooding, dissociative responses to clients' trauma experiences, triggering previous traumatic experiences; increased feelings of vulnerability, increased reactivity or hypervigilance, feelings of guilt or irritability, and decreased compassion and empathy (Adams & Riggs, 2008; Arvay, 2001; Buchanan, Anderson, Uhlemann & Horwitz, 2006; Cukor et al., 2010; Helm, 2016; Keim et al., 2008; Nelson, 2016). A counselor who is impaired or compromised by these symptoms risks harming the client and the counseling profession as whole. Examining the development and impact of VCT and subthreshold PTSD symptoms among counselors is critical; however, it is also essential to understand the variables or factors that counselors might develop while working with clients who have experienced trauma such as resilience. This may help identify factors linked to resiliency, as it relates to VCT and subthreshold PTSD among professional counselors working with traumatized populations. Thus far, only qualitative studies have been conducted to explore this relationship, and many have stated the need for a quantitative study exploring the relationship between resilience, VCT and subthreshold PTSD in

professional counselors. Moreover, by examining the possible presence of resiliency in counselors, we can better examine this relationship and better inform counselor education programs to protect future counselors and their clients from possible harm.

Purpose of the Study

The purpose of this study was to gain an understanding of the frequency of VCT and subthreshold PTSD symptoms among professional counselors and the factors, primarily resiliency, that may protect counselors from developing these symptoms. In order to better understand potential protective factors from VCT and subthreshold PTSD symptoms, the current study examined counselor resilience, as resiliency has never been examined in the VCT and subthreshold PTSD literature as a quantitative study. To fully understand VCT, subthreshold PTSD and resilience, this study also examined years of professional counseling experience, the extent of exposure to traumatic client experiences, and any personal history of trauma, and the influence that these factors have on VCT, subthreshold PTSD, and resilience. The results from this study provide implications for counselor educators to better train and prepare counselors-in-training to decrease VCT and subthreshold PTSD symptoms and maximize resiliency among professional counselors.

Research Questions

This study aims to investigate the following research questions:

Q1: What are the experiences of VCT and subthreshold PTSD among professional counselors who work with clients who have experienced trauma?

Q2: What is the relationship among the presence of VCT symptoms, subthreshold PTSD symptoms, and the level of resilience in professional counselors?

Q3a: What is the relationship among years of professional counseling experience, the amount of

client trauma exposure, and a personal experience of trauma on VCT symptoms in professional counselors?

Q3b: What is the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on subthreshold PTSD symptoms in professional counselors?

Q3c: What is the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on the level of resiliency in professional counselors?

Summary

There are multiple risk factors that professional counselors have identified that might contribute to increased risk of developing VCT and subthreshold PTSD symptoms. Research indicates that counselors who experience VCT and subthreshold PTSD symptoms may be negatively impacted both personally and professionally. However, there is limited information about the presence of VCT and subthreshold PTSD symptoms among professional counselors and the protective factors such as resiliency that may help prevent or alleviate some of these symptoms. This chapter reviewed the literature about these concerns, and the current study will further examine the relationship between the presence of VCT, subthreshold PTSD symptoms and resilience in professional counselors in order to help prevent these symptoms and provide implications for counselor education programs.

Chapter 2

Research Methodology

The purpose of this chapter is to discuss the research methodology that was used in this study, including the participants, procedures, measures, and data analysis. In this study, the relationship among the presence of VCT symptoms, subthreshold PTSD symptoms, and level of resiliency of professional counselors was examined. The presence of VCT symptoms and the presence of subthreshold PTSD symptoms in professional counselors was explored as well as the level of resilience in practicing counselors. In addition, the influence of years of professional counselor experience, client trauma exposure, and a personal experience of trauma was examined to determine if these factors contribute to the development of these symptoms or the level of resilience.

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Q3b: What is the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on subthreshold PTSD symptoms in professional counselors?

Q3c: What is the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on the level of resiliency in professional counselors?

Research Design

The current study was a quantitative design that utilized survey research. The purpose of quantitative survey research was to study a sample of population, provide a numeric description of trends of a population, and inferences are then drawn to that population (Creswell, 2014). This study utilized survey research to collect data on VCT symptoms, subthreshold PTSD symptoms, and the level of resiliency of professional counselors in order to examine the factors that protect professional counselors working with traumatized populations from developing these symptoms. In addition, survey research was used to gather data on the years of professional counselor experience, client trauma exposure, and any history of personal traumatic experiences. Data was collected through self-report surveys via an online link through Qualtrics specifically designed for research and data collection.

Participants

Participants for this study were recruited from a sample of currently practicing professional counselors. In order to participate in this study, participants were at least 19 years of age and had a minimum of a Master's degree in a counseling field, such as clinical mental health counseling, school counseling, community mental health counseling, clinical rehabilitation counseling, or marriage and family counseling. In addition, participants were practicing professional counseling for a minimum of six months, as these counselors are still considered novice counselors, but are acclimated to their job and seeing clients at that point. Finally, participants worked with clients who have experienced trauma to be included in this study.

Examples of traumatized populations include sexual assault, domestic violence, child abuse, substance misuse/recovery, offender rehabilitation programs, and prison populations. Following Auburn University IRB approval, the counselors in this study were recruited through various counseling association list-serves emails requesting their participation. These list-serves included: the American Counseling Association (ACA), the Alabama Counseling Association (ALCA), the Counselor Education and Supervision Network (CESNET), and the Alabama Network of Child Advocacy Centers (ANCAC) and other similar counseling list-serves. Each of these list-serves included practicing professional counselors who work with traumatized client populations. Snowball sampling was also utilized in this study to gain access to additional participants who might not be a part of these list-serves. Snowball sampling can be particularly beneficial because it allows the researcher to utilize current participants to gain access to other professionals within a unique population, such as counselors working with traumatized populations (Creswell, 2014; Vogt, 1999).

Procedures

Following approval from the Auburn University IRB, participants were recruited to participate in this study via email request through the American Counseling Association (ACA), the Alabama Counseling Association (ALCA), the Counselor Education and Supervision Network (CESNET), and the Alabama Network of Child Advocacy Centers (ANCAC), and similar counseling list-serves. Upon receiving the participation solicitation email, participants reviewed the informational letter and then provided assent to participate in this study. In the informational letter, participants were able to view the IRB approval letter and were informed that participation in this study does not pose any known risks to them and that they can chose to withdraw from the study and discontinue taking the survey at any time. A link with the surveys

was emailed via Qualtrics, and participants were able to take the survey anonymously at their convenience. Data were screened and cleaned prior to data analysis, and all incomplete surveys were removed from this study. Calculated GPower with a power of at least 0.80 and a small effect size indicates that approximately 140 participants were needed for this study based on the number of variables for a linear regression analysis. The surveys used for this study included a demographics questionnaire (see Appendix III), the *Secondary Trauma Stress Scale* (see Appendix IV), the *PTSD Checklist for DSM-5* (see Appendix V), and the *Resilience Scale* (see Appendix VI). All data were analyzed using SPSS software.

Instruments

The participants were asked to complete a demographic questionnaire and three other surveys as a part of this study. The demographic questionnaire included basic demographic information as well as years of professional experience, the percentage of their client caseload that participants identified as having been impacted by trauma, and whether or not participants had experienced any incidences of trauma themselves. Three established surveys were utilized to acquire data on the presence of VCT symptoms (*Secondary Trauma Stress Scale*), the presence of subthreshold PTSD symptoms (*PTSD Checklist for the DSM-5*), and the level of resilience (*The Resilience Scale*). These surveys were provided via Qualtrics to participants who were professional counselors. The data collected from these surveys was used to conduct data analysis.

Demographic Questionnaire

Demographic information was gathered by a demographic questionnaire that solicited data on the participants' age, gender, race, years of professional counseling experience, counseling population served, the percentage of their client caseload that they identified as

having been impacted by trauma, and whether or not the participant has ever personally experienced a traumatic event. These demographics and additional information provided necessary information on the relationship between these variables and the presence of trauma symptoms and level of resiliency in professional counselors.

Secondary Trauma Stress Scale **(STSS)**

The present study used the *Secondary Trauma Stress Scale* (STSS; Appendix IV) to examine the presence of VCT symptoms among professional counselors. The STSS was initially designed to assess for secondary trauma symptoms in social workers and other mental health professionals (Bride et al., 2004). The STSS is a 17-item self-report measure where responses are rated on a five-point Likert scale ranging from 1 (never) to 5 (very often) within the last seven days. The STSS assesses the frequency of trauma symptoms using three subscales: intrusion, avoidance, and arousal (Bride et al., 2004; Ting, Jacobson, Sanders, Bride, & Harrington, 2005). The possible range of STSS scores are as follows: STSS complete scale 17 – 85; STSS five item intrusion subscale 5 – 25; STSS seven item avoidance subscale 7 – 35; STSS five item arousal subscale 5 – 25 (Bride et al., 2004). Higher scores in each area reflect higher presence of traumatic symptoms (Bride et al., 2004).

Bride et al. (2004) demonstrated very good internal consistency reliability on the STSS complete scale (α=0.93), intrusion subscale (α=0.80), avoidance subscale (α=0.87), and arousal subscale (α=0.83). Similarly, Ting et al. (2005) demonstrated similar levels of internal reliability; however, they showed a high degree of covariation among the three subscales (Intrusion-Avoidance, r=0.96; Intrusion-Arousal, r=0.96; Avoidance-Arousal, r=1.0), suggesting that the full STSS measure is a sufficient measure of secondary traumatic symptoms such as symptoms

of VCT (Ting et al., 2005). Sample survey items include “I felt emotionally numb”, “I had trouble sleeping”, and “I expected something bad to happen”.

PTSD Checklist for DSM-5 **(PCL-5)**

The *PTSD Checklist for the DSM-5* (PCL-5; Appendix V) is a 20-item self-report questionnaire that measures the presence of PTSD symptoms (Blevins, Weathers, Davis, Witte, & Domino, 2015). The PCL-5 was derived from the original PCL after the DSM-5 was published in 2013, and the PCL-5 is the only inventory that measures PTSD according to the DSM-5 diagnostic criteria (Blevins et al., 2015). Each question asks respondents to indicate how much they have been bothered by a specific symptom within the last month. Sample items include “feeling distant or cut off from people,” “being super-alert, jumpy, or on guard,” and “trouble remembering important parts of the stressful experience.” The PCL-5 has a 5 point Likert scale for each question: 0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit, or 4 = extremely. Responses are then added to compile a total severity score, with a maximum score of 80 (Blevins et al., 2015).

The PCL-5 assessed each of the DSM-5 symptom criteria for PTSD (intrusions, avoidance, negative changes in cognition and mood, and arousal and reactivity) with the exception of criteria A (exposure to a traumatic event). Studies have found high internal consistency of α=0.94 (Blevins et al., 2015) and α=0.96 (Bovin, Marx, Weathers, Gallagher, Rodriguez, Schnurr, & Keane, 2015). In addition, test-retest reliability coefficients of r=0.82 (Blevins et al., 2015) and r=0.84 (Bovin et al., 2015) were found.

The Resilience Scale **(RS)**

Wagnild and Young (1990) developed the Resilience Scale (Appendix VI) and identified and defined five characteristics of resilience: purpose, perseverance, equanimity, self-reliance,

and existential aloneness. The RS assesses each of these five characteristics across 25 items (Wagnild & Young, 1990). The 25 items are rated on a 7-point Likert scale ranging from 1 – Strongly Disagree to 7 – Strongly Agree. Participants are asked to indicate the extent to which they agree with statements such as "my life has meaning," "I don't dwell on things that I can't do anything about," and "I am determined." Total resilience scores range from 25 – 175, with scores below 125 indicating a low level of resilience, scores between 125 – 145 indicating a moderate level of resilience, and scores above 145 indicating a moderately high to high level of resilience (Wagnild & Young, 1990). A meta-analysis of studies (Wagnild & Collins, 2009) using the Resilience Scale provided internal consistency coefficients that were consistently acceptable and moderately high (α=0.73 to 0.91). Futhermore, Wagnild and Collins (2009) found that RS scores were inversely related to stress, depression, loneliness, and hopelessness.

Data Analysis

The current study had three aims: 1) to identify the experiences of VCT and subthreshold PTSD among professional counselors who work with clients who have experienced trauma, 2) to examine the relationship between the presence of VCT symptoms, subthreshold PTSD symptoms, and the level of resilience in professional counselors, and 3) to explore the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on VCT symptoms, subthreshold PTSD, and the level of resilience in professional counselors. The presence of VCT symptoms was determined by the STSS, the presence of subthreshold PTSD symptoms was determined by the PCL-5, and the level of resiliency was determined by the *Resilience Scale*. Years of professional experience, the amount of client trauma exposure, and whether or not there is a history of a personal incidence of a traumatic experience was examined in the Demographic Questionnaire.

Descriptive statistics and linear multiple regression analyses were utilized for the current study. Findings are organized and displayed in charts and graphs.

Limitations

Non-experimental self-report survey research by nature is a limitation as there is no experimental control group, manipulation to the independent variable, or randomized selection of groups (Creswell, 2014). Considering these limitations, no causal links between variables can be inferred (Creswell, 2014). In addition, the self-report nature of this study poses limitations to the validity of the study, as participants' self-reported responses are the only sources of data. The Internet survey will be emailed to participants through counseling listservs; however, if professional counselors are not signed up within these listservs, they will not receive this survey unless recruited by a participant via snowball sampling. While this is the most efficient way to reach many professional counselors, it poses a limitation in that not all professional counselors will receive the survey.

Summary

This chapter discussed the methodology and procedures that were followed to explore the presence of VCT symptoms, the presence of subthreshold PTSD symptoms, and the level of resilience in professional counselors. Other variables that were examined include the years of professional counseling experience, the amount of client trauma exposure, and whether or not a history of a personal incidence of trauma has occurred. Data was collected using a demographics questionnaire, the *Secondary Trauma Stress Scale* (Bride et al., 2004), the *PTSD Checklist for DSM-5* (Blevins et al., 2015), and the *Resilience Scale* (Wagnild & Young, 1990). Descriptive statistics and linear regression models using SPSS were utilized to examine these relationships.

Chapter 3

Results

Introduction

The purpose of this quantitative study was to gain an understanding of the frequency of VCT and subthreshold PTSD symptoms among professional counselors and the factors, primarily resiliency, that may protect counselors from developing these symptoms. Additionally, this study aimed to investigate the relationship between years of professional experience, trauma caseload, and a personal experience of trauma on VCT symptoms, subthreshold PTSD symptoms, and the level of resiliency in professional counselors. For this study, the researcher utilized the *Secondary Trauma Stress Scale* (STSS), the *PTSD Checklist for the DSM-5* (PCL-5), the *Resilience Scale* (RS), and a brief demographic questionnaire.

The present study sought to explore the experiences of VCT and subthreshold PTSD among professional counselors who work with clients who have experienced trauma, as well as the relationship among the presence of VCT symptoms and subthreshold PTSD symptoms on the level of resilience in professional counselors. Additionally, this study sought to examine the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on VCT symptoms, subthreshold PTSD symptoms, and level of resiliency in professional counselors. Descriptive statistical analyses were used to describe the experiences of VCT and subthreshold PTSD among professional counselors who work with clients who have experienced trauma (research question 1). A linear regression was used to determine the relationship of VCT symptoms and subthreshold PTSD symptoms on the level of resiliency in professional counselors (research question 2). Finally, linear regression analyses were used to determine the relationship among years of professional

counseling experience, the amount of client trauma exposure, and a personal experience of trauma on VCT symptoms, subthreshold PTSD symptoms, and level of resiliency in professional counselors who work with traumatized populations.

Demographics

As reported in **Table 1**, a total of 211 professional counselors participated in the current study. Of the 211 participants, 199 participants reported their gender; 17 (8.1%) participants indicated they identified as male, 179 (84.8%) participants indicated they identified as female, and 2 (0.9%) participants indicated they identified as nonbinary. Studies show that the national population of counselors is an estimated 73% females and 27% males, so this sample is representative of the national population (Rocheleau, 2019).

A total of 198 participants reported their highest level of completed education; 152 (76.8%) of participants indicated having a Master's Degree, 43 (21.7%%) of participants indicated having a Doctoral Degree, and 3 (1.5%) participants indicated having an Education Specialist Degree. Of the 211 total participants, 198 participants indicated whether or not they are currently licensed in counseling, and 181 (91.4%%) reported they are currently licensed and 17 (8.6%) participants reported that they are not licensed. 195 participants indicated their years of professional counseling experience, and participants reported a range of 1 – 40 years of counseling experience, with an average of 9.94 years of professional counseling experience.

Participants were also asked to indicate the current client population(s) that they currently serve, and 180 (85.3%) participants indicated child abuse/neglect, 164 (77%) participants indicated sexual assault/violence, 143 (67.8%) participants indicated loss/grief/bereavement, 70 (33.2%) participants indicated severe mental illness, 63 (29.9%) participants indicated substance misuse/recovery, 63 (29.9%) participants indicated intimate partner violence, 43 (20.4%)

participants indicated combat/military duty, 14 (6.6%) participants indicated offender rehabilitation programs, and 8 (3.8%) participants indicated working with the prison population.

Participants were also asked to indicate the approximate percentage of their current caseload of clients who have experienced a traumatic event, and 192 participants indicated a range of 25% - 100%, with an average trauma caseload of 75.1%. Finally, 194 participants indicated the extent to which they have directly experienced a traumatic event themselves; 22 (10.4%) participants reported never having personally experienced a traumatic event, 113 (53.6%) participants indicated that they have experienced a traumatic event to some extent, and 59 (28%) participants indicated that they have experienced a traumatic event to a severe or great extent. Participants were asked to indicate whether or not they have ever sought out counseling services for their own personal experience(s) of trauma, and 126 (59.7%) participants reported that they have, 64 (30.3%) participants reported that they have not, and 7 (3.3%) participants indicated that they preferred not to answer.

The mean, standard deviation, and reliability statistics are reported in **Table 2** for the *Secondary Trauma Stress Scale* (STSS), the *PTSD Checklist for the DSM-5* (PCL-5), and the *Resilience Scale* (RS).

Table 1
Demographic Information

Characteristic		N	Percentage
Gender	Female	179	84.8%
	Male	17	8.1%
	Nonbinary	2	0.9%
Race/Ethnicity	White	156	73.9%
	African American	22	10.4%
	Asian	3	1.4%
	Hispanic/Latinx	18	8.5%
	Native Hawaiian	2	0.9%
	American Indian	1	0.5%
	Biracial/Multiracial	2	0.9%

Education	Master's Degree	152	76.8%
	Doctoral Degree	43	21.7%
	Education Specialist Degree	3	1.5%
Licensed	Yes	181	91.4%
	No	17	8.6%
Client Population(s)	Child Abuse/Neglect	180	85.3%
	Sexual Assault/Violence	164	77.7%
	Loss/Grief/Bereavement	143	67.8%
	Severe Mental Illness	70	33.2%
	Substance Misuse/Recovery	63	29.9%
	Intimate Partner Violence	63	29.9%
	Combat/Military Duty	43	20.4%
	Offender Rehabilitation	14	6.6%
	Prison Population	8	3.8%
Personal Traumatic Experience	None At All	22	11.3%
	Some Extent	113	58.2%
	Severe or Great Extent	59	30.4%
Sought Counseling For Traumatic Experience	Yes	126	64%
	No	64	32.5%
	Prefer Not To Answer	7	3.5%

Table 2
Scale Reliability Statistics

Scale	N	Mean	SD	Cronbach's Alpha
STSS (Full Scale)	17	1.93	.58	.899
STSS – Intrusion Scale	5	1.887	.564	.679
STSS – Avoidance Scale	7	1.903	.686	.83
STSS – Arousal Scale	5	2.013	.74	.783
PCL-5	20	1.418	.46	.924
Resilience Scale	25	5.872	.61	.921

Research Question 1: What are the experiences of VCT and subthreshold PTSD among professional counselors who work with clients who have experienced trauma?

Descriptive statistics based on participants' responses indicated that there are symptoms of vicarious trauma presently experienced by professional counselors. In contrast, descriptive statistics indicated that there are few symptoms of subthreshold PTSD being experienced by

professional counselors. Regarding the STSS, a majority of the vicarious trauma symptoms were experienced by at least 50% of the participants to some degree. Symptoms were rated significant if they scored "Never" higher than 50% on the STSS, indicating that the participant had experienced the symptom to some degree in the past seven days.

The most common symptom of vicarious trauma experienced by the participants was thinking about work with clients when the counselor did not intend to do so (88.1%), as indicated by the STSS. Other vicarious trauma symptoms experienced by more than 50% of the participants include: being easily annoyed (71%), trouble concentrating (71%), trouble sleeping (70.5%), feeling emotionally numb (69.7%), wanting to avoid working with some clients (69%), getting upset by reminders of work with clients (61.9%), feeling discouraged about the future (59.5%), experiencing his/her heart pounding when thinking about work with clients (59%), feeling less active than normal (54.3%), and having little interest in being around others (53.3%). Having disturbing dreams about his/her work with clients (29.5%) was the least common experienced symptom of various trauma by the participants. **Table 3** outlines the vicarious trauma symptoms measured by the STSS in descending order.

The PCL-5 was utilized to measure symptoms of subthreshold PTSD, and participants' responses indicated that few symptoms of subthreshold PTSD are being experienced by professional counselors. Symptoms were rated as significant if they scored higher than "Not at All", indicating that they had experienced the symptom to some degree within the past seven days. Participants indicated that they experienced two subthreshold PTSD symptoms within the past seven days: having difficulty concentrating (52.2%) and having difficulty falling or staying asleep (51.7%). Suddenly acting or feeling as if his/her client's traumatic experience were happening again within his/herself (6.5%) and having repeated, disturbing dreams of his/her

client's traumatic experience (9.5%) were the least common experienced symptoms of subthreshold PTSD by the participants. **Table 4** outlines the subthreshold PTSD symptoms measured by the PCL-5 in descending order.

Table 3
STSS Symptom Distribution

Item in Descending Order	N (%)
I thought about my work with clients when I didn't intend to.	185 (88.1%)
I was easily annoyed.	149 (71%)
I had trouble concentrating.	149 (71%)
I had trouble sleeping.	148 (70.5%)
I felt emotionally numb.	147 (69.7%)
I wanted to avoid working with some clients.	145 (69%)
Reminders of my work with clients upset me.	130 (61.9%)
I felt discouraged about the future.	125 (59.5%)
My heart started pounding when I thought about my work with clients.	124 (59%)
I was less active than usual.	114 (54.3%)
I had little interest in being around others.	112 (53.3%)
I expected something bad to happen.	96 (45.7%)
It seemed as if I was reliving the trauma(s) experienced by my client(s).	91 (43.3%)
I noticed gaps in my memory about client sessions.	89 (42.4%)
I felt jumpy.	88 (41.9%)
I avoided people, places, or things that reminded me of my work with clients.	87 (41.4%)
I had disturbing dreams about my work with clients.	62 (29.5%)

Table 4
PCL-5 Symptom Distribution

Item in Descending Order	N (%)
I have difficulty concentrating.	105 (52.2%)
I have trouble falling or staying asleep.	104 (51.7%)
I feel irritable or have angry outbursts.	97 (48.3%)
I have strong negative beliefs about myself, other people, or the world (such as the world is completely dangerous, or no one can be trusted).	93 (46.3%)
I am "super alert" or watchful or on guard.	83 (41.3%)
I feel distant or cut off from other people.	82 (40.8%)
I feel very upset when something reminds me of a client's traumatic experience.	66 (32.8%)
I have strong negative feelings such as fear, horror, anger, guilt, or shame.	65 (32.2%)
I have trouble experiencing positive feelings.	63 (31.3%)
I feel jumpy or am easily startled.	60 (29.9%)
I have lost interest in activities I used to enjoy.	58 (28.9%)
I avoid memories, thoughts, or feelings related to my client's traumatic experience.	57 (28.4%)
I avoid external reminders of my client's traumatic experience (such as people, places, conversations, activities, objects, or situations).	45 (22.4%)
I have trouble remembering important parts of my client's traumatic experience.	43 (21.4%)
I have repeated, disturbing, and/or unwanted memories of a client's traumatic experience.	41 (20.4%)
I have strong physical reactions when something reminds me of a client's traumatic experience (such as heart pounding, trouble breathing, or sweating).	34 (16.9%)

I blame myself or someone else for the traumatic experience or for what happened after it.	32 (15.9%)
I take too many risks that could cause myself harm.	22 (10.9%)
I have repeated, disturbing dreams of my client's traumatic experience.	19 (9.5%)
I suddenly act or feel as if my client's traumatic experience were happening again within myself.	13 (6.5%)

Research Question 2: What is relationship among the presence of VCT symptoms and subthreshold PTSD symptoms on the level of resilience in professional counselors?

A backward linear regression model was run to determine the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms on the level of resilience in professional counselors. The three STSS subscales (Intrusion, Avoidance, and Arousal) that measured vicarious trauma symptoms were each entered as dependent variables as well as the PCL-5, which measured subthreshold PTSD symptoms, and the Resilience Scale, measuring level of resilience, was entered as the independent variable in a backward linear regression model. Results indicate that fewer vicarious trauma and subthreshold PTSD symptoms experienced by counselors, the higher the level of resiliency in professional counselors. The assumptions for linearity, homoscedasticity, and the absence of autocorrelation were found to be true through the examination of scatterplots. The assumption of multivariate normality was found to be true through a goodness of fit test. The assumption of the absence of multicollinearity was found to be true by examining Pearson's Bivariate Correlation matrix.

Results indicate a significant relationship between all three STSS subscales, the PCL-5, and resilience. There was a significant relationship between Intrusion symptoms and level of resilience ($r = -.282$, $p < .001$), indicating the fewer intrusion symptoms of vicarious trauma experienced, the higher the resiliency in the professional counselor. There was also a significant

relationship between Avoidance symptoms and level of resilience ($r = -.43$, $p < .001$), meaning the fewer avoidance symptoms of vicarious trauma experienced, the higher the resiliency in the professional counselor. Finally, there was a significant relationship between Arousal symptoms and level of resilience ($r = -.433$, $p < .001$), indicating the fewer intrusion symptoms of vicarious trauma experienced, the higher the resiliency in the professional counselor. Results also indicate a significant relationship between subthreshold PTSD symptoms and resilience in professional counselors ($r = -.469$, $p < .001$), meaning the fewer subthreshold PTSD symptoms experienced, the higher level of resilience in professional counselors.

Fewer subthreshold PTSD symptoms was the most predictive variable associated with higher levels of resilience in professional counselors, as evidenced in the restricted model regression summary. In the backward regression model, the Intrusion subscale of the STSS was first eliminated as the least significant variable, and the Arousal variable was then eliminated as the next least significant variable. This indicates that the fewer subthreshold PTSD symptoms experienced by professional counselors, the higher the level of resiliency. In the Full Model (R^2 Full = .246, ($F = 15.721$), $p < .001$), results indicate a significant relationship, and the Full Model explained 24.6% of variance in Resilience Scale scores. The Restricted Model, comprised of the PCL-5 and Avoidance STSS subscale, (R^2 Restricted = .236, ($F = 30.17$), $p < .001$), results also yield a significant relationship. The Restricted Model explained 23.6% of the variance in Resilience Scale scores. Regression results and correlation summaries are outlined in **Table 5**.

Table 5
Regression Findings – Backward Regression – STSS & PCL on Resilience Scale

Factor	R^2	S.E Estimate	Beta	Semi-partial	r
Full Model	.246[a]	.536			
PCL-5			-.310**	-.177	-.469***
STSS-Intrusion			.097	.071	-.282***
STSS-Avoidance			-.251	-.098	-.430***
STSS-Arousal			-.269	-.078	-.433***
Restricted Model	.236[b]	.537			
PCL-5			-.334***	-.228	
STSS-Avoidance			-.185*	-.126	

p<.05,p<.01,***p<.001*
a-F = 15.721, p < .001***
b-F = 30.17, p < .001***

Research Question 3a: What is the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on VCT symptoms in professional counselors?

Three backward linear regression models were utilized to determine the relationship between years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on vicarious trauma symptoms. Backward elimination linear regression analyses on the STSS subscales of vicarious trauma symptoms (intrusion, avoidance, and arousal) yielded significant findings regarding arousal vicarious symptoms in professional counselors. The assumptions for linearity, homoscedasticity, and the absence of autocorrelation were found to be true through the examination of scatterplots. The assumption of multivariate normality was found to be true through a goodness of fit test. The assumption of the absence of multicollinearity was found to be true by examining Pearson's Bivariate Correlation matrix.

There were two significant relationships found within the Arousal STSS subscale regression. There was a slight significant negative correlation between years of professional experience and arousal vicarious trauma symptoms ($r = -.143$, $p = .025$), indicating that the more years of experience a counselor has, the fewer vicarious trauma symptoms the counselor experienced. The second significant correlation denoted that counselors who personally experienced a trauma event were more likely to experience more arousal vicarious trauma symptoms ($r = 0.148$, $p = 0.21$). Overall, the results from the backward elimination regression model indicate a significant relationship between arousal vicarious trauma symptoms and the relationship between years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma in professional counselors, $R^2 = .053$, $F= 15.721$, $p = .017$. In this Full Model, years of professional counseling experience and arousal symptoms resulted in a significant relationship, indicating that the more years of experience a counselor has can possibly lessen the experience of arousal vicarious trauma symptoms in professional counselors. In contrast, a personal experience of trauma and arousal symptoms also yielded a significant relationship, indicating that a personal traumatic experience can possibly increase a person's arousal vicarious trauma symptoms. The Full Model explained 5.3% of the variance in STSS Arousal scores. The Restricted Model (R^2 Restricted = .035, ($F = 4.46$), $p = .013$), results also yield a significant relationship between years of experience and personal experiences of trauma in predicting arousal vicarious trauma symptoms. The Restricted Model explained 3.5% of variance in STSS Arousal scores. Regression results and correlation summaries for the Arousal STSS subscale are outlined in **Table 6**.

No significant relationships between years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on the Intrusion or

Avoidance STSS subscale were found. Regression results and correlation summaries for the Intrusion and Avoidance STSS subscale are outlined in **Table 6.**

Table 6
RQ3a: Regression Findings – Backward Regression (DV=STSS Arousal)

Factor	R^2	S.E Estimate	Beta	Semi-partial	r
Full Model	.053[a]	.720			
Years of Experience			-.149*	-.148	-.143*
Trauma Caseload			.089	.087	.116
Personal Trauma Experience			.148*	.147	.148*
Restricted Model	.035[b]	.721			
Years of Experience			-.155*	-.155	
Personal Traumatic Experience			.159*	.159	

p<.05,p<.01,***p<.001*
a-F = 15.721, p = .017*
b-F = 4.46, p = .013*

RQ3a: Regression Findings – Backward Regression (DV=STSS Intrusion)

Factor	R^2	S.E Estimate	Beta	Semi-partial	r
Full Model	.018[a]	.572			
Years of Experience			-.124	-.122	-.114
Trauma Caseload			-.020	-.020	-.007
Personal Trauma Experience			.068	.067	.051
Restricted Model	.013[b]	.573			

*p<.05,**p<.01,***p<.001
a-F = 1.114, p = .345
b-F = 2.463, p = .118

RQ3a: Regression Findings – Backward Regression (DV=STSS Avoidance)

Factor	R^2	S.E Estimate	Beta	Semi-partial	r
Full Model	.028[a]	.6907			
Years of Experience			-.097	-.097	-.099
Trauma Caseload			.069	.069	.085
Personal Trauma Experience			.110	.110	.114
Restricted Model	.013[b]	.692			

*p<.05,**p<.01,***p<.001
a-F = 1.78, p = .152
b-F = 2.479, p = .117

Research Question 3b: What is the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on subthreshold PTSD symptoms in professional counselors?

A backward elimination linear regression model was utilized to determine the relationship between years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on subthreshold PTSD symptoms. While no significant relationships were found in regard to subthreshold PTSD symptoms, a slight correlation between a personal experience of trauma and subthreshold PTSD symptoms was found to be just above the significance level of .05 (r = .119, p = .051), indicating that counselors who personally experienced a trauma event were more likely to experience subthreshold PTSD symptoms. Regression results and correlation summaries for the PCL-5 are outlined in **Table 7**.

Table 7
RQ3b: Regression Findings – Backward Regression (DV=PCL-5)

Factor	R^2	S.E Estimate	Beta	Semi-partial	r
Full Model	.022[a]	.467			
Years of Experience			-.068	-.068	-.066
Trauma Caseload			.054	.054	.07
Personal Trauma Experience			.116	.116	.119
Restricted Model	.014[b]	.46625			

p<.05,p<.01,***p<.001*
a-F = 1.403, p = .244
b-F = 2.707, p = .102

Research Question 3c: What is the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on the level of resiliency in professional counselors?

A backward linear regression model was used to determine the relationship between years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on the level of resiliency in professional counselors. A backward elimination linear regression analysis on the Resilience Scale yielded significant findings regarding years of professional counseling experience. The significant correlation denoted that counselors who had more years of professional counseling experience were more likely to have a higher level of resilience ($r = 0.233$, $p > 0.001$).

Overall, these results indicate a significant relationship between the level of resilience and the relationship between years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma in professional counselors, $R^2 = .061$, $F = 4.026$, $p = .008$. In this Full Model, years of professional counseling experience and level of

resilience resulted in a significant relationship, indicating that the more years of experience a counselor has is predictive of a higher level of resilience in professional counselors. The Full Model explained 6.1% of variance in Resilience Scale scores. The Restricted Model (R^2 Restricted = .054, (F = 10.699), p = .001) indicates that years of professional experience is predictive of a higher level of resilience in professional counselors. The Restricted Model explained 5.4% of variance in Resilience Scale scores. Regression results for the Resilience Scale are outlined in **Table 8**. All Beta values for Years of Professional Experience, Trauma Caseload, and a Personal Experience of Trauma are reported in **Table 9**.

Table 8
RQ3c: Regression Findings – Backward Regression (DV=Resilience Scale)

Factor	R^2	S.E Estimate	Beta	Semi-partial	r
Full Model	.061[a]	.585			
Years of Experience			.227**	.226	.233***
Trauma Caseload			.012	.012	-.002
Personal Trauma Experience			.084	.084	.101
Restricted Model	.054[b]	.584			
Years of Experience			.233***	.233	

p<.05,p<.01,***p<.001*
a-F = 4.024, p = .008**
b-F = 10.699, p = .001***

Table 9
Beta Values: Variables Retained in Final Model for Each Construct

Constructs (DV)	RQ3a - Arousal	RQ3a - Intrusion	RQ3a - Avoidance	RQ3b - PCL-5	RQ3c - Resilience
Years of Experience	-.155*				.233***
Trauma Caseload					
Personal Trauma Experience	.159*				

p<.05,p<.01,***p<.001*

Summary

This study was conducted to gain an understanding of the frequency of and the relationships between vicarious trauma symptoms, subthreshold PTSD symptoms, and level of resilience among professional counselors. Furthermore, this study aimed to investigate the relationship between years of professional experience, trauma caseload, and a personal experience of trauma on VCT symptoms, subthreshold PTSD symptoms, and the level of resiliency in professional counselors. To answer these questions, a brief demographic questionnaire, the *Secondary Trauma Stress Scale* (STSS), *the PTSD Checklist for the DSM-5* (PCL-5), and the *Resilience Scale* (RS) were used. Results from the current study indicate that there are significant relationships between the Intrusion, Avoidance, and Arousal STSS subscales and resilience in professional counselors, indicating that the fewer vicarious trauma symptoms experienced, the higher the level of resilience in counselors. Additionally, this study found years of professional experience resulted in fewer arousal vicarious trauma symptoms and a higher level of resilience. Furthermore, having personally experienced a traumatic event resulted in higher arousal vicarious trauma symptoms.

Chapter 4

Discussion

The purpose of the current study was to develop an understanding of the vicarious trauma and subthreshold PTSD symptoms experienced by professional counselors and the factors related to resiliency that protect counselors from developing these symptoms, such as years of professional counseling experience, the amount of one's trauma caseload, and a personal experience of trauma. Results from the *Secondary Trauma Stress Scale* (STSS), the *PTSD Checklist for the DSM-5* (PCL-5), the *Resilience Scale* (RS), and a brief demographic questionnaire will be reviewed in this chapter. Additionally, implications for professional counselors and counselor educators to mitigate and lessen the symptoms of vicarious trauma and subthreshold PTSD and maximize resiliency will also be discussed within this chapter. Finally, limitations to the current study and recommendations for future research will be discussed in this chapter.

Overview

National surveys indicate that at least 70% of adults have experienced at least one traumatic event in their lifetime (PTSD United, 2013). Types of traumatic experiences include an isolated incident or multiple circumstances perceived by the individual as emotionally or physically threatening, harmful, or overwhelming, that have the ability to cause long lasting negative and adverse effects on the individual's mental, physical, social, emotional, and/or spiritual well-being (Substance Abuse and Mental Health Services Administration, 2016). Nearly eight million people experience symptoms of post-traumatic stress disorder (PTSD) on a daily basis from both indirect and direct exposure to traumatic events (Tuma, 2013; Kilpatrick et al., 2013). Counselors are being increasingly exposed to the traumatic experiences of their clients,

and these numbers reflect the heightened risk for counselors to be exposed to the secondary trauma of their clients, resulting in possible vicarious trauma or subthreshold PTSD. In fact, Bride (2004) found that in community mental health agencies, as many as 82% and 94% of clients receiving mental health services had experienced some form of trauma.

As counselors empathically listen to their clients' traumatic experiences on a regular basis, there is a potential for counselors to be negatively impacted and become impaired (Abassary & Goodrich, 2014; Harrison, 2009). Additionally, without appropriate or effective protective factors in place, counselors are at risk of experiencing vicarious trauma from exposure to clients' traumatic events (Harrison, 2009; Nelson, 2016). Vicarious trauma results in a negative transformation within the counselor that disrupts and alters the counselor's view of their self, others, and the world as a result of chronic engagement with their clients (Jordan, 2010; McCann & Pearlman, 1990; Michalopoulos & Aparicio, 2012; Nelson, 2016; Williams et al., 2012). In fact, the prevalence rate of vicarious trauma is 45.9% among professional counselors (Dunkley & Whelan, 2006). Vicarious trauma symptoms closely mirror the symptoms of PTSD (Bergman et al., 2015; Nelson, 2016). Counselors who may develop these symptoms do not typically meet full the full diagnostic criteria of PTSD, but instead experience subthreshold PTSD which is the presence of clinically significant PTSD symptoms that fall short of the full PTSD diagnostic criteria (Bergman et al., 2015).

While it is important to examine the presence and severity of VCT and subthreshold PTSD, it is equally as important to examine what keeps experienced professional counselors who are exposed to trauma content in their work from developing these symptoms. Numerous studies have explored various protective factors to mitigate and lessen the detrimental effects of vicarious trauma and subthreshold PTSD in professional counselors (Abassary & Goodrick,

2014; Foreman, 2018; Knight, 2013; Lambert & Lawson, 2013; Lonn & Haiyasoso, 2016; Nelson, 2016). Resilience has also been described as the successful adaptation to stressful circumstances and one's ability to "bounce back" from unfavorable circumstances (Cohen, Ferguson, Harms, Pooley, & Tomlinson, 2011; Wagnild & Collins, 2009). More recent studies have explored the relationship between resilience and the clinical experience of mental health professionals (Lambert & Lawson, 2013; Pack, 2014). In a recent comprehensive review, Hernandez-Wolfe (2018) discussed the paucity of quantitative research that explores the relationship between resilience and mental health professional working with traumatized populations. Results from the present study can be used in professional counseling settings and by counselor educators to mitigate VCT and subthreshold PTSD and maximize resilience in professional counselors.

The current study was designed to develop an understanding of the frequency of VCT and subthreshold PTSD symptoms among professional counselors and the factors, such as resiliency, that may protect counselors from developing these detrimental symptoms as well as the relationship between years of professional experience, trauma caseload, and a personal experience of trauma on VCT symptoms, subthreshold PTSD symptoms, and the level of resilience in professional counselors.

Discussion of Results

As many as 50% of professional counselors are at risk for developing VCT symptoms, and the estimated prevalence rate of VCT among counselors is 45.9% (Dunkley & Whelan, 2006; National Child Traumatic Stress Network, 2011). The present study sought to develop an understanding of the frequency of VCT symptoms and subthreshold PTSD symptoms experienced by professional counselors. A majority of all of the vicarious trauma symptoms (11

out of the 17 symptoms), as measured by the STSS, were experienced by at least 50% of the participants, indicating that a majority of the VCT symptoms were experienced by the participants within the last seven days to some degree. The most common symptom of vicarious trauma experienced by professional counselors (88.1%) was thinking about work with clients when the counselor did not intend to do so. This finding adds to the existing literature that a majority of counselors are at risk of experiencing symptoms of vicarious trauma.

The current study also aimed to gain an understanding of the frequency of subthreshold PTSD symptoms by professional counselors. Based on the existing literature, it was expected that the frequency of subthreshold PTSD symptoms be consistent with the symptoms of VCT experienced. In this study, only two subthreshold PTSD symptoms were experienced by at least 50% of the participants, indicating that professional counselors in this study did not experience as many symptoms of subthreshold PTSD as they experienced symptoms of VCT. This finding suggests that the relationship may not exist as indicated in the current literature and further research exploring this relationship would be beneficial.

The present study also aimed to develop an understanding of the relationship between VCT and subthreshold PTSD symptoms on the level of resilience in professional counselors. Results indicated significant negative correlations between the VCT symptoms and resilience as well as between subthreshold PTSD symptoms and resilience, indicating lower symptoms of VCT and subthreshold PTSD were correlated with higher levels of resilience in professional counselors.

Results in this study suggest that the fewer subthreshold PTSD and VCT symptoms experienced by counselors, the higher the level of resilience experienced by professional counselors. The overall results also suggest that the fewer subthreshold PTSD symptoms and

avoidance vicarious trauma symptoms experienced, the higher level of resilience in professional counselors. Additionally, results from this study indicate that arousal and intrusion vicarious trauma symptoms were not found to be significant indicators of level of resilience. The results from this study are consistent with the recent finding from recent study that found that counselors with higher levels of wellness who were exposed to client trauma exhibited significantly lower levels of vicarious traumatization (Foreman, 2018). While this study didn't directly examine level of resilience, they explored wellness, and research suggests that resilience is considered to be a form of wellness (Wagnild & Collins, 2009).

Finally, the current study aimed to examine the relationship between specific factors of resilience such as years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on the VCT symptoms, subthreshold PTSD symptoms, and the level of resilience in professional counselors. When examining the relationship between years of experience, trauma caseload, and a personal traumatic incident on vicarious trauma symptoms, the findings of this study suggested a significant relationship between arousal vicarious trauma symptoms and the relationship between years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma in professional counselors.

Results in this study also suggest a significant relationship between years of experience and personal experiences of trauma in predicting arousal vicarious trauma symptoms. More specifically, these results indicate that the more years of experience a professional counselor has, the fewer arousal VCT symptoms experienced. This finding suggests that years of experience may serve as a buffer to developing symptoms of VCT or that counselors with more years of experience have learned to address and cope with their VCT symptoms in order to lessen their

experiences of VCT. It would be beneficial for future studies to further explore this relationship to gain a better understanding of what occurs within counselors who work with traumatized populations over time to better understand what correlates with keeping counselors in the profession so they can attain higher levels of professional experience. Another significant finding of this study indicates a personal experience of trauma is predictive of higher arousal VCT symptoms. In essence, this finding suggests that personally experiencing trauma may make professional counselors more vulnerable to experiencing arousal VCT symptoms.

When examining the relationship between the level of resilience in professional counselors and years of professional counseling experience, trauma caseload, and a personal experience of trauma, the findings of this study suggest that counselors who had more years of professional counseling experience were more likely to have a higher level of resilience. More specifically, this finding suggests that the more professional counseling experience a counselor has may be a protective factor in that counselor's work with clients. This finding adds to the counseling literature as years of experience has been previously found to be predictive of higher resilience in the medical helping field (Gillespie, Chaboyer, Wallis, & Grimbeek, 2007), but never in the counseling literature to date.

Overall, the results from this study indicate that having a high trauma client caseload was not found to be a significant indicator of VCT symptoms, subthreshold PTSD, or level of resilience in professional counselors. Previous research suggests that high counseling caseloads consisting of treating clients with a history of trauma put counselors at a greater risk for developing vicarious trauma (Brockhouse, Msetfi, Cohen & Joseph, 2011; Devilly, Wright & Varker, 2009). However, a recent study found that higher trauma caseloads had no impact on the counselor's development of vicarious trauma (Foreman, 2018), which is consistent with the

findings of this study. When examining the relationship between subthreshold PTSD symptoms and years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma, the results of this study did not indicate any significant relationships or findings. The results of this study suggest that the relationship may not exist as indicated in the current literature and further research exploring protective factors for subthreshold PTSD would be beneficial.

Implications for Counselors and Counselor Educators

The results of the present study provide counselors, counselors educators, and supervisors with valuable information to better educate and prepare counselors-in-training to ideally avoid or to mitigate VCT symptoms and subthreshold PTSD symptoms. Findings from this research study provide evidence that professional counselors are experiencing numerous VCT symptoms currently. In fact, this study found that a majority of the VCT symptoms measured were experienced by at least 50% of the participants. With a majority of participants reporting experienced VCT symptoms to some extent, it is evident that continued education, training, and professional development regarding vicarious trauma symptoms is needed.

For maximum effectiveness, it is imperative that this occurs throughout various levels of counselor development. For example, counselors-in-training should be educated on vicarious trauma and how to recognize VCT symptoms within themselves. In fact, CACREP (2014) mandates that accredited counselor programs educate counseling students on trauma related counseling skills and to effectively take care of themselves to avoid developing VCT and subthreshold PTSD symptoms. This education should be imbedded within counselor education curriculum, with special, targeted emphasis on this content in Crisis Intervention Counseling courses and within practicum and internship. Keim et al. (2008) suggested that educational

trainings and workshops be provided to counselors-in-training to decrease symptoms of vicarious trauma and subthreshold PTSD. Finally, counseling supervisors would greatly benefit from training and continuing education on recognizing the signs and symptoms of vicarious trauma and how to reduce those symptoms, which would benefit counselors of all developmental levels (Sommer, 2008).

This study denoted that years of professional counseling experience is predictive of fewer arousal vicarious trauma symptoms and a higher level of resilience. Years of experience may serve as a buffer to developing symptoms of VCT or that counselors with more years of experience have learned to address and cope with their VCT symptoms in order to lessen their experiences of VCT. It would be beneficial for future studies to further explore this relationship to gain a better understanding of what occurs within counselors who work with traumatized populations over time. For example, it is possible that over time, counselors learn how to effectively cope with the trauma content of their clients and are able to more effectively protect themselves from experiencing arousal VCT symptoms. It is also possible that counselors with more experience and trauma exposure might learn to respond to this increased trauma content by disengaging with their clients over time, thus reducing arousal VCT symptoms in an unethical way. These are important considerations to include in counseling education programs to better prepare future counselors with effective coping and self-care strategies as well as how to recognize when one is experiencing VCT symptoms.

Furthermore, it is especially important that professional counselors be aware of the signs of burnout in order to minimize counselors leaving the counseling profession prematurely and maximize their years of professional counseling experience. Burnout can develop from work related stress and commonly experienced symptoms of burnout include poor work performance,

inadequacy, sleeplessness, and physical and emotional exhaustion as a result from being overloaded at work (Howlett & Collins, 2014; Jordan, 2010). More specifically, burnout has been defined as fatigue or frustration related to feeling a failure to produce a desired outcome often due to excessive demands on energy, time, strength, and personal resources within the work setting (Nelson, 2016). It would benefit counseling agencies to be aware of and acknowledge the effects of burnout as well as be proactive in their efforts to minimize counselor burnout rates by implementing benefits such as leave time, competitive pay, manageable caseloads, professional development opportunities, providing a supportive professional work environment, etc. Continuing education opportunities and trainings on ways to maximize years of professional experience would benefit professional counselors and the counseling profession as a whole.

Findings from this study also indicated that counselors who personally experienced a traumatic event experienced more arousal vicarious trauma symptoms. While it is important to provide counselors-in-training with general education on VCT and the effects of VCT, it is equally important to educate future counselors that a personal experience of trauma may increase one's vulnerability in experiencing arousal VCT symptoms and how to recognize these symptoms within oneself. Within this research study, 88.7% of participants indicated that they have been impacted by a personal traumatic event at least to some extent, and of those participants who had personally experienced a traumatic event, 64% indicated that they have sought out counseling services related to that traumatic experience. Future studies might consider comparing those who sought counseling services and those who didn't among those who reported personal experiences of trauma to further explore these relationships. It is important that counselor educators, supervisors, and counseling agencies to be intentional with counseling

students, supervisees, and professional counselors in creating an encouraging environment of pursuing personal counseling services when needed. Within counseling agencies, this could involve providing counseling professionals with leave time to pursue their own counseling services within business hours as needed.

Limitations

One limitation of the current research study is the low number of male counselor participants (N=17, 8.1%). While female counselors characteristically dominate the counseling profession, it would have been beneficial to have a more male experiences in the results of this study. Due to the low number of male participants, the results of this study are not as applicable to male lives.

Another limitation of the present study is the lack of racial diversity represented within this study's participants, as a large majority of the participants identified as white (N=156, 73.9%). It would have been beneficial to have more participants from various racial and ethnic groups represented in this study to have a more diverse inclusion of experiences, so these results may not be applicable to all racial groups.

Finally, this study examined a select few factors that can influence resilience in professional counselors. Years of professional experience, trauma caseload, and a personal experience of a traumatic event are a limited selection of factors that could influence resiliency, and other factors could possibly relate to lower levels of VCT and subthreshold PTSD in professional counselors.

Future Recommendations for Research

Future studies on VCT and subthreshold PTSD symptoms and resilience would benefit from focusing on the various type of trauma work counseling participants engage in. This study

provides demographic information on the type of client population served, but future studies would benefit from examining the relationship between this factor and levels of resilience and symptoms of VCT and subthreshold PTSD. Further research on this factor could help provide more detailed information that could be beneficial in the development of specific workshops and trainings to increase and maximize resilience in professional counselors within agencies that serve those specific populations.

It would be beneficial for future studies to further explore the relationship between years of professional experience and the development of arousal VCT symptoms to gain a better understanding of what occurs within counselors who work with traumatized populations over time. Future studies should explore how counselors with various years of experience cope with their clients' traumatic content. This information would better inform counselor education programs for how train counselors to lessen the experience of arousal VCT symptoms.

Due to the lack of male perspectives in this study, a qualitative study that focuses on male counselor experiences as compared to female counselor experiences with VCT, subthreshold PTSD, and resilience is needed to better understand how different genders view and experience these detrimental symptoms and how their resilience is influenced by these symptoms. It is important to have a better understanding of the most prevalent VCT and subthreshold PTSD symptoms in males and females to more effectively inform counseling supervisors and counselor education programs so that they are able to more effectively target reducing these symptoms and maximizing resilience.

Finally, this study explored three specific factors related to resilience in professional counselors. Future research is needed on other factors related to resilience to examine other factors could reduce symptoms of VCT and subthreshold PTSD to discover if other factors are

more strongly correlated and related to higher levels of resilience or lower VCT symptoms greater than years of professional experience. Future quantitative studies on other factors will greatly benefit the paucity of literature regarding resilience and vicarious trauma.

Summary

This research study established an understanding of the frequency of VCT symptoms and subthreshold PTSD symptoms experienced by professional counselors and the relationship between these symptoms and resilience. Further, this study explored the relationship between years of professional experience, trauma caseload, and a personal experience of trauma on VCT symptoms, subthreshold PTSD symptoms, and the level of resilience, and determined that years of professional experience decreased arousal symptoms of VCT and increased level of resilience in professional counselors. These findings can be used by professional counselors, supervisors, and counselor educators to decrease symptoms of VCT and subthreshold PTSD and increase resilience in counselors.

Chapter 5: Manuscript

Introduction and Background of the Problem

Counselors in all clinical settings work with clients who have experienced trauma to some extent in their lifetime. PTSD United (2015) estimates as many as 70% of adults in the United States have experienced at least one traumatic event in their lives. In addition, the National Child Traumatic Stress Network (2011) states that at least ten million children experience a traumatic event per year. Trauma can be defined generally as any exposure to an event or situation in which an individual is confronted with an incident that involves perceived, actual, or threatened death or serious injury to self or others' well-being (American Psychiatric Association, 2013). Types of traumatic experiences include an isolated incident or multiple circumstances perceived by the individual as emotionally or physically threatening, harmful, or overwhelming, that have the ability to cause long lasting negative and adverse effects on the individual's mental, physical, social, emotional, and/or spiritual well-being (Substance Abuse and Mental Health Services Administration, 2016). As counselors empathically listen to their clients' traumatic experiences on a regular basis, there is a potential for counselors to be negatively impacted and become impaired (Abassary & Goodrich, 2014; Harrison, 2009). Additionally, without appropriate or effective protective factors in place, counselors are at risk of experiencing vicarious trauma from exposure to clients' traumatic events (Harrison, 2009; Nelson, 2016).

Vicarious Trauma (VCT)

The term vicarious trauma (VCT) has been used to describe counselors' reactions to directly working with clients who have experienced trauma (McCann & Pearlman, 1990). Vicarious trauma results in a negative transformation within the counselor that disrupts and alters

the counselor's view of their self, others, and the world as a result of chronic engagement with their clients (Jordan, 2010; McCann & Pearlman, 1990; Michalopoulos & Aparicio, 2012; Nelson, 2016; Williams et al., 2012). In fact, the prevalence rate of vicarious trauma is 45.9% among professional counselors (Dunkley & Whelan, 2006). Such changes can manifest in the counselors' feelings, relationships, and quality of life (Helm, 2016). Counselors affected by VCT may also experience negative changes in identity, worldview, spiritual beliefs, self-esteem, resources, and cognitive schemas (Elwood et al., 2011; Helm, 2016; Pearlman & Saavkvitne, 1995b; Saakvitne and Pearlman, 1996). VCT can also cause negative mental health effects such as problems with trauma-related memory, perception, dissociation, intrusive imagery, and depersonalization (Elwood et al., 2011; Helm, 2016; Pearlman, 1999).

This negative shift can compromise the counselor's personal well-being and effectiveness in professional practice, as these symptoms can negatively influence the therapist's capacity for empathy and the ability to appropriately respond to the client (Briere & Scott, 2015; Trippany, White Kress, & Wilcoxon, 2004). Counselors with high caseloads that consist of a majority of intense trauma cases and counselors with little professional counseling experience have been found to be risk factors for developing VCT (Meichenbaum, 2007; Michalopoulos & Aparicio, 2012). Additionally, counselors with unresolved personal traumatic experiences has been found to be a risk factor for developing VCT (Baird & Kracen, 2006). Should these symptoms of VCT remain untreated, they could negatively affect counselors' ability to provide the client effective treatment (ACA, 2017; Helm, 2016; Lonn & Haiyasoso, 2016).

Symptoms of VCT closely align with those of post-traumatic stress disorder (PTSD) (Briere & Scott, 2015). Research has found that individuals who experience symptoms of VCT meet criteria for subthreshold PTSD, as the symptoms are similar to one another (Briere & Scott,

2015; Jordan, 2010; Keim et al., 2008). Symptoms include recurring nightmares, recalling images of clients' traumas, feeling disconnected and isolated from loved ones, become socially withdrawn from friends and family members, feeling no energy, being more sensitive to loss and to trauma, emotional numbing and flooding (Lonn & Haiyasoso, 2016; Neumann & Gamble, 1995; Saakvitne & Pearlman, 1996). Furthermore, symptoms of VCT that are highly correlated with symptoms of PTSD include recurring and distressing thoughts about work or a specific client's trauma, emotional numbing and flooding, dissociative responses to clients' trauma experiences, triggering previous traumatic experiences; increased feelings of vulnerability, increased reactivity or hyper vigilance, feelings of guilt or irritability, and decreased compassion and empathy (Briere & Scott, 2015; Helm, 2016; Jordan, 2010; Keim et al., 2008; Lonn & Haiyasoso, 2016; Nelson, 2016).

Subthreshold PTSD

Subthreshold PTSD has been defined as the presence of clinically significant PTSD symptoms that do not meet the full *Diagnostic and Statistical Manual of Mental Disorders* PTSD diagnostic criteria (Bergman et al., 2015). More specifically, subthreshold PTSD is defined as meeting two or three of the PTSD Criteria B-E (McLaughlin et al., 2015). Criterion A is classified as exposure to death or threatened death, actual or threatened serious injury, or actual or threatened sexual violence (American Psychiatric Association, 2013). Criterion B states that the traumatic event is persistently re-experienced, and Criterion C is classified by avoidance of trauma-related stimuli after the trauma (American Psychiatric Association, 2013). Criterion D involves negative thoughts or feelings that began or worsened after the trauma, and Criterion E includes trauma-related arousal and reactivity that began or worsened after the trauma (American Psychiatric Association, 2013).

In addition to the clinical significance of subthreshold PTSD, research indicates that subthreshold PTSD symptoms may be longstanding (Cukor et al., 2010; McLaughlin et al., 2015; Muller et al., 2014; Zlotnick, Franklin & Zimmerman; 2002). Cukor et al. (2010) studied the long-term effects of subthreshold PTSD symptoms and found that of individuals with subthreshold PTSD studied, 30% met criteria for subthreshold PTSD or full PTSD one year later, and 25% still met the diagnostic criteria two years later. Research indicates that subthreshold PTSD is not simply a normative reaction to a traumatic event, as it can cause significant impairment if untreated (Cukor et al., 2010; McLaughlin et al., 2015; Muller et al., 2014; Zlotnick, Franklin & Zimmerman; 2002). While understanding the potential presence and severity of subthreshold PTSD is important, it is equally as important to examine what keeps experienced professional counselors who are exposed to trauma content in their work from developing these symptoms.

Resilience

Resilience refers to one's ability to "bounce back" from unfavorable experiences and refers to one's inner strength, competence, optimism, and flexibility (Wagnild & Collins, 2009). Resilience has also been described as the successful adaptation to stressful circumstances (Cohen, Ferguson, Harms, Pooley, & Tomlinson, 2011; Masten, Best, & Garmezy, 1991; Smith, Tooley, Christopher & Kay, 2010). Resilience reflects one's ability to utilize internal and external resources to cope effectively with adverse circumstances (Wagnild & Young, 1993). It is not regarded as a fixed characteristic, but rather as a quality of one's adaptive trajectory (Luthar & Zelazo, 2003; Smith et al., 2010). Resilience is a malleable and adaptive ability that can be highly dependent on life's stressors and other environmental factors (Smith et al., 2010; Wagnild & Collins, 2009).

Individuals can and often do return to prior levels of functioning after a traumatic experience and in turn, are able to more effectively adapt to adversity (Paton, Violanti, Smith, 2003). There is an intrinsic quality that makes individual's responses to stress or negative symptoms more adaptive than others who have not experienced an event of trauma (Paton et al., 2003; Smith et al., 2010). Furthermore, individuals with high levels of resilience are often more resistant to the negative effects of various life stressors and are able to cope effectively despite adversity (Bartone, 2003).

More recently, studies have explored the relationship between resilience characteristics and clinical experience in helping professionals. Lambert and Lawson (2013) explored mental health, self-care, burnout, resilience, and VCT in professional counselors who worked with individuals affected by Hurricanes Katrina and Rita, and they found that resiliency may serve to buffer the negative effects of adverse life experiences. Similarly, a qualitative study explored the resilience of mental health professionals in crisis care community mental health in Australia (Edward, 2005). The findings from this study suggested that there is a relationship between resilience and level of clinical experience in mental health professionals in that the theme of resilience was present within the participants with more professional experience. In a recent comprehensive review of the literature, Hernandez-Wolfe (2018) emphasizes the paucity of quantitative research exploring the relationship between levels of resilience and mental health professionals working with trauma.

Statement and Significance of the Problem

VCT and subthreshold PTSD can be detrimental to both the professional counselor and the client, and these symptoms can be viewed as an occupational hazard for the employee, the workplace, and the client (Bercier & Maynard, 2015; Howlett & Collins, 2014). VCT commonly

occurs when counselors work directly with clients who have experienced a traumatic event (Lonn & Haiyasoso, 2016). Practicing counseling while experiencing symptoms of VCT or subthreshold PTSD can negatively influence the counselor's judgment, increase the risk for re-traumatization, and possibly harm the client (ACA, 2017; Helm, 2016; Trippany et al., 2004). While it's important to understand the negative symptoms that a counselor might encounter, it is equally as important to understand factors such as resilience that protect and motivate counselors in their clinical work when working with traumatized populations.

Several studies have documented the wide range of risks associated with working directly with traumatized individuals on a regular basis, including recurring and distressing thoughts about work or a specific client's trauma, emotional numbing and flooding, dissociative responses to clients' trauma experiences, triggering previous traumatic experiences; increased feelings of vulnerability, increased reactivity or hyper vigilance, feelings of guilt or irritability, and decreased compassion and empathy (Adams & Riggs, 2008; Arvay, 2001; Buchanan, Anderson, Uhlemann & Horwitz, 2006; Cukor et al., 2010; Helm, 2016; Keim et al., 2008; Nelson, 2016). A counselor who is impaired or compromised by these symptoms risks harming the client and the counseling profession as whole. Examining the development and impact of VCT and subthreshold PTSD symptoms among counselors is critical; however, it is also important to understand the variables or factors that counselors might develop while working with clients who have experienced trauma such as resilience. This may help identify factors linked to resiliency, as it relates to VCT and subthreshold PTSD among professional counselors working with traumatized populations. Thus far, only qualitative studies have been conducted to explore this relationship, and many have stated the need for a quantitative study exploring the relationship between resilience, VCT and subthreshold PTSD in professional counselors. Moreover, by

examining the possible presence of resiliency in counselors, we can better examine this relationship and better inform counselor education programs to protect future counselors and their clients from possible harm.

The purpose of this study was to gain an understanding of the frequency of VCT and subthreshold PTSD symptoms among professional counselors and the factors, primarily resiliency, that may protect counselors from developing these symptoms. In order to better understand potential protective factors from VCT and subthreshold PTSD symptoms, the current study examined counselor resilience, as resiliency has never been examined in the VCT and subthreshold PTSD literature as a quantitative study. To fully understand VCT, subthreshold PTSD and resilience, this study also examined years of professional counseling experience, the extent of exposure to client traumatic experiences, and any personal history of trauma, and the influence that these factors have on VCT, subthreshold PTSD, and resilience.

Methodology

Research Questions:

Q1: What are the experiences of VCT and subthreshold PTSD among professional counselors who work with clients who have experienced trauma?

Q2: What is relationship among the presence of VCT symptoms, subthreshold PTSD symptoms, and the level of resilience in professional counselors?

Q3a: What is the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on VCT symptoms in professional counselors?

Q3b: What is the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on subthreshold PTSD symptoms in professional counselors?

Q3c: What is the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on the level of resiliency in professional counselors?

Participants

Participants for this study were recruited from a sample of currently practicing professional counselors. In order to participate in this study, participants were at least 19 years of age, had a minimum of a Master's degree in a counseling field, such as clinical mental health counseling, school counseling, community mental health counseling, clinical rehabilitation counseling, or marriage and family counseling. In addition, participants were practicing professional counseling for a minimum of six months. Finally, participants worked with clients who have experienced trauma to be included in this study. Examples of traumatized populations include sexual assault, domestic violence, child abuse, substance misuse/recovery, offender rehabilitation programs, and prison populations.

Procedures

The professional counselors in this study were recruited through various counseling association list-serves emails requesting their participation. Each of these list-serves included practicing professional counselors who work with traumatized client populations. Snowball sampling was also be utilized in this study to gain access to additional participants who might not be a part of these list-serves. Participants were provided with information about the study and were asked to click on the survey link via Qualtrics if they were interested in participating in the study. Participants were able to review the IRB approval and were informed that there were no risked associated with the study and that their participation was voluntary. Surveys completed by the participants included demographics questionnaire, the *Secondary Trauma Stress Scale* (STSS), the *PTSD Checklist for DSM-5* (PCL-5), and the *Resilience Scale* (RS). All data was analyzed using SPSS software.

Data Analysis

The current study aimed to identify the experiences of VCT and subthreshold PTSD among professional counselors who work with clients who have experienced trauma, to examine the relationship between the presence of VCT symptoms, subthreshold PTSD symptoms, and the level of resilience in professional counselors, and to explore the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on VCT symptoms, subthreshold PTSD, and the level of resilience in professional counselors. The presence of VCT symptoms was determined by the STSS, the presence of subthreshold PTSD symptoms was determined by the PCL-5, and the level of resiliency was determined by the *Resilience Scale*. Years of professional experience, the amount of client trauma exposure, and whether or not there is a history of a personal incidence of a traumatic experience was examined in the Demographic Questionnaire. Data was analyzed using SPSS. Descriptive statistics and linear multiple regression analyses were utilized for the current study. Findings are organized and displayed in charts and graphs.

Results

The present study sought to explore the experiences of VCT and subthreshold PTSD among professional counselors who work with clients who have experienced trauma, as well as the relationship among the presence of VCT symptoms and subthreshold PTSD symptoms on the level of resilience in professional counselors. Additionally, this study sought to examine the impact of the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on VCT symptoms, subthreshold PTSD symptoms, and level of resiliency in professional counselors. Descriptive statistical analyses were used to describe the experiences of VCT and subthreshold PTSD among

professional counselors who work with clients who have experienced trauma. Linear regression was used to determine the impact of the relationship of VCT symptoms and subthreshold PTSD symptoms on the level of resiliency in professional counselors. Finally, linear regression analyses were used to determine the effects of the relationship among years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma on VCT symptoms, subthreshold PTSD symptoms, and level of resiliency in professional counselors who work with traumatized populations.

Demographics

As reported in **Table 1**, a total of 211 professional counselors participated in the current study. Of the 211 participants, 199 participants reported their gender; 17 (8.1%) participants indicated they identified as male, 179 (84.8%) participants indicated they identified as female, and 2 (0.9%) participants indicated they identified as nonbinary.

A total of 198 participants reported their highest level of completed education; 152 (76.8%) of participants indicated having a Master's Degree, 43 (21.7%%) of participants indicated having a Doctoral Degree, and 3 (1.5%) participants indicated having an Education Specialist Degree. Of the 211 total participants, 198 participants indicated whether they are currently licensed in counseling, and 181 (91.4%%) reported they are currently licensed and 17 (8.6%) participants reported that they are not licensed. 195 participants indicated their years of professional counseling experience, and participants reported a range of 1 – 40 years of counseling experience, with an average of 9.94 years of professional counseling experience.

Participants were also asked to indicate the current client population(s) that they currently serve, and 180 (85.3%) participants indicated child abuse/neglect, 164 (77%) participants indicated sexual assault/violence, 143 (67.8%) participants indicated loss/grief/bereavement, 70

(33.2%) participants indicated severe mental illness, 63 (29.9%) participants indicated substance misuse/recovery, 63 (29.9%) participants indicated intimate partner violence, 43 (20.4%) participants indicated combat/military duty, 14 (6.6%) participants indicated offender rehabilitation programs, and 8 (3.8%) participants indicated working with the prison population.

Participants were also asked to indicate the approximate percentage of their current caseload of clients who have experienced a traumatic event, and 192 participants indicated a range of 25% - 100%, with an average trauma caseload of 75.1%. Finally, 194 participants indicated the extent to which they have directly experienced a traumatic event themselves; 22 (10.4%) participants reported never having personally experienced a traumatic event, 113 (53.6%) participants indicated that they have experienced a traumatic event to some extent, and 59 (28%) participants indicated that they have experienced a traumatic event to a severe or great extent. Participants were asked to indicate whether or not they have ever sought out counseling services for their own personal experience(s) of trauma, and 126 (59.7%) participants reported that they have, 64 (30.3%) participants reported that they have not, and 7 (3.3%) participants indicated that they preferred not to answer.

The mean, standard deviation, and reliability statistics are reported in **Table 2** for the *Secondary Trauma Stress Scale* (STSS), the *PTSD Checklist for the DSM-5* (PCL-5), and the *Resilience Scale* (RS).

Table 1
Demographic Information

Characteristic		N	Percentage
Gender	Female	179	84.8%
	Male	17	8.1%
	Nonbinary	2	0.9%
Race/Ethnicity	White	156	73.9%
	African American	22	10.4%
	Asian	3	1.4%

	Hispanic/Latinx	18	8.5%
	Native Hawaiian	2	0.9%
	American Indian	1	0.5%
	Biracial/Multiracial	2	0.9%
Education	Master's Degree	152	76.8%
	Doctoral Degree	43	21.7%
	Education Specialist Degree	3	1.5%
Licensed	Yes	181	91.4%
	No	17	8.6%
Client Population(s)	Child Abuse/Neglect	180	85.3%
	Sexual Assault/Violence	164	77.7%
	Loss/Grief/Bereavement	143	67.8%
	Severe Mental Illness	70	33.2%
	Substance Misuse/Recovery	63	29.9%
	Intimate Partner Violence	63	29.9%
	Combat/Military Duty	43	20.4%
	Offender Rehabilitation	14	6.6%
	Prison Population	8	3.8%
Personal Traumatic Experience	None At All	22	11.3%
	Some Extent	113	58.2%
	Severe or Great Extent	59	30.4%
Sought Counseling For Traumatic Experience	Yes	126	64%
	No	64	32.5%
	Prefer Not To Answer	7	3.5%

Table 2
Scale Reliability Statistics

Scale	N	Mean	SD	Cronbach's Alpha
STSS (Full Scale)	17	1.93	.58	.899
STSS – Intrusion Scale	5	1.887	.564	.679
STSS – Avoidance Scale	7	1.903	.686	.83
STSS – Arousal Scale	5	2.013	.74	.783
PCL-5	20	1.418	.46	.924
Resilience Scale	25	5.872	.61	.921

Descriptive statistics based on participants' responses indicated that there are symptoms of vicarious trauma presently experienced by professional counselors. In contrast, descriptive statistics indicated that there are few symptoms of subthreshold PTSD being experienced by

professional counselors. Regarding the STSS, a majority of the vicarious trauma symptoms were experienced by at least 50% of the participants to some degree. Symptoms were rated significant if they scored "Never" higher than 50% on the STSS, indicating that the participant had experienced the symptom to some degree in the past seven days. The most common symptom of vicarious trauma experienced by the participants was thinking about work with clients when the counselor did not intend to do so (88.1%), as indicated by the STSS. The PCL-5 was utilized to measure symptoms of subthreshold PTSD, and participants' responses indicated that few symptoms of subthreshold PTSD are being experienced by professional counselors, and only two subthreshold PTSD symptoms were experienced by more than 50% of participants within the last seven days.

A backward linear regression model was run to determine the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms on the level of resilience in professional counselors. Results indicate a significant relationship between all three STSS subscales, the PCL-5, and resilience. Fewer subthreshold PTSD symptoms was the most predictive variable associated with higher levels of resilience in professional counselors, as evidenced in the restricted model regression summary. In the Full Model (R^2 Full = .246, (F = 15.721), $p < .001$), results indicate a significant relationship, and the Full Model explained 24.6% of variance in Resilience Scale scores. The Restricted Model, comprised of the PCL-5 and Avoidance STSS subscale, (R^2 Restricted = .236, (F = 30.17), $p < .001$), results also yield a significant relationship. The Restricted Model explained 23.6% of the variance in Resilience Scale scores. Regression results and correlation summaries are outlined in **Table 3**.

Table 3
Regression Findings – Backward Regression – STSS & PCL on Resilience Scale

Factor	R^2	S.E Estimate	Beta	Semi-partial	r
Full Model	.246[a]	.536			
PCL-5			-.310**	-.177	-.469***
STSS-Intrusion			.097	.071	-.282***
STSS-Avoidance			-.251	-.098	-.430***
STSS-Arousal			-.269	-.078	-.433***
Restricted Model	.236[b]	.537			
PCL-5			-.334***	-.228	
STSS-Avoidance			-.185*	-.126	

p<.05,p<.01,***p<.001*
a-F = 15.721, p < .001***
b-F = 30.17, p < .001***

Backward elimination linear regression analyses on the STSS subscales of vicarious trauma symptoms (intrusion, avoidance, and arousal) yielded significant findings regarding arousal vicarious symptoms in professional counselors. There was a slight significant negative correlation between years of professional experience and arousal vicarious trauma symptoms (r = -.143, p = .025), and the second significant correlation denoted that counselors who personally experienced a trauma event were more likely to experience more arousal vicarious trauma symptoms (r = 0.148, p = 0.21). In this Full Model (R^2 = .053, F = 15.721, p = .017), years of professional counseling experience and arousal symptoms resulted in a significant relationship, indicating that the more years of experience a counselor has can possibly lessen the experience

of arousal vicarious trauma symptoms in professional counselors. The Full Model explained 5.3% of the variance in STSS Arousal scores. The Restricted Model (R^2 Restricted = .035, (F = 4.46), p = .013), results also yield a significant relationship between years of experience and personal experiences of trauma in predicting arousal vicarious trauma symptoms. The Restricted Model explained 3.5% of variance in STSS Arousal scores. Regression results and correlation summaries for the Arousal STSS subscale are outlined in **Table 4**.

Table 4
RQ3a: Regression Findings – Backward Regression (DV=STSS Arousal)

Factor	R^2	S.E Estimate	Beta	Semi-partial	r
Full Model	.053[a]	.720			
Years of Experience			-.149*	-.148	-.143*
Trauma Caseload			.089	.087	.116
Personal Trauma Experience			.148*	.147	.148*
Restricted Model	.035[b]	.721			
Years of Experience			-.155*	-.155	
Personal Traumatic Experience			.159*	.159	

p<.05,p<.01,***p<.001*
a-F = 15.721, p = .017*
b-F = 4.46, p = .013*

A backward elimination linear regression analysis on the Resilience Scale yielded significant findings regarding years of professional counseling experience. The significant correlation denoted that counselors who had more years of professional counseling experience were more likely to have a higher level of resilience (r = 0.233, p > 0.001). Overall, these results

indicate a significant relationship between the level of resilience and the relationship between years of professional counseling experience, the amount of client trauma exposure, and a personal experience of trauma in professional counselors, $R^2 = .061$, $F = 4.026$, $p = .008$. The Full Model explained 6.1% of variance in Resilience Scale scores. The Restricted Model (R^2 Restricted = .054, ($F = 10.699$), $p = .001$) indicates that years of professional experience is predictive of a higher level of resilience in professional counselors. The Restricted Model explained 5.4% of variance in Resilience Scale scores. Regression results for the Resilience Scale are outlined in **Table 5**.

Table 5
RQ3c: Regression Findings – Backward Regression (DV=Resilience Scale)

Factor	R^2	S.E Estimate	Beta	Semi-partial	r
Full Model	.061[a]	.585			
Years of Experience			.227**	.226	.233***
Trauma Caseload			.012	.012	-.002
Personal Trauma Experience			.084	.084	.101
Restricted Model	.054[b]	.584			
Years of Experience			.233***	.233	

p<.05,p<.01,***p<.001*
a-F = 4.024, p = .008**
b-F = 10.699, p = .001***

Discussion

This study was conducted to gain an understanding of the frequency of and the relationships between vicarious trauma symptoms, subthreshold PTSD symptoms, and level of resilience among professional counselors. Furthermore, this study aimed to investigate the

relationship between years of professional experience, trauma caseload, and a personal experience of trauma on VCT symptoms, subthreshold PTSD symptoms, and the level of resiliency in professional counselors. Results from the current study indicate that there are significant relationships between the Intrusion, Avoidance, and Arousal STSS subscales and resilience in professional counselors, indicating that the fewer vicarious trauma symptoms experienced, the higher the level of resilience in counselors. Additionally, this study found years of professional experience resulted in fewer arousal vicarious trauma symptoms and a higher level of resilience. Furthermore, having personally experienced a traumatic event resulted in higher arousal vicarious trauma symptoms.

Implications for Counselors and Counselor Educators

The results of the present study provide counselors, counselors educators, and supervisors with valuable information to better educate and prepare counselors-in-training to ideally avoid or to mitigate VCT symptoms and subthreshold PTSD symptoms. Findings from this research study provide evidence that professional counselors are experiencing numerous VCT symptoms currently. In fact, this study found that a majority of the VCT symptoms measured were experienced by at least 50% of the participants. With a majority of participants reporting experienced VCT symptoms to some extent, it is evident that continued education, training, and professional development regarding vicarious trauma symptoms is needed.

For maximum effectiveness, it is imperative that this occurs throughout various levels of counselor development. For example, counselors-in-training should be educated on vicarious trauma and how to recognize VCT symptoms within themselves. In fact, CACREP (2014) mandates that accredited counselor programs educate counseling students on trauma related counseling skills and to effectively take care of themselves to avoid developing VCT and

subthreshold PTSD symptoms. This education should be imbedded within counselor education curriculum, with special, targeted emphasis on this content in Crisis Intervention Counseling courses and within practicum and internship. Keim et al. (2008) suggested that educational trainings and workshops be provided to counselors-in-training to decrease symptoms of vicarious trauma and subthreshold PTSD. Finally, counseling supervisors would greatly benefit from training and continuing education on recognizing the signs and symptoms of vicarious trauma and how to reduce those symptoms, which would benefit counselors of all developmental levels (Sommer, 2008).

This study denoted that years of professional counseling experience is predictive of fewer arousal vicarious trauma symptoms and a higher level of resilience. Years of experience may serve as a buffer to developing symptoms of VCT or that counselors with more years of experience have learned to address and cope with their VCT symptoms in order to lessen their experiences of VCT. It would be beneficial for future studies to further explore this relationship to gain a better understanding of what occurs within counselors who work with traumatized populations over time. For example, it is possible that over time, counselors learn how to effectively cope with the trauma content of their clients and are able to more effectively protect themselves from experiencing arousal VCT symptoms. It is also possible that counselors with more experience and trauma exposure might learn to respond to this increased trauma content by disengaging with their clients over time, thus reducing arousal VCT symptoms in an unethical way. These are important considerations to include in counseling education programs to better prepare future counselors with effective coping and self-care strategies as well as how to recognize when one is experiencing VCT symptoms.

Furthermore, it is especially important that professional counselors be aware of the signs of burnout in order to minimize counselors leaving the counseling profession prematurely and maximize their years of professional counseling experience. Burnout can develop from work related stress and commonly experienced symptoms of burnout include poor work performance, inadequacy, sleeplessness, and physical and emotional exhaustion as a result from being overloaded at work (Howlett & Collins, 2014; Jordan, 2010). More specifically, burnout has been defined as fatigue or frustration related to feeling a failure to produce a desired outcome often due to excessive demands on energy, time, strength, and personal resources within the work setting (Nelson, 2016). It would benefit counseling agencies to be aware and acknowledge the effects of burnout as well as be proactive in their efforts to minimize counselor burnout rates by implementing benefits such as leave time, competitive pay, manageable caseloads, professional development opportunities, providing a supportive professional work environment, etc. Continuing education opportunities and trainings on ways to maximize years of professional experience would benefit professional counselors and the counseling profession as a whole.

Findings from this study also indicated that counselors who personally experienced a traumatic event experienced more arousal vicarious trauma symptoms. While it is important to provide counselors-in-training with general education on VCT and the effects of VCT, it is equally important to educate future counselors that a personal experience of trauma may increase one's vulnerability in experiencing arousal VCT symptoms and how to recognize these symptoms within oneself. Within this research study, 88.7% of participants indicated that they have been impacted by a personal traumatic event at least to some extent, and of those participants who had personally experienced a traumatic event, 64% indicated that they have sought out counseling services related to that traumatic experience. It is important that counselor

educators, supervisors, and counseling agencies to be intentional with counseling students, supervisees, and professional counselors in creating an encouraging environment of pursuing personal counseling services when needed. Within counseling agencies, this could involve providing counseling professionals with leave time to pursue their own counseling services within business hours as needed.

Limitations

One limitation of the current research study is the low number of male counselor participants (N=17, 8.1%). While female counselors characteristically dominate the counseling profession, it would have been beneficial to have a more male experiences in the results of this study. Due to the low number of male participants, the results of this study are not as applicable to male lives.

Another limitation of the present study is the lack of racial diversity represented within this study's participants, as a large majority of the participants identified as white (N=156, 73.9%). It would have been beneficial to have more participants from various racial and ethnic groups represented in this study to have a more diverse inclusion of experiences, so these results may not be applicable to all racial groups.

Finally, this study examined a select few factors that can influence resilience in professional counselors. Years of professional experience, trauma caseload, and a personal experience of a traumatic event are a limited selection of factors that could influence resiliency, and other factors could possibly relate to lower levels of VCT and subthreshold PTSD in professional counselors.

Future Recommendations for Research

Future studies on VCT and subthreshold PTSD symptoms and resilience would benefit from focusing on the various type of trauma work counseling participants engage in. This study provides demographic information on the type of client population served, but future studies would benefit from examining the relationship between this factor and levels of resilience and symptoms of VCT and subthreshold PTSD. Further research on this factor could help provide more detailed information that could be beneficial in the development of specific workshops and trainings to increase and maximize resilience in professional counselors within agencies that serve those specific populations.

It would be beneficial for future studies to further explore the relationship between years of professional experience and the development of arousal VCT symptoms to gain a better understanding of what occurs within counselors who work with traumatized populations over time. Future studies should explore how counselors with various years of experience cope with their clients' traumatic content. This information would better inform counselor education programs for how train counselors to lessen the experience of arousal VCT symptoms.

Due to the lack of male perspectives in this study, a qualitative study that focuses on male counselor experiences as compared to female counselor experiences with VCT, subthreshold PTSD, and resilience is needed to better understand how different genders view and experience these detrimental symptoms and how their resilience is influenced by these symptoms. It is important to have a better understanding of the most prevalent VCT and subthreshold PTSD symptoms in males and females to more effectively inform counseling supervisors and counselor education programs so that they are able to more effectively target reducing these symptoms and maximizing resilience.

Finally, this study explored three specific factors related to resilience in professional counselors. Future research is needed on other factors related to resilience to examine other factors could reduce symptoms of VCT and subthreshold PTSD to discover if other factors are more strongly correlated and related to higher levels of resilience or lower VCT symptoms greater than years of professional experience. Future quantitative studies on other factors will greatly benefit the paucity of literature regarding resilience and vicarious trauma.

Summary

This research study established an understanding of the frequency of VCT symptoms and subthreshold PTSD symptoms experienced by professional counselors and the relationship between these symptoms and resilience. Further, this study explored the relationship between years of professional experience, trauma caseload, and a personal experience of trauma on VCT symptoms, subthreshold PTSD symptoms, and the level of resilience, and determined that years of professional experience decreased arousal symptoms of VCT and increased level of resilience in professional counselors. These findings can be used by professional counselors, supervisors, and counselor educators to decrease symptoms of VCT and subthreshold PTSD and increase resilience in counselors.

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Appendix I. IRB Approval

INFORMATIONAL LETTER

For a Research Study entitled

"Vicarious Trauma, Subthreshold PTSD, and Resilience in Professional Counselors Working with Traumatized Populations"

You are invited to participate in a research study to investigate the frequency of vicarious trauma and subthreshold PTSD symptoms in professional counselors and factors such as resiliency that protect counselors from developing these symptoms. This study is being conducted by Sarah Flint, under the direction of Dr. Jamie Carney in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You were selected as a participant because you are a practicing professional counselor.

What will be involved if you participate? If you decide to participate in this research study, you will be asked to complete an online survey. You will receive an email with the link to the online survey. Your total time commitment will be approximately 15-25 minutes.

Are there any risks or discomforts? The risks associated with participating in this study are minimal. You may experience discomfort from thinking about vicarious trauma or subthreshold PTSD symptoms when answering survey questions. You will also be asked to indicate whether or not you have ever received counseling services for a traumatic experience. However, if at any time you begin to feel uncomfortable, you may withdraw your participation in the study with no penalty.

Are there any benefits to yourself or others? There are no direct benefits from participating in this study. However, if you participate in this study, you will be contributing to the research on preventing vicarious trauma and subthreshold PTSD in professional counselors. Preventing vicarious trauma in counselors will benefit the counseling profession as a whole and will help protect client welfare by decreasing symptoms of vicarious trauma and subthreshold PTSD.

Will you receive compensation for participating? No, there is no compensation for completing this survey.

Are there any costs? If you decide to participate, it will be at no cost to you.

If you change your mind about participating, you can withdraw at any time during the study. Your participation in this study is completely voluntary. If you choose to withdraw during this survey, your data will not be used. Your decision about whether or not to participate or to withdraw from the study will not jeopardize your future relations with the researcher, Auburn University, or the Department of Special Education, Rehabilitation, and Counseling.

If you decide to participate in this research study, you will be asked to complete an online survey through Qualtrics. Your total time commitment will be approximately 15-25 minutes.

Your privacy will be protected. Any information obtained in connection with this study will remain anonymous and confidential. No identifying information will be asked or gathered during the survey. Information obtained through your participation may be published in a professional journal or presented at a professional conference.

If you have questions about this study, please contact Sarah Flint at sam0058@auburn.edu or Dr. Jamie Carney at carnejs@auburn.edu.

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

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER OR NOT YOU WISH TO PARTICIPATE IN THIS RESEARCH STUDY. BY SELECTING "I AGREE" YOU INDICATE YOUR WILLINGNESS TO PARTICIPATE.

- o I AGREE
- o I DO NOT AGREE

Appendix II. Informed Consent Document

INFORMATIONAL LETTER

For a Research Study entitled

"Vicarious Trauma, Subthreshold PTSD, and Resilience in Professional Counselors Working with Traumatized Populations"

You are invited to participate in a research study to investigate the frequency of vicarious trauma and subthreshold PTSD symptoms in professional counselors and factors such as resiliency that protect counselors from developing these symptoms. This study is being conducted by Sarah Flint, under the direction of Dr. Jamie Carney in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You were selected as a participant because you are a practicing professional counselor.

What will be involved if you participate? If you decide to participate in this research study, you will be asked to complete an online survey. You will receive an email with the link to the online survey. Your total time commitment will be approximately 15-25 minutes.

Are there any risks or discomforts? The risks associated with participating in this study are minimal. You may experience discomfort from thinking about vicarious trauma or subthreshold PTSD symptoms when answering survey questions. You will also be asked to indicate whether or not you have ever personally experienced a traumatic event, if you feel comfortable to share. However, if at any time you begin to feel uncomfortable, you may withdraw your participation in the study with no penalty.

Are there any benefits to yourself or others? There are no direct benefits from participating in this study. However, if you participate in this study, you will be contributing to the research on preventing vicarious trauma and subthreshold PTSD in professional counselors. Preventing vicarious trauma in counselors will benefit the counseling profession as a whole and will help protect client welfare by decreasing symptoms of vicarious trauma and subthreshold PTSD.

Will you receive compensation for participating? No, there is no compensation for completing this survey.

Are there any costs? If you decide to participate, it will be at no cost to you.

If you change your mind about participating, you can withdraw at any time during the study. Your participation in this study is completely voluntary. If you choose to withdraw during this survey, your data will not be used. Your decision about whether or not to participate or to withdraw from the study will not jeopardize your future relations with the researcher, Auburn University, or the Department of Special Education, Rehabilitation, and Counseling.

If you decide to participate in this research study, you will be asked to complete an online survey through Qualtrics. Your total time commitment will be approximately 15-25 minutes.

Your privacy will be protected. Any information obtained in connection with this study will remain anonymous and confidential. No identifying information will be asked or gathered during the survey. Information obtained through your participation may be published in a professional journal or presented at a professional conference.

If you have questions about this study, please contact Sarah Flint at sam0058@auburn.edu or Dr. Jamie Carney at carnejs@auburn.edu.

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

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER OR NOT YOU WISH TO PARTICIPATE IN THIS RESEARCH STUDY. BY SELECTING "I AGREE" YOU INDICATE YOUR WILLINGNESS TO PARTICIPATE.

- o I AGREE
- o I DO NOT AGREE

Appendix III
Brief Demographic Questionnaire

What is your gender?
- Male
- Female
- Transgender
- Non-binary
- Other (Please specify): _____.

Please indicate your age: _____.

Please select all that apply to your race/ethnicity:
- White
- Black
- Asian
- Hispanic/Latino
- Pacific Islanders
- Native Hawaiian
- American Indian
- Biracial/Multiracial
- Other (Please specify): _____.

Please select your highest level of completed education:
- Bachelor's Degree
- Master's Degree
- Education Specialist Degree
- Doctoral Degree

Are you currently licensed?
- Yes
- No

If yes, please select all current licenses and certifications you currently have:
- Licensed Professional Counselor (LPC)
- LPC in Progress (such as Associate Licensed Counselor)
- Licensed Marriage and Family Therapist (LMFT)
- LMFT in Progress
- National Certified Counselor (NCC)
- Certified Rehabilitation Counselor (CRC)
- Licensed School Counselor
- Other (Please Specify): _____

Please indicate your current job title: _____.

Please indicate how many years (or months) you have practiced as a professional counselor:
_____ months
_____ years

Please select the client population(s) you currently serve. Select all that currently apply:

- Sexual assault/violence
- Child abuse/neglect
- Combat/military duty
- Loss/grief/bereavement
- Substance misuse/recovery
- Offender rehabilitation programs
- Prison population
- Intimate partner violence
- Severe mental illness
- Other (Please specify): _____.
- Other (Please specify): _____.

Please indicate the ***approximate percentage*** of your current caseload of clients who have experienced a traumatic event: (i.e.: 20%) _____.

This day in age, trauma has touched and is interwoven in most lives. If you are willing to share, please answer the following:

- To what extent have you directly experienced a traumatic event?
    - None at all
    - Some extent
    - Severe (great extent)
- I have sought out counseling services for my own personal experience(s) of trauma.
    - Yes
    - No
    - Prefer not to answer

Appendix IV

SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the **past month** by circling the corresponding number next to the statement.

NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You *may substitute another noun that better represents your work such as consumer, patient, recipient, etc.*

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb.....	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients.....	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s).....	1	2	3	4	5
4. I had trouble sleeping.....	1	2	3	4	5
5. I felt discouraged about the future.....	1	2	3	4	5
6. Reminders of my work with clients upset me.....	1	2	3	4	5
7. I had little interest in being around others.....	1	2	3	4	5
8. I felt jumpy.....	1	2	3	4	5
9. I was less active than usual.....	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to.....	1	2	3	4	5
11. I had trouble concentrating.....	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients.....	1	2	3	4	5
13. I had disturbing dreams about my work with clients.....	1	2	3	4	5
14. I wanted to avoid working with some clients.....	1	2	3	4	5
15. I was easily annoyed.....	1	2	3	4	5
16. I expected something bad to happen.....	1	2	3	4	5
17. I noticed gaps in my memory about client sessions.....	1	2	3	4	5

Intrusion Subscale (add items 2, 3, 6, 10, 13)
Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17)
Arousal Subscale (add items 4, 8, 11, 15, 16)
TOTAL (add Intrusion, Arousal, and Avoidance Scores)

Citation: Bride, B.E., Robinson, M.R., Yegidis, B., & Figley, C.R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14,* 27-35.

Appendix V
PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong	0	1	2	3	4

with me, no one can be trusted, the world is completely dangerous)?					
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Appendix VI

Resilience Scale™

Please read each statement and select the number to the right of each statement that best indicates your feelings about the statement. Respond to all statements.

1 = Strongly Disagree
7 = Strongly Agree

Select the number in the appropriate column							
1. When I make plans, I follow through with them.	1	2	3	4	5	6	7
2. I usually manage one way or another.	1	2	3	4	5	6	7
3. I am able to depend on myself more than anyone else.	1	2	3	4	5	6	7
4. Excluded for Copyright	1	2	3	4	5	6	7
5. I can be on my own if I have to.	1	2	3	4	5	6	7
6. I feel proud that I have accomplished things in life.	1	2	3	4	5	6	7
7. Excluded for Copyright	1	2	3	4	5	6	7
8. I am friends with myself.	1	2	3	4	5	6	7
9. I feel that I can handle many things at a time.	1	2	3	4	5	6	7
10. Excluded for Copyright	1	2	3	4	5	6	7
11. I seldom wonder what the point of it all is.	1	2	3	4	5	6	7
12. I take things one day at a time.	1	2	3	4	5	6	7
13. Excluded for Copyright	1	2	3	4	5	6	7
14. I have self-discipline.	1	2	3	4	5	6	7
15. Excluded for Copyright	1	2	3	4	5	6	7
16. I can usually find something to laugh about.	1	2	3	4	5	6	7
17. Excluded for Copyright	1	2	3	4	5	6	7
18. In an emergency, I'm someone people can generally rely on.	1	2	3	4	5	6	7
19. I can usually look at a situation in a number of ways.	1	2	3	4	5	6	7
20. Sometimes I make myself do things whether I want to or not.	1	2	3	4	5	6	7
21. Excluded for Copyright	1	2	3	4	5	6	7
22. I do not dwell on things that I can't do anything about.	1	2	3	4	5	6	7
23. When I'm in a difficult situation, I can usually find my way out of it.	1	2	3	4	5	6	7
24. Excluded for Copyright	1	2	3	4	5	6	7
25. It's okay if there are people who don't like me.	1	2	3	4	5	6	7