

**Practicing Counselors, Vicarious Trauma, and Subthreshold PTSD: Implications for
Counselor Educators**

by

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Abstract

The purpose of the current study was to gain an understanding of the relationship of vicarious trauma symptoms and subthreshold Posttraumatic Stress Disorder (PTSD) symptoms among practicing counselors. Research indicates that counselors that experience vicarious trauma symptoms and subthreshold PTSD symptoms are at risk to become an occupational hazard due to the chance of causing harm to themselves, the client, and the workplace (Howlett & Collins, 2014). Additionally, research indicates that counselors who develop vicarious trauma symptoms and subthreshold PTSD symptoms are at particular risk to leave the profession early (Keim et al., 2008). Participants for this study were a national sample of practicing counselors recruited through counseling listservs. This study developed an understanding of the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms experienced among practicing counselors. Additionally, in developing implications for counselor educators, the researcher determined common contributing factors among practicing counselors that participants feel contributed to the development of vicarious trauma symptoms (i.e. working primarily with adolescents and sexual assault/domestic violence). Implications were developed for counselor educators to determine how they best can prepare students to avoid vicarious trauma symptoms and decrease subthreshold PTSD symptoms among practicing counselors' post-degree.

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Table of Contents

Abstract	ii
Acknowledgments	iii
List of Tables	vi
Chapter 1	1
Chapter 2	18
Chapter 3	24
Chapter 4	39
Chapter 5	49
References	80
Appendix A	85
Appendix B	87
Appendix C	89
Appendix D	92
Appendix E	94

List of Tables

Table 1	27
Table 2	28
Table 3	30
Table 4	31
Table 5	34
Table 6	34
Table 7	36
Table 8	38
Table 9	63
Table 10	64
Table 11	66
Table 12	67
Table 13	70
Table 14	70
Table 15	72
Table 16	74

Chapter 1

Introduction and Background of the Problem

All practicing counselors have the possibility of working with clients who have experienced trauma in their lifetime (Trippany, White Kress, Wilcoxon, 2004; Sommer, 2008). Whether the counselor works in a school setting or community mental health center, the likelihood that the counselor will not interact with a client experiencing trauma is slim. Although estimates may differ based on the study at hand, it has been reported that as many as 50% of counselors are at risk of developing vicarious trauma (National Child Traumatic Stress Network, 2011). Counseling requires an immense amount of empathetic acceptance on part of the counselor which increases the counselors' vulnerability of taking on their clients' traumatic experiences (Jordan, 2010; Finklestien, Stein, Greene, Bronstein, & Solomon, 2015). Empathic acceptance on part of the counselor and increased vulnerability may increase the counselors' likelihood of developing vicarious trauma symptoms. In such, counselor educators are ethically bound to provide counseling students research to understand, detect, and treat vicarious trauma among themselves and peers to protect against the development of vicarious trauma symptoms (Sommer, 2008). Understanding vicarious trauma is essential for counselor educators and practicing counselors as well as developing best practices to decrease the occurrence of vicarious trauma are important components that are needed in counselor preparation programs.

Vicarious Trauma

Vicarious trauma is a relatively new term used within the counseling profession. Although the term is new, vicarious trauma itself has been a prevalent issue for counselors for an extended length of time (Jordan, 2010). Historically, the term vicarious trauma has been used synonymously with other similar terms such as burnout, compassion fatigue, and secondary

trauma (Trippany, White Kress, & Wilcoxon, 2004; Jordan, 2010; Howlett & Collins, 2014). It is important to define vicarious trauma and differentiate it from burnout, compassion fatigue, and secondary trauma although there may be overlap. Vicarious trauma was initially described in 1990 by McCann and Pearlman as the psychological consequences of being exposed to a client's traumatic material (Nelson, 2016).

A closely related term to vicarious trauma is secondary trauma. Secondary trauma has been defined as the “natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other or client and the stress resulting from helping or wanting to help a traumatized or suffering person or client” (Figley, 1995, pg. 7). Secondary trauma may be hard to distinguish from vicarious trauma due to the close relatedness of definition and symptoms experienced by the counselor. To distinguish between secondary trauma and vicarious trauma, it is best to think of vicarious trauma as a cognitive shift on the counselor's part while secondary trauma places more emphasis on the behavioral responses on the counselor (Newell & MacNeil, 2010).

Compassion fatigue should also not be confused with the term vicarious trauma. Compassion fatigue has been defined as the the empathy a counselor feels and the consequences a counselor experiences after being exposed to clients' traumatic experiences (Figley, 2002). Unlike vicarious trauma which happens rapidly, compassion fatigue tends to develop cumulatively over time due to the chronic use of empathy when working with clients who are suffering (Newell & MacNeil, 2010).

Although symptoms of burnout and vicarious trauma heavily overlap (Parker & Henfield, 2012), there are distinct differences between burnout and vicarious trauma and these two terms should not be confused with one another (Jordan, 2010). Parker and Henfield (2012) reported in

their qualitative study on vicarious trauma and school counselors, that the majority of their participants did not know much about vicarious trauma and three participants reported vicarious trauma and burnout to be synonymous. Burnout symptoms develops over time while vicarious trauma symptoms occur suddenly with a rapid onset (Jordan, 2010). Burnout can develop from work stress with symptoms presenting as poor work performance, irritability, inadequacy, feelings of failure, sleeplessness, and exhaustion among others (Jordan, 2010). Symptoms of vicarious trauma can be the same but vicarious trauma affects the counselors trust, issues with intimacy, safety concerns, and/or intrusive imagery stemming from the client's trauma stories (Jordan, 2010). Burnout has been defined by Howlett and Collins (2014) as emotional and physical exhaustion often as a result of being overloaded at work while vicarious trauma has been defined as negative responses that are a direct result of working with a specific traumatized client, not as a secondary factor (ie. Large caseload). Further, burnout has been defined by Nelson (2016), as "a state of fatigue or frustration brought about by a devotion to a cause, way of life, or relationship, which, over time, failed to produce a desired outcome or reward often due to excessive demands on energy, time, strength, and personal resources in the work setting."

For the purposes of this research study, vicarious trauma has been defined as a disruption in schemas and worldview due to chronic empathic engagement with clients often accompanied by symptoms similar to those of posttraumatic stress disorder which occurs as a result of secondary exposure to traumatic material that can result in a cognitive shift in the way the therapist experiences self, others, and the world (Michalopoulos & Aparicio, 2012; Jordan, 2010).

Vicarious trauma experienced by practicing counselors is a detrimental workplace hazard for both the counselor and the client (Howlett & Collins, 2014). According to National Child

Traumatic Stress Network, (2011) approximately 50% of practicing counselors suffer from vicarious trauma when working with traumatic client stories and continually hearing unpleasant details that have affected the client negatively. Counselors that experience vicarious trauma may experience a variety of symptoms that are similar to the symptomology of PTSD (Finklestien et al., 2015). Further, vicarious trauma symptoms often mirror the clients' symptoms which may be anger, grief, rage, distress, diminished energy, sleep disturbances, intrusive thoughts, increased vigilance regarding safety, and can have damaging effects on the therapeutic relationship (Howlett & Collins, 2014; Michalopoulos & Aparicio, 2012).

For practicing counselors, vicarious trauma can be a career-ending experience. The traumatic experience is so severe that it can lead counselors to taking extended personal leave as well as terminating their counseling role (Keim et al., 2008). Vicarious trauma can impair a counselors' ability to disengage from clients presenting problems and take on the traumatic experience of their clients can be a dilapidating reality of vicarious trauma (Trippany, White Kress, & Wilcoxon, 2004). Not only does vicarious trauma lead counselors to leave the field prematurely, it also can lead to increased burnout, disengagement from professional and personal roles, increased awareness of negative life events, increased illness, and increased physical complaints among other possible negative experiences (Bergman, Kline, Feeny, & Zoellner, 2015; Trippany, White Kress, & Wilcoxon, 2004). Vicarious trauma symptomology is very similar to that of posttraumatic stress disorder (PTSD) and counselors who experience vicarious trauma symptoms may meet criteria for subthreshold PTSD.

Subthreshold PTSD Symptoms

Posttraumatic stress disorder (PTSD) has been in and out of the DSM from the first edition to the most current edition, DSM-V. Posttraumatic stress disorder, like vicarious trauma,

has been termed various names in the past and was not coined as a diagnosis until 1980 in the DSM-III (Echterling, Field, & Stewart, 2016). The National Institute of Mental Health (nd.) defines PTSD as a disorder that develops in some people who have seen or lived through a shocking, scary, or dangerous event. Posttraumatic stress disorder is defined in the DSM-V within the Trauma and Stress-Related Disorders and includes eight criteria to fulfill the diagnosis. Criterion A, the stressor, is identified in the DSM-V as exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: directly experiencing the traumatic event; witnessing the event(s) as it occurred to others, learning that the traumatic event(s) occurred to a close family member or close friend, or experiencing repeated or extreme exposure to aversive details of the traumatic event(s)” (APA, 2013). Criterion B defines the intrusion symptoms the individual may be experiencing, Criterion C defines the avoidance symptoms, Criterion D identifies the negative alterations in cognitions and mood, while Criterion D identifies marked alterations in arousal and reactivity associated with the traumatic event(s) (APA, 2013). The remaining criterion look at the duration of symptoms (Criterion E), functioning (Criterion F), and the final criterion (Criterion G) clarifies that symptoms are not due to substance use or other medical conditions (APA, 2013). The US Department of Veterans Affairs (2015) estimates that approximately 8 million adults have diagnosed PTSD within a given year, which is only a small portion of the individuals that have actually experienced a trauma sometime in their life (about 60% of the population). Although there are a significant number of individuals suffering from full-diagnosis PTSD (approximately 8% of the population will develop PTSD at some point in their lifetime), (US Department of Veterans Affairs, 2015), there are also a large amount of individuals suffering from PTSD

symptoms but do not meet the full criteria to be diagnosed with PTSD; this is known as subthreshold PTSD.

Subthreshold PTSD has been defined as the presence of clinically significant PTSD symptoms that fall short of the full *Diagnostic and Statistical Manual of Mental Disorders* PTSD diagnostic criteria (Bergman, Kline, Feeny, & Zoellner, 2015). Subthreshold PTSD prevalence rate appears to be consistent with that of full PTSD but due to a lack of reporting and variations of methodology in researching subthreshold PTSD, it is difficult to obtain the percentage of actual cases that may be diagnosable as subthreshold PTSD (Brancu et al., 2016). In a meta-analysis of subthreshold PTSD literature, Brancu et al., (2016) found that psychological (suicidal ideation, depressive symptoms) and behavioral (substance abuse, social and occupational functioning, physical health) symptoms among those identifying with subthreshold PTSD were higher than those individuals who did not identify with any PTSD symptoms but lower than those who identified as full PTSD. These results indicate that individuals who experience subthreshold PTSD are at risk for the same negative concerns as those individuals who are diagnosed with PTSD.

Subthreshold PTSD and Vicarious Trauma

Vicarious trauma and subthreshold PTSD are closely related phenomena's. Many counselors who experience vicarious trauma meet the diagnostic criteria for subthreshold PTSD (Keim, Olguin, Marley, & Thieman, 2008). Symptoms that may occur for counselors experiencing vicarious trauma are similar to those of post-traumatic stress disorder (Jordan, 2010; Finklestien et al., 2015). Counselors who experience vicarious trauma are in essence, experiencing post-traumatic stress symptoms in response to hearing trauma stories from their clients (Bercier & Maynard, 2015). Finklestien et al., (2015) reported that mental health

professionals in their study who worked with individuals in the Gaza Strip rocket attacks were at risk for both PTSD and vicarious trauma. Additionally, Finklestein et al., (2015) suggested that PTSD and vicarious trauma were highly correlated. Indicators of vicarious trauma that are comparable to PTSD symptoms are identified by Nelson (2016) as “recurring, distressing thoughts about work, a specific client or trauma; numbing or dissociative responses (feeling saturated); increased reactivity or hyper vigilance; feeling of guilt; increased irritability; and decreased compassion or empathy.”

Counselor Educator and Supervisor Implications

Counselor educators and supervisors should be aware of the effects vicarious trauma symptoms can play on practicing counselors. As counselor educators are preparing future counselors, they must educate the students on vicarious trauma as well as the possible contributors to vicarious trauma and the development of subthreshold PTSD. All counselors will likely counsel a client, but more than likely numerous clients, that have experienced trauma. In a study on counselors-in-training and vicarious trauma, Keim et al. (2008) found that 12% of their participants who were current counselors-in-training at a CACREP program qualified for a PTSD diagnosis. Further, 12.5% of the same participants revealed that they had worked with a client that caused personal traumatic stress to the counselor-in-training (Keim et al., 2008). CACREP (2014) requires accredited counselor preparation programs to educate counselors-in-training on trauma related counseling skills and to prepare counselors-in-training to not only effectively assist their clients in coping, but also take care of themselves to avoid such things as vicarious trauma symptoms and subthreshold PTSD symptoms. To effectively be able to educate students on vicarious trauma and subthreshold PTSD, counselor educators must understand the causes of vicarious trauma and subthreshold PTSD themselves (Keim et al., 2008). According to

a study completed by Parker and Henfield (2012), there is an ambiguity of the meaning of vicarious trauma in that the counselors had an idea of what vicarious trauma entailed but could not define it.

Counselor educators and supervisors are ethically bound by The American Counseling Association (2014) as well as by The Council for Accreditation of Counseling and Related Education (2014) to observe student development of counselors-in-training. Specifically, counselor educators and supervisors are to monitor students for impairment (ACA Code F.5.b) and provide adequate supervision should the counselor-in-training experience vicarious trauma and/or subthreshold PTSD symptoms to address concerns (ACA Code F.8.d). Additionally, ACA Code F.8.c states that counselor educators must provide students with appropriate self-growth experiences that allow for students to process and discuss self-growth experiences in class with peer support if students feel obliged to do so. Keim et al. (2008) suggests that programs should work proactively in the classroom to provide students with ways of preventing burnout and trauma symptoms prior to developing vicarious trauma and subthreshold PTSD symptoms if and when something does happen clinically with a client. In addition, Keim et al. (2008) suggests that counselor educators include modules into their curriculum that focus specifically on counselor self-care, increasing student awareness of safety issues when working with clients, educating students on vicarious trauma, normalizing the experience of vicarious trauma, developing coping strategies with counselors-in-training to cope with vicarious trauma, and have students develop and implement self-care plans (Parker & Henfield, 2012).

Although counselor educators and supervisors are in the perfect position to provide counselors-in-training with adequate skills to cope with vicarious trauma symptoms, there are instances where educators and supervisors may fall short in assisting their students with

development. Additionally, although counselor educators may adequately prepare their students, once counselors-in-training become practicing counselors, their roles and responsibilities change which can mean new challenges for the practicing counselor. Practicing counselors that experience vicarious trauma symptoms and subthreshold PTSD symptoms may leave the profession prematurely (Keim et al., 2008). Not only might practicing counselors experiencing vicarious trauma and subthreshold PTSD leave the profession early, they may also experience emotional and physical disorders, suicidal ideation, strained relationships, increased or continuous burnout, anger, and possibly abuse substances (Keim et al., 2008; Bergman, Kline, Feeny, & Zoellner, 2015). Additionally, vicarious trauma increases the counselors' potential for clinical error when continuing to counsel clients while experiencing subthreshold PTSD and vicarious trauma symptoms (Trippany, White Kress, & Wilcoxon, 2004). There are numerous variables that may contribute to the vulnerability of practicing counselors developing vicarious trauma symptoms and subthreshold PTSD symptoms that counselor educators and supervisors should be constantly aware of as they prepare counselors-in-training and supervise practicing counselors. These contributors may also be defined as preventive factors if the practicing counselor is utilizing all supports and develops ways to counteract vicarious trauma and subthreshold PTSD symptoms if they are educated on the contributors. A component of this process involves supervisors and counselor educators understanding the factors related to vicarious trauma symptoms and subthreshold PTSD symptoms. Further, this includes consideration of the variables that may decrease and increase vulnerability.

Years of experience

Vicarious trauma and subthreshold PTSD are professional work hazards that can affect any practicing counselor. Although all practicing counselors are at risk, novice counselors are

particularly at risk for developing vicarious trauma and subthreshold PTSD symptoms while working with traumatized clients (Michalopoulos & Aparicio, 2012). The risks associated with vicarious trauma have been experienced at a higher rate among those practicing counselors with less clinical experience (Parker & Henfield, 2012). Novice counselors tend to have a lack of experience with high risk cases, may have a lack of life experience related to traumatic experiences, and a lack of training which can all affect how they respond to traumatized clients (Parker & Henfield, 2012; Newell & MacNeil, 2010).). Further, novice counselors may have trouble establishing boundaries during the early stages of professional identify development which may also contribute to the increase of vicarious trauma symptoms and subthreshold PTSD symptoms among this particular subset of counselors (Howlett & Collins, 2014).

Although there is no way to increase years of experience at the onset of one's career, counselor educators can prepare novice counselors for the workforce through education and training. Through coursework, discussion in practicum courses, role-play demonstrations, workshops, and case studies, counselor educators can provide counselors-in-training with protective factors and ways to implement preventive strategies to effectively cope with vicarious trauma symptoms and subthreshold PTSD symptoms (Parker & Henfield, 2012; Trippany, White Kress, & Wilcoxon, 2004). By providing evidence-based practices to counseling students, these novice counselors can be better suited to effectively prevent and subdue symptoms of vicarious trauma and subthreshold PTSD through awareness and preventative strategies on the forefront (Alpert & Paulson, 1990).

Support

Support from peers and through supervision is of utmost importance for practicing counselors that may be experiencing vicarious trauma (Parker & Henfield, 2012; Whitfield &

Kanter, 2014). In order to alleviate the symptomology of vicarious trauma and subthreshold PTSD, practicing counselors require not only collegial support in relation to case conceptualization but also in relation to identification of impairment among each other that may be a consequence of the traumatic material developed through client stories (Newell & MacNeil, 2010).). Collaboration and consultation with peers and supervisors at the workplace are vital to minimize the adverse effects of vicarious trauma and subthreshold PTSD (Jordan, 2010). Unfortunately, there appears to be a lack of clinical supervision at counseling sites which can increase a counselor's risk of developing vicarious trauma symptoms and experiencing subthreshold PTSD symptoms (O'Neill, 2010). Additionally, counselors should seek supervision specific to trauma to ensure they are not developing vicarious trauma symptoms and subthreshold PTSD symptoms while working with traumatized clients (Whitfield & Kanter, 2014).

It is also essential that practicing counselors receive support from outside sources such as family members and friends that are not familiar with the counselors' caseload and who can provide peer support and identify needed supports outside of the workplace (Jordan, 2010). By developing separation between the workplace and the counselors' personal environment, counselors may be able to more effectively cope with vicarious trauma symptoms and subthreshold PTSD symptoms (Parker & Henfield, 2012). Vicarious trauma and subthreshold PTSD symptoms can operate as a barrier to social interaction between the counselor and their friends and family (Michalopoulos & Aparicio, 2012; Trippany, White Kress, & Wilcoxon, 2004). Practicing counselors need social support from their peers as vicarious trauma can affect the counselors' ability to trust others (Trippany, White Kress, & Wilcoxon, 2004).

Counselors can incorporate preventative measures to protect against the development of vicarious trauma and subthreshold PTSD by engaging in peer support and supervisory relationships. Counseling centers that encourage peer interaction and support increase their counselor's well-being by boosting staff morale, encouraging case conceptualizations, as well as increasing others abilities to identify if another counselor appears to be experiencing vicarious trauma and subthreshold PTSD symptoms (Jordan, 2010). Further, workplaces that implement and encourage participation at regularly scheduled staff meetings and case reviews decrease counselor's chances of developing vicarious trauma and subthreshold PTSD symptoms (Howlett & Collins, 2014; Newell & MacNeil, 2010).

Counselor self-care routines that include social support outside of the workplace is also of utmost importance to ensure counselors do not develop vicarious trauma symptoms and subthreshold PTSD (Howlett & Collins, 2014). Individuals that engage in social activities outside of the workplace with individuals other than coworkers tend to lead a healthier work lifestyle and are able to disengage from the stresses of trauma-related material (Mailloux, 2014). By engaging in activities with a social group, counselors can disengage from the strains of their job. In addition, social support from peers can increase the chance that others will recognize if a counselor is experiencing vicarious trauma symptoms and assist the counselor in developing a self-care plan to alleviate the symptoms (Michalopoulos & Aparicio, 2012).

Unmanageable Caseloads

Large or unmanageable caseloads are a prevalent concern among practicing counselors. Vicarious trauma and subthreshold PTSD symptoms may increase due to a counselors' large caseload as the counselor may not be able to spend adequate amounts of time on each case and may overextend their time to addressing case needs (Whitfield & Kanter, 2014). In addition,

counselors with caseloads that are primarily trauma-related are at an increased rate of developing vicarious trauma and subthreshold PTSD symptoms, especially if they have little clinical experience (Newell & MacNeil, 2010).

All counselors that are working directly with clients are at risk for developing vicarious trauma and developing subthreshold PTSD symptoms as they are working directly with survivors of trauma (Howlett & Collins, 2014). Those counselors that work specifically with traumatized clients on a regular basis are at higher risk of developing vicarious trauma and subthreshold PTSD symptoms due to the fact they are constantly being inundated with traumatic stories (Trippany, White Kress, & Wilcoxon, 2004; O'Neill, 2010). Further, by working with traumatized clients, counselors are placing themselves at risk of developing negative stress (Bercier & Maynard, 2015). By limiting the counselors load to a reduced number of trauma cases, the counselors' potential for developing vicarious trauma symptoms and subthreshold PTSD symptoms decreases (Trippany, White Kress, & Wilcoxon, 2004).

Monitoring counselor's caseloads is a particular reasonability of supervisors that should not be overlooked. By ensuring that counselors have a manageable number of cases on their roster at any given time and ensuring that are on a continuum of severity, the supervisor is assisting the counselor in effectively being able to manage their caseload (Newell & MacNeil, 2010).

Lack of Training

Practicing counselors who have experienced vicarious trauma and may identify with subthreshold PTSD symptoms agree that a lack of training related specifically to vicarious trauma and subthreshold PTSD contributed to their development of these symptoms (Parker & Henfield, 2012). Specific training on traumatology is critical for counselors-in-training as well as

practicing counselors to reduce the effects of vicarious trauma and subthreshold PTSD (Trippany, White Kress, & Wilcoxon, 2004). Counselors are ethically bound to obtain training specific to the types of counseling they provide and trauma-specific counseling is no different. Counselors must receive training specific to their client's needs in regards to trauma whether this is during their Masters program or provided at their clinical site or conference (Jordan, 2010). Unfortunately, due to a lack of trauma-specific training during their degree program, counselors piece together various trauma trainings to develop their own understanding which can leave holes in the counselors' development of trauma resources (Mailloux, 2014). Counselors need to be trained on the key features of trauma, warning signs, and symptoms as well as self-care strategies to prevent the development of vicarious trauma and subthreshold PTSD symptoms (Newell & MacNeil, 2010).

Through coursework and workshops provided during a counselor's preparation program, counselors can develop an understanding of trauma among clients and vicarious traumatization of counselors. Counselor educators are in an exceptional position to provide counselors-in-training with information on trauma, interventions that may be beneficial when working with clients, information on vicarious trauma, and preventive measures that counselors can use to decrease the possibility of developing vicarious trauma and subthreshold PTSD symptoms (Mailloux, 2014). Additionally, counselor educators can help bridge the gap between educational program and workplace by providing trauma-specific and/or vicarious trauma workshops at local counseling agencies and/or schools (Whitfield & Kanter, 2014). Through awareness, counselors can prepare themselves and understand the contributors of vicarious trauma and subthreshold PTSD to counteract when they may begin noticing symptoms themselves or in someone else.

Self-Care Implementation

Counselors spend a sizeable amount of their time ensuring that others take care of themselves while neglecting their own personal self-care (Whitfield & Kanter, 2014). In an effort to decrease vicarious trauma and subthreshold PTSD symptoms, practicing counselors must ensure they are incorporating various types of self-care on a regular basis. Self-care activities such as adequate sleep, social interaction, exercise, healthy diet, reading, and journaling may be ways that practicing counselors can incorporate self-care into their routine but all too often, practicing counselors let these activities slip (Jordan, 2010; Nelson, 2016). Counselors that neglect self-care are at an increased rate for developing the negative effects of vicarious trauma and subthreshold PTSD symptoms (Mailloux, 2014).

Counselor educators can better prepare counselors by encouraging the development of self-care plans and holding their students accountable for carrying out their plans. By ensuring counselors-in-training understand the importance of self-care and motivating students to implement self-care plans, counselor educators are setting up their students for success by promoting wellness and recognition of the emotional toll counseling traumatized clients can play (Nelson, 2016).

Statement of the Problem

Vicarious trauma among practicing counselors can be dangerous for both the counselor and the client (Bercier & Maynard, 2015). Counselors experiencing vicarious trauma symptoms can be viewed as an occupational hazard due to the burdens it can place on the employee, the workplace, and the consumer (Howlett & Collins, 2014; Newell & MacNeil, 2010). Continuing to work with clients while experiencing symptoms of vicarious trauma can impede the counselor's judgment, increase risk for the client to be traumatized again by the counselor,

increase countertransference, and possibly harm the client (Trippany, White Kress, & Wilcoxon, 2004; Michalopoulos & Aparicio, 2012;). Further, it is possible that counselors who experience vicarious trauma may meet the subthreshold for Post-Traumatic Stress Disorder (PTSD).

Significance of the Study

This study will have a direct impact on counselor preparation programs. Implications related to counselor development will be provided for counselor educators to gain an understanding of aspects that may need to be addressed more thoroughly in counselor preparation programs to decrease vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. The best defense against counselors experiencing vicarious trauma is by providing efficient education on the topic as well as preventive measures to be taken by the counselor (Newell & MacNeil, 2010). By preparing the students more fully while in counselor preparation programs, students can be equipped to cope with challenging clients, heavy caseloads, lack of supervision, and other common factors that increase vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. This study will provide implications that are relatable to both mental health counseling students as well as school counseling students.

Purpose of the Study

The purpose of this study was to gain an understanding of the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. Additionally, in developing implications for counselor educators, the researcher determined common contributing factors among practicing counselors that participants feel contributed to the development of vicarious trauma symptoms and subthreshold PTSD symptoms (i.e. lack of educational training, large caseload, and lack of supervision). Implications have been developed

for counselor educators to determine how they best can prepare students to avoid vicarious trauma symptoms and decrease subthreshold PTSD symptoms among practicing counselors' post-degree.

Research Questions

The study presented investigated the following research questions:

1. What symptoms of vicarious trauma and subthreshold PTSD do practicing counselors experience?
2. What is the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors?
3. a. What is the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors on vicarious trauma?
b. What is the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors on subthreshold PTSD?

Summary

Unfortunately, there are numerous risk factors that practicing counselors have identified as potential contributors to their development of vicarious trauma symptoms. Counselor educators are ethically bound to provide training and knowledge to students in counselor preparation programs. Research indicates that counselors experiencing vicarious trauma symptoms and subthreshold PTSD symptoms may be negatively impacted, both personally and in their ability to provide counseling services to their clients. However, we have limited information about the experiences of vicarious trauma symptoms and subthreshold PTSD symptoms among counselors and the protective factors which may prevent or diminish their experiences of these symptoms. This chapter reviewed literature pertaining to these issues and outlined a research study that has developed implications for counselor educators to help prevent vicarious trauma and subthreshold PTSD among practicing counselors through proactive, preventative strategies.

Chapter 2

Methodology

For this study, vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors has been examined. The rates of both vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors has been examined as well as the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms.

Additionally, the number of years of counseling experience, as well as other variables such as work setting, cliental, and others, has been collected to determine if these variables have an impact on practicing counselors' vicarious trauma symptomology and subthreshold PTSD symptomology. The impact of the number and type of professional supports utilized by practicing counselors has also been examined to determine if they play a role in counselors' development of vicarious trauma and subthreshold PTSD.

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 - b. What is the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors on subthreshold PTSD?

Participants

The participants for this study were individuals who were either (1) practicing mental health counselors or (2) practicing school counselors. In order to participate in this study, respondents must have been at least 19 years of age, have completed a Master's degree in a

Counselor Education (ie. School Counseling, Clinical Mental Health Counseling, Rehabilitation Counseling, Family and Marriage Counseling) and have been a practicing counselor for at least 6 months at the time of survey participation. Participants were recruited through counseling association listservs such as Alabama Counseling Association (ALCA), American School Counselors Association (ASCA), and the American Counseling Association (ACA). An invitation to participate in the study was posted on CESNET.

Procedures

Upon approval from Auburn University IRB (Appendix A), participants were recruited via email through listserv solicitation. Participants reviewed an informed consent document (Appendix B) and assented to participation. Surveys were sent via Qualtrics and participants could complete surveys online at their convenience. The participants were informed that there was no known risk associated with completing the surveys and that they may withdraw from participation at anytime. Due to the anonymous nature of the survey, participants may withdraw at any time but their data cannot be retracted as the researcher will not know which survey to remove. All incomplete surveys were removed prior to data analysis. IRB-approval information was attached to the informed consent document for the participant's review. The surveys that were completed by participants were a Brief Demographic Questionnaire (Appendix C), the Secondary Trauma Stress Scale (Appendix D), and the PCL-5 (Appendix E). Upon completion of data collection from participants, $n=220$, the surveys were examined for exclusion criteria such as incomplete surveys from participant withdrawal. GPower was calculated utilizing a GPower calculator with 6 predictors at a power of .80 and small effect size that indicated a need for approximately 170-200 participants. After all surveys are completed, the data was analyzed using SPSS software.

Instrumentation

The participants were asked to complete a brief demographic questionnaire and complete two surveys. To understand the impact years of experience plays on vicarious trauma and subthreshold PTSD among practicing counselors and the number of contributors and/or preventive measures related vicarious trauma and subthreshold PTSD symptoms, participants did so within the brief demographic questionnaire. Participants in this study completed a series of measures assessing the rate of vicarious trauma among practicing counselors, the number of participants that meet the criteria for subthreshold PTSD, and the impact of the types and number of professional supports had on practicing counselors through a series of measures.

Brief Demographic Measure

A basic demographic survey (Appendix C) was developed and utilized to collect data on respondent's age, gender, current position, years of counseling experience, primary type of client served, and any licenses and/or credentials. Text entry was utilized to understand the type and number of professional supports respondents identified: lack of supervision, lack of peer support, years of experience, lack of training specific to trauma, large or unmanageable caseloads, and lack of self-care implementation.

Secondary Trauma Stress Scale

The current study used the Secondary Trauma Stress Scale (STSS) to understand the number of vicarious trauma symptoms among practicing counselors as well as to determine the relationship of vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. The STSS (Appendix D) was originally developed in response to a paucity of instruments to measure secondary trauma among helping professionals (Briere, Robinson, Yegidis, & Figley, 2004). The STSS is a 17-item self-report measure designed to assess helping

professionals that may have experienced secondary traumatic stress and the frequency of intrusion, avoidance, and arousal symptoms (Briere et al., 2004; Ting, Jacobson, Sanders, Briere, & Harrington, 2005).

The STSS asks that respondents endorse how frequently an item was true for them in the past seven days (Briere, et al., 2004). Responses range from 1 to 5 in Likert-form with 1 = never and 5 = very often. Psychometric data for the STSS indicates very good internal consistency reliability with coefficient alpha levels of .93 for the total STSS scale, .80 for the Intrusion subscale, .87 for the Avoidance subscale, and .83 for the Arousal subscale (Briere et al., 2004). Ting et al. (2004) determined in their validation study of the STSS that internal consistency reliability for the total STSS 17-items was very high (.94) and was moderately high for the five-item Intrusion subscale (.79), the Avoidance subscale (.85), and the Arousal subscale (.87) and all three factors were highly correlated with each other (Intrusion-Avoidance $r = .96$, Intrusion-Arousal $r = .96$, Avoidance-Arousal $r = 1.0$) as indicated by a confirmatory factor analysis. Statements on the Intrusion subscale inquire on respondents' intrusion symptomology on a Likert-scale with statements such as "My heart started pounding when I thought about my work with clients" and "I had disturbing dreams about my work with clients." The Avoidance subscale ask respondents to respond to inquire on the Likert-scale to statements such as "I felt emotionally numb" and "I had little interest in being around others." The final subscale, Arousal, ask respondents to respond on a Likert-scale to statements such as "I had trouble sleeping" and "I expected something bad to happen."

PTSD Checklist for the DSM-V (PCL-5)

The PTSD Checklist for the DSM-V (PCL-5) is a revision of the PTSD Checklist (PCL) that specifically assesses for self-report measure of PTSD symptoms as outlined in the DSM-V

(Blevins, Weathers, Davis, Witte, & Domino, 2015). The PCL is one the most widely used measures of PTSD symptoms and the revised PCL-5 (Appendix E) is the only instrument that specifically measures criteria defined in the DSM-V (Blevins et al., 2015). The PCL-5 is a 20-item survey that corresponds to the 20 PTSD symptoms in the DSM-V (Bovin, Marx, Weathers, Gallagher, Rodriguez, Schnurr, & Keane, 2015). Respondents are asked to rank from 0-4, how little to how much, they have been bothered by the presented symptom within the last month (Bovin et al., 2015). Sample statements are as follows: having difficulty sleeping, feeling jumpy or easily startled, and avoiding memories, thoughts, or feelings related to the stressful event.

In a validation study of the PCL-5, Blevins et al. (2015) found high internal consistency (.94) and fell within the recommended range of interitem correlation of .15 to .50. Test-retest reliability was $r=.82$, 95% confidence interval [.71, .89] and paired t-tests were significant ($p<.01$) for the PCL-5 between two test validations (Blevins et al., 2015). Additionally, in a validation study by Bovin et al. (2015), Cronbachs Alpha indicated high internal consistency (.96) and test-retest reliability of $r=.84$.

Data Analysis

This study was focused on identifying and understanding the presence of symptoms of vicarious trauma and subthreshold PTSD among practicing counselors. The relationship between vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors was also be examined as well as the relationship between years of experience among practicing counselors on vicarious trauma and subthreshold PTSD symptoms. Additionally, this study examined the relationship between work setting and type of cliental among practicing counselors on vicarious trauma and subthreshold PTSD symptoms. The final relationship examined was between the number and type of professional supports utilized by practicing counselors on

vicarious trauma symptoms and subthreshold PTSD symptoms. Vicarious trauma symptoms experienced by practicing counselors was established by completion of the Secondary Trauma Stress Scale and subthreshold PTSD symptoms were examined by completion of the PCL-5. Years of experience, work setting, type of cliental, and professional supports were examined through the Brief Demographic Measure. Data analysis was performed using SPSS. Descriptive statistics and linear multiple regressions were used for this study. Charts and needed graphs have been developed to display data analysis findings.

Definition of Terms

Posttraumatic Stress Disorder (PTSD)- a disorder that develops in some people who have seen or lived through a shocking, scary, or dangerous event (National Institute of Mental Health, nd.)

Subthreshold PTSD- the presence of clinically significant PTSD symptoms that fall short of the full *Diagnostic and Statistical Manual of Mental Disorders* PTSD diagnostic criteria (Bergman, Kline, Feeny, & Zoellner, 2015)

Vicarious Trauma- a disruption in schemas and worldview due to chronic empathic engagement with clients often accompanied by symptoms similar to those of posttraumatic stress disorder (PTSD) which occurs as a result of secondary exposure to traumatic material that can result in a cognitive shift in the way the therapist experiences self, others, and the world (Michalopoulos & Aparicio, 2012; Jordan, 2010)

Summary

Within this chapter, the research study participants, procedures, measures, and data analysis were reviewed by the researcher. The research participants were recruited through online counseling listservs that consisted of a national sample of practicing counselors.

Participation was anonymous and participants could withdraw from completing the online Qualtrics surveys at any time. The surveys that were utilized were a Brief Demographic Measure, the Secondary Trauma Stress Scale, and the PCL-5 to answer the research questions. Procedures for data analysis were presented as well as IRB protocol.

Chapter 3: Results

Introduction

The purpose of the present quantitative study was to investigate the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms experienced by practicing counselors. Additionally, the present study was interested in developing implications for counselor educators and supervisors that provided needed professional supports for practicing counselors to decrease vicarious trauma symptoms and subthreshold PTSD symptoms. The researcher for this study utilized a brief demographic questionnaire, the Secondary Trauma Stress Scale (STSS), and the Posttraumatic Checklist (PCL5). The present study sought to determine the what vicarious trauma symptoms and subthreshold PTSD symptoms practicing counselors experience, the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms, and the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports utilized by practicing counselors and vicarious trauma symptoms and subthreshold PTSD symptoms. Descriptive analysis was used to determine what symptoms of vicarious trauma and subthreshold PTSD practicing counselors experience (research question 1). A linear regression was used to determine the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms. For research question 3, linear regressions were utilized to determine the relationship years of experience, work setting and type of cliental, and professional supports have on vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors.

Demographics

Two hundred and twenty individuals completed the survey. Of the 220 participants, 219 participants reported their gender; 23 (10.3%) of respondents indicated they identified as male and 196 (87.9%) of respondents indicated they identified as female. Two hundred and fifteen respondents indicated holding a Masters degree (84.8%). Exclusion criteria removed 4 (1.8%) of respondents from the data set for only holding a Bachelors degree as well as one (0.4%) other respondent for not indicating a degree level. Two hundred and seventeen participants (98.6%) reported they were over 19 years of age.

Current work setting was reported by 207 of the respondents. Of the 207 that reported, 137 (62.3%) identified as school counselors, 24 (10.9%) reported working in a community mental health center, 16 (7.35%) reported working in a private practice, 17 (7.7%) reported working in a higher education center, and 13 (5.9%) reported “other” which included settings such as Employee Assistance Programs and Crisis Centers.

Six respondents (2.7%) reported less than one year of cumulative counseling experience, 50 (22.7%) reported 1-3 years of cumulative counseling experience, 31 (14.1%) reported 4-5 years of cumulative counseling experience, 47 (21.4%) reported 6-10 years of cumulative counseling experience, and 72 (32.7%) reported 10 years or more of cumulative counseling experience. Of the 220 respondents, 14 (6.4%) did not report their cumulative years of counseling experience. Participants also reported their reported the number of years they have been in their current position. Of the 220 respondents, 12 (5.5%) did not report how many years they have been in their current position while 8 (3.6%) reported being in their current position less than one year, 103 (10.9%) reported 1-3 years, 31 (14.1%) reported 4-5 years, 30 (13.6%)

reported 6-10 years, and 36 (16.4%) reported being in their current position 10 or more years.

Refer to Table 1 for a summary of the demographic information reported.

The mean, standard deviation, and reliability statistics are reported in Table 2 for the Secondary Trauma Stress Scale (STSS) and the Posttraumatic Checklist (PCL5). The internal consistency for the STSS, PCL-5, and the subscales of the PCL-5 were reliable and supportive ($r > .08$) of use in this study.

Table 1

Demographic Information

Characteristic		N	Percentage
Gender	Male	23	10.5%
	Female	196	89.1%
	Total	219	
Age	19-29	40	18.2%
	30-39	79	35.9%
	40-49	49	22.3%
	50-59	39	17.7%
	60+	10	4.5%
	Total	217	98.6%
Work Setting	School Setting	137	62.3%
	Community Mental Health Center	24	10.9%
	Private Practice	16	7.35%
	Higher Education Center	17	7.7%
	Other	13	5.9%
	Total	220	
Years in Current Position	Less than 1 year	8	3.6%
	1-3 years	103	46.8%
	4-5 years	31	14.1%
	6-10 years	30	13.6%
	10+ years	36	16.4%
	System Missing	12	5.5%
	Total	220	
Years of Experience	Less than 1 year	6	2.7%
	1-3 years	50	22.7%
	4-5 years	31	14.1%
	6-10 years	47	21.4%
	10+ years	72	32.7%
	System Missing	14	6.4%
	Total	220	

Table 2

Scale Reliability Statistics

Scale	N	Mean	SD	Cronbach's Alpha
PCL-5	20	1.758	.224	.954
STSS (Full Scale)	17	2.079	.336	.942
STSS-Intrusion	5	2.005	.502	.804
STSS-Avoidance	7	2.109	.235	.857
STSS-Arousal	5	2.123	.338	.890

Research Question 1: What symptoms of vicarious trauma and subthreshold PTSD do practicing counselors experience?

Descriptive statistics based on participant's responses indicated that there are symptoms of vicarious trauma and subthreshold PTSD being experienced by practicing counselors. On the STSS, all symptoms were experienced by at least 50% of the participants to some degree. Symptoms were rated significant if they scored higher than "Never" on the STSS, indicating they had experienced the symptom to some degree within the past seven days. The most common symptom of vicarious trauma experienced by the participants was thinking about work with clients when not intending to do so (85.5%) as measured by the STSS. Additional symptoms of vicarious trauma symptoms experienced commonly by participants included: feeling emotionally numb (80.5%), becoming easily annoyed (79.1%), difficulty concentrating (75.5%), and feeling discouraged about their future (75.5%) as measured by the STSS. Experiencing disturbing dreams about their clients (49.5%) and feeling jumpy (56.4%) were the least common symptoms experienced by participants, but still 50% of the participants experienced these symptoms. Table 3 outlines the vicarious trauma symptoms measured by the STSS in descending order.

The PCL-5, utilized to measure subthreshold PTSD symptoms, suggested practicing counselors are experiencing subthreshold PTSD symptoms. Symptoms were rated as significant if they scored higher than "Not at all," indicating they had experienced the symptom to some

degree within the past month. The most common symptom reported to have been experienced by all participants (100%) was repeated, disturbing, or unwarranted memories of the stressful experience. Other symptoms that were reported to have been experienced commonly by practicing counselors included: trouble falling asleep or staying asleep (71.4%), having difficulty concentrating (70.9%), feeling distant or cut off from other people (68.2%), and feeling very upset when something reminded them of the stressful experience (66.8%). Taking too many risks or doing things that could cause you harm (36.8%), feeling or acting as if the stressful experience were actually happening again (42.7%), and experiencing repeated, disturbing dreams of the stressful experience (49.1%) were experienced least commonly by 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	188 (85.5%)
I felt emotionally numb	177 (80.5%)
I was easily annoyed	174 (79.1%)
I felt discouraged about the future	166 (75.5%)
I had trouble concentrating	166 (75.5%)
I had trouble sleeping	165 (75%)
I wanted to avoid working with some clients	162 (73.6%)
I was less active than usual	156 (70.9%)
Reminders of my work with clients upset me	155 (70.5%)
My heart started pounding when I thought about my work with clients	155 (70.5%)
I had little interest in being around others	149 (67.6%)
It seemed as if I was reliving the trauma(s) experienced by my client(s)	133 (60.5%)
I expected something bad to happen	132 (60%)
I avoided people, places, or things that reminded me of my work with clients	126 (57.3%)
I noticed gaps in my memory about client sessions	126 (57.3%)
I felt jumpy	124 (56.4%)
I had disturbing dreams about my work with clients	109 (49.5%)

Table 4

PCL-5 Symptom Distribution

Item in Descending Order	n (%)
Repeated, disturbing, and unwanted memories of the stressful experience?	220 (100%)
Trouble falling or staying asleep?	157 (71.4%)
Having difficulty concentrating?	156 (70.9%)
Feeling distant or cut off from other people?	150 (68.2%)
Feeling very upset when something reminded you of the stressful experience?	147 (66.8%)
Irritable behavior, angry outbursts, or acting aggressively?	139 (63.2%)
Avoiding memories, thoughts, or feelings related to the stressful experience?	139 (63.2%)
Having strong negative feelings such as fear, horror, anger, guilt, or shame?	134 (60.9%)
Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	130 (59.1%)
Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	127 (57.7%)
Being “superalert” or watchful or on guard?	125 (56.8%)
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 with me, no one can be trusted, the world is completely dangerous)?	125 (56.8%)
Loss of interest in activities that you used to enjoy?	123 (55.9%)
Blaming yourself or someone else for the stressful experience or what happened after it?	121 (55%)
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	119 (54.1%)
Feeling jumpy or easily startled?	116 (52.7%)
Trouble remembering important parts of the stressful experience?	113 (51.4%)

Repeated, disturbing dreams of the stressful experience?	108 (49.1%)
Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	94 (42.7%)
Taking too many risks or doing things that could cause you harm?	81 (36.8%)

Research Question 2: What is the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors?

Linear regression models were run to determine the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. In a backward regression, the PCL-5 measuring subthreshold PTSD symptoms was entered as the dependent variable and the subscales of the STSS, measuring vicarious trauma symptoms, were entered as the independent variables. Results indicate that the more vicarious trauma symptoms experienced by practicing counselors, the more subthreshold PTSD symptoms experienced. There was a significant relationship between PCL-5 and all three STSS Subscales. The relationship between subthreshold PTSD symptoms and the Intrusion subscale was significant ($r = .676, p < .001$). There was also a significant relationship between subthreshold PTSD symptoms and Avoidance symptoms ($r = .759, p < .001$) and between subthreshold PTSD symptoms and Arousal symptoms ($r = .790, p < .001$). Avoidance vicarious trauma symptoms and Arousal vicarious trauma symptoms were the most predictive variables associated with developing subthreshold PTSD symptoms as evidenced in the restricted model regression summary. In the backward regression model, the Intrusion subscale of the STSS was eliminated as the least significant variable, which indicates the more arousal and avoidance symptoms experienced as vicarious trauma, the more subthreshold PTSD symptoms experienced by the practicing counselors. In the Full Model ($R^2 \text{ Full} = .656, (F = 103.4), p < .001$), results indicate a

significant relationship. Through the Restricted Model R^2 Restricted = .655, ($F = 155.75$), $p < .001$) and the F change test results indicate the restricted model is not worse than the full model due to the Observed F (.00000892), $p = .647$ that does not exceed the Critical F ($df = 1, 163$) which is 3.94. Correlation summaries can be viewed in the Table 5. Regression results are outlined in the Table 6.

Table 5

Correlation Summary PCL-5 vs. STSS Subscales

	r	Significance
STSS-Intrusion	.676	<.001
STSS-Avoidance	.758	<.001
STSS-Arousal	.790	<.001

Table 6

Regression Summary

Scale	Full Model		Restricted Model	
	Beta	p	Beta	p
STSS-Intrusion	.037	.647	--	--
STSS-Avoidance	.310	.001	.323	<.001
STSS-Arousal	.501	<.001	.520	<.001

Note: R^2 Full= .656, (F=103.4), $p<.001$ R^2 Restricted= .655, (F=155.75), $p<.001$

Research Question 3a: What is the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors on vicarious trauma?

A backward linear regression model was utilized to determine the relationship between years of experience, work setting and type of cliental, and type of professional supports among practicing counselors on vicarious trauma symptoms. There were two significant relationships

within this regression in the Restricted Model of the regression. There was a significant negative correlation between vicarious trauma symptoms and having a manageable caseload, indicating the more manageable caseload the counselor has, the less vicarious trauma symptoms. In addition, there was a significant negative correlation between vicarious trauma symptoms and having adequate supervision indicating the more supervision received, the less vicarious trauma symptoms experienced. Overall, the two variables (caseload and supervision) correlate with the dependent variable, vicarious trauma symptoms, ($R = .273$, $R^2 = .074$). This overall correlation is unlikely due to chance ($F = 8.159$, $p < .001$). The F Change test indicated the Observed F (2.008), $p = .158$ does not exceed the Critical F ($df = 1, 202$) which is 3.89. The semi-partial correlation between caseload and vicarious trauma symptoms was $-.173$ while the semi-partial correlation between supervision and vicarious trauma symptoms was $-.150$. The semi-partial correlation indicates the uniqueness of the relationship. The squared semi-partial correlation for supervision was, $(-.173)^2 = .029$ and the squared semi-partial correlation for caseload, $(-.150)^2 = .02$. Regression results are outlined in Table 7.

Table 7

Regression Findings – Backward Regression

Factor	<hr/> <hr/>				
	R ²	S.E	Estimate		
			r	Semi-partial	Beta
Full Model	.117	.32497			
Years of Experience			.037	-.043	-.045
Population-Children			-.115	-.064	-.077
Population-F&M			-.172	-.086	-.118
Population-SubAbuse			-.138	-.012	-.021
Population-Adults			-.104	.070	.105
Population-SA/DV			-.075	.094	.151
Population-Prison			-.161	-.115	-.170
Population-Other			-.014	-.004	-.004
Supervision*			-.211	-.111	-.133
Training			-.127	-.013	-.014
Peer Support			-.160	-.037	-.043
Caseload*			-.228	-.155	-.179
Other			.054	.059	.063
Restricted Model	.074	.32350			
Supervision				-.150	-.157
Caseload				-.173	-.182

*p<.05

Research Question 3b: What is the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors on subthreshold PTSD symptoms?

A backward linear regression model was utilized to determine the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors on subthreshold PTSD symptoms. With subthreshold PTSD as the dependent variable and years of experience, work setting and type of cliental, and type of professional supports as the independent variables, a backward linear regression was run to understand the relationship between the variables in the Restricted Model of the regression. Results indicate a significant relationship between subthreshold PTSD symptoms and those counselors that work primarily with adolescents and those counselors that work primarily with sexual assault/domestic violence clients. Overall, the two variables (adolescents and sexual assault/domestic violence) correlate with our dependent variable, subthreshold PTSD symptoms, ($R = .242$, $R^2 = .059$). This overall correlation is unlikely due to chance ($F = 5.080$, $p = .007$). The F Change test indicated the Observed F (2.255), $p = .135$ does not exceed the Critical F ($df = 1, 162$) which is 3.94. The semi-partial correlation between adolescents and subthreshold PTSD symptoms subthreshold PTSD symptoms was .159 while the semi-partial correlation between sexual assault/domestic violence and subthreshold PTSD was .187. The semi-partial correlation indicates the uniqueness of the relationship. The squared semi-partial correlation for adolescents was, $(.159)^2 = .025$ and the squared semi-partial correlation for sexual assault/domestic violence, $.187^2 = .03$. Regression results are outlined in Table 8.

Table 8

Regression Findings – Backward Regression

	R ²	S.E Estimate			
Factor			r	Semi-partial	Beta
Full Model	.147	.70910			
Years of Experience			-.001	-.038	-.041
Population-Children			.148	.083	.091
Population-Adolescents*			.154	.134	.148
Population-F&M			.016	-.041	-.053
Population-SubAbuse			.001	-.040	-.070
Population-Adults			.083	.120	.181
Population-SA/DV*			.183	.141	.201
Population-Prison			-.015	-.076	-.109
Population-Other			.118	.063	.066
Supervision			-.097	-.057	-.066
Training			-.086	-.063	-.071
Peer Support			-.075	-.053	-.056
Caseload			-.105	-.078	-.090
Self-Care			.063	.086	.092
Other			.137	.124	.133
Restricted Model	.059 ^b	.71448			
Population-Adolescents*				.159	.159

Summary

The current study was developed to gain an understanding of the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms that are experienced by practicing counselors. Further, this study sought to examine the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms as well as contributing factors to these symptoms that practicing counselors may be experiencing. In an effort to retort these research questions, a Brief Demographic Questionnaire, the Secondary Trauma Stress Scale (STSS), and the Posttraumatic Checklist (PCL5) were utilized. Results from this study indicated that vicarious trauma symptoms measured by the STSS were experienced by at least 50% of the participants. There was also a significant correlation between the frequency of vicarious trauma symptoms experienced by practicing counselors and subthreshold PTSD symptoms. Further, having a manageable caseload and adequate supervision decreased participants' vicarious trauma symptoms. Finally, results indicated that working primarily with adolescents and primarily with sexual assault/domestic violence survivors increased participants subthreshold PTSD symptoms.

Chapter 4: Discussion

The purpose of this study was to develop an understanding of the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. Additionally, the researcher sought to develop implications for counselor educators by determining common contributing factors that participants felt contributed to the development of vicarious trauma symptoms and subthreshold PTSD symptoms. Results from the Brief Demographic Survey, the

Secondary Trauma Stress Scale (STSS), and the Posttraumatic Checklist (PCL5) will be discussed in this chapter. Additionally, implications for counselor educators to determine how they best can prepare students to avoid vicarious trauma symptoms and decrease subthreshold PTSD symptoms among practicing counselors' post-degree will be discussed in this chapter. Limitations of the current study and recommendations for future research will also be reviewed within this chapter.

Overview

Counselors are empathic beings that hear traumatic stories from their clients on a regular basis (Harrison, 2009). Further, when counselors do not have appropriate protective factors in place, they may begin to experience vicarious traumatization from empathically listening to the traumatic experiences of their clients (Harrison, 2009). Initially described in 1990 by McCann and Pearlman as the psychological consequences of being exposed to a client's traumatic material (Nelson, 2016), vicarious trauma is defined as a disruption in schemas and worldview due to chronic empathic engagement with clients often accompanied by symptoms similar to those of posttraumatic stress disorder which occurs as a result of secondary exposure to traumatic material that can result in a cognitive shift in the way the therapist experiences self, others, and the world (Michalopoulos & Aparicio, 2012; Jordan, 2010). The vicarious trauma symptoms experienced by counselors often mirror those symptoms experienced by individuals suffering from posttraumatic stress disorder (PTSD) and may include recurring, distressing thoughts about work, a specific client or trauma; numbing or dissociative responses (feeling saturated); increased reactivity or hyper vigilance; feeling of guilt; increased irritability; and decreased compassion or empathy (Nelson, 2016). Counselors that may develop these symptoms, do not typically develop enough symptoms to be diagnosed with PTSD; instead, they may develop

subthreshold PTSD which is the presence of clinically significant PTSD symptoms that fall short of the full *Diagnostic and Statistical Manual of Mental Disorders* PTSD diagnostic criteria (Bergman, Kline, Feeny, & Zoellner, 2015).

Counselor educators and supervisors are ethically bound by governing bodies such as CACREP and ACA to monitor student development and provide supervision to alleviate vicarious trauma symptoms and educate counselors-in-training on the effects of vicarious trauma (CACREP, 2014; ACA, 2014). Research has suggested that counselor educators should work proactively to decrease vicarious trauma and burnout in counselors by including modules into their curriculum that focus specifically on counselor self-care, increasing student awareness of safety issues when working with clients, educating students on vicarious trauma, normalizing the experience of vicarious trauma, developing coping strategies with counselors-in-training to cope with vicarious trauma, and have students develop and implement self-care plans (Parker & Henfield, 2012; Keim, 2008). There are various components of the work environment that may lead to the develop of vicarious trauma symptoms and subthreshold PTSD symptoms that counselor educators and supervisors should be aware of in preparing their students. Consideration of variables such as unmanageable caseloads, professional and personal support, continual trainings, and self care implementation can better prepare counselors-in-training to effectively cope with symptoms of vicarious trauma and subthreshold PTSD.

The present study was designed to develop an understanding of the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors and to provide counselor educators and supervisors with methods to prepare their students to recognize and manage symptoms.

Discussion of Results

As many as 50% of counselors are at risk for developing vicarious trauma symptoms (National Child Traumatic Stress Network, 2011). The first research question in this study was related to developing an understanding of the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms experienced by practicing counselors. All vicarious trauma symptoms, as measured by the STSS, were experienced by at least 50% of the participants indicating all 17 vicarious trauma symptoms measured has been experienced by the counselors that participated in this study to some degree. The most common vicarious trauma experienced by participants (85.5%) was thinking about their work with clients when they did not intend to outside of work. This finding is significant for counselor educators and supervisors as it indicates that every vicarious trauma symptom measured is being experienced by the majority of counselors in this study. The current study adds to the current literature reported by Bride (2007) that 50% of child welfare counselors experience traumatic stress symptoms within the severe range. In addition, Cornille and Meyers (1999) reported 37% of their sample of child protection service workers reported clinical levels of emotional distress associated with secondary trauma and Conrad and Kellar-Guenther (2006) reported 50% of child protection workers suffered “high” to “very high” levels of compassion fatigue.

In addition to measuring vicarious trauma symptoms, the first research question was also developed to acquire an understanding of the frequency of subthreshold PTSD symptoms experienced by counselors. Subthreshold PTSD symptoms were measured by the PCL-5 and suggest practicing counselors are experiencing subthreshold PTSD symptoms. Of the 20 items in the PCL-5, all but 3 were experienced by at least 50% of the participants. All 220 (100%) of participants reported experiencing repeated, disturbing and unwanted memories of the stressful

experience. This finding is similar to that found by the STSS in that over 85% of participants had unwanted thought about experiences with clients outside of work. Further, over 70% participants reported trouble sleeping and having difficulty concentrating in both the STSS and PCL-5 as symptoms of vicarious trauma and subthreshold PTSD. Understanding the symptoms of vicarious trauma and subthreshold PTSD experienced by participants was important as previous studies have indicated that those who experience vicarious trauma symptoms also experience subthreshold PTSD symptoms (Jordan 2010). Additionally, the literature has reported vicarious trauma symptoms and subthreshold PTSD symptoms being one in the same (Finklestein et al., 20015).

The second research question was developed to gain an understanding of the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms. A linear backward regression with the PCL-5 measuring subthreshold PTSD symptoms was entered as the dependent variable and the subscales of the STSS, measuring vicarious trauma symptoms, were entered as the independent variables. Results from the regression model indicate that the more vicarious trauma symptoms experienced by practicing counselors, the more subthreshold PTSD symptoms experienced. In the backward regression model, the Intrusion subscale of the STSS was eliminated as the least significant variable, which indicates the more arousal and avoidance symptoms experienced as vicarious trauma, the more subthreshold PTSD symptoms experienced by the practicing counselors with the Intrusion scale not being significant. This finding is consistent with prior literature that reported vicarious trauma symptoms being analogous to PTSD symptoms (Keim et al., 2008). Further, this finding is also consistent with prior literature that reported counselors who experience vicarious trauma symptoms also experience PTSD

symptoms (Bercier & Maynard, 2015) as found in Bride's (2007) study in which 34% of child welfare workers met the PTSD diagnostic criteria due to vicarious trauma.

In an effort to answer the last research question that was interested in the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms among years of experience, work setting and type of cliental, and the number and type of professional supports, two backward linear regression models were established. The first linear regression model was interested in the relationship between vicarious trauma symptoms and years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors. In this model, the STSS served as the dependent variable with years of experience, work setting and type of cliental, and the number and type of professional supports serving as the independent variables in the backwards linear regression model. Results indicate a significant relationship between vicarious trauma symptoms and having manageable caseload as well as between vicarious trauma and utilizing supervision. A negative correlation between vicarious trauma symptoms and having a manageable caseload indicates that the more manageable a counselor's caseload, the less likely they were to experience vicarious trauma symptoms. This finding is consistent with prior studies that indicate a manageable caseload being a protective factor for counselors that can decrease their chance of developing both vicarious trauma symptoms and subthreshold PTSD symptoms (Trippany, White Kress, & Wilcoxon, 2004). Additionally, there was a negative correlation between supervision as a professional support and the development of vicarious trauma symptoms among counselors. Adequate supervision has been identified as a protective factor against the development of vicarious trauma (Harrison, 2009). Both of this findings are important implications for counselor educators and supervisors

as they be initiated in the classroom while counselors-in-training are preparing for a career in the counseling field.

The second linear regression model was interested in the relationship between subthreshold PTSD symptoms and years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors. In this model, the PCL-5 served as the dependent variable with years of experience, work setting and type of cliental, and the number and type of professional supports serving as the independent variables in the backwards linear regression model. Results indicate a significant relationship between subthreshold PTSD symptoms and counselors that primarily work with adolescents and sexual assault/domestic violence. These findings are consistent with prior literature that indicate sexual assault counselors report more vicarious trauma symptoms and subthreshold PTSD symptoms. For instance, Bride (2007) reported 65% of domestic violence and sexual assault social workers that participated in this reported at least one symptom of vicarious trauma while Lobel (1997) reported 70% of sexual assault counselors experienced vicarious trauma. Further, Schauben and Frazier (1995) reported that counselors who work with a higher percentage of sexual assault survivors report more disrupted beliefs about themselves and others, more subthreshold PTSD symptoms, and more vicarious trauma than counselors who see fewer sexual assault survivors.

Implications for Counselor Educators and Supervisors

The results of this study provide counselor educators and supervisors with various tools to prepare counselors-in-training to avoid vicarious trauma symptoms and subthreshold PTSD symptoms. The current study established evidence that practicing counselors are experiencing numerous vicarious trauma symptoms and subthreshold PTSD symptoms. In fact, this study found that all vicarious trauma symptoms measured were experienced by at least 50% of the

participants and 17 of the 20 PTSD symptoms measured were experienced by participants. Further, in an open-ended question in the Brief Demographic Survey, participants provided the researcher with ideas they felt would decrease vicarious trauma and subthreshold PTSD symptoms. Over 40% of responses indicated more education on vicarious trauma and subthreshold PTSD symptoms. With close to or at 50% of participants reporting vicarious trauma symptoms and subthreshold PTSD symptoms, it is evident that additional education is needed related to these symptoms. Keim et al. (2008) suggested educational trainings and/or workshops be provided to counselors-in-training proactively to decrease vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. Counselor educators and supervisors can also provide trainings on the signs and symptoms of vicarious trauma and subthreshold PTSD experienced by counselors to practicing counselors and supervisors to raise awareness of these symptoms and ways to recognize and alleviate them before causing harm to the counselor.

This study denoted that counselors that work primarily with adolescents and sexual assault/domestic violence survivors are experiencing more subthreshold PTSD symptoms. As counselor educators prepare counselors-in-training for practicum, internship, and employment as counselors, it is vital for counselor educators to acknowledge the unique challenges that may stem with working with adolescents and survivors of sexual assault/domestic violence. It will be imperative that counselor educators and supervisors integrate specific educational material through coursework related to these specific populations in an effort to best prepare counselors-in-training. Evidence-based practices that are sufficient for counseling these populations should be implemented within counselor education programs, supervision practices, and

workshops/trainings outside of the degree, such as at conferences (Mailloux, 2014; Whitfield & Kanter, 2014; Alpert & Paulson, 1990).

Education on the significance of professional supports such as adequate supervision and manageable caseloads are fundamental for counselors-in-training to best be prepared to lessen the hazard of developing vicarious trauma symptoms and subthreshold PTSD symptoms. By providing sufficient supervision during practicum and internship, counselor educators and supervisors can prepare counselors-in-training for coping with vicarious trauma and subthreshold PTSD symptoms should they develop. In addition, through modeling appropriate supervision, counselors-in-training will comprehend the supervisory process and seek supervision post-degree.

Limitations

One limitation for this study was the high percentage of school counselors (62.3%) that participated. This could have possibly skewed the primary type of client that the practicing counselors worked with that exhibited the most symptoms of vicarious trauma and subthreshold PTSD. Additionally, this large percentage of school counselors may make the implications suggested in this study not as applicable for counselors in higher education settings.

Another limitation of this study was the low percentage of male counselors (10.5%) that participated. Although the counseling profession is primarily female, the low amount of male participants may not make the results applicable to the male gender.

A final limitation of this study was the lack of demographics available to identify if counselors were in a rural setting or urban setting. Although the implications suggested are applicable to all counselors, demographic location may serve as an additional barrier to implementing the professional supports suggested.

Future Recommendations for Research

Future studies on vicarious trauma symptoms and subthreshold PTSD symptoms needs to focus solely on clinical mental health or school counselors to develop implications specific to site. Although this study was great for counselor educators and supervisors preparing counselors-in-training, it is important for site specific aspects to be available practicing counselors. Further research devoted to the development of workshops and trainings to educate counselors on vicarious trauma and subthreshold PTSD is needed.

A qualitative study that focuses on male counselor experiences and female counselor experiences with vicarious trauma symptoms and subthreshold PTSD symptoms is needed to understand how different genders view and cope with these symptoms. It will be important to understand what symptoms present most often in different genders as well as how different genders cope most effectively. This will be important for supervisors as they work with counselors who may be experiencing these symptoms to be able to effectively identify and respond to vicarious trauma and subthreshold PTSD that may emerge.

A future study that compares counselors in rural settings and urban settings will be important to understand barriers to coping with and addressing vicarious trauma symptoms and subthreshold PTSD symptoms. For example, in a rural setting, the counselor may not have adequate supervision and may be overloaded with cases which can decrease the amount of self-care they are able to implement. Conversely, counselors in urban settings may be experiencing more cases with traumatic high crime. It will be important for future research to understand what barriers to professional supports counselors face in these different demographic communities.

Due to this study's finding that counselors who work primarily with adolescents and individuals who have experienced sexual assault and/or domestic violence increases the chances

of experiencing vicarious trauma symptoms and subthreshold PTSD symptoms, a qualitative and/or quantitative study focused on vicarious trauma among counselors working with these populations will be desirable. In an effort to best prepare students that may work with these populations, an understanding of what exactly aspects of working with these clients increases the vicarious trauma symptoms and subthreshold PTSD symptoms is essential.

Summary

The current study developed an understanding of the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms experienced by practicing counselors. Further, this study identified the most prevalent vicarious trauma symptoms and subthreshold PTSD symptoms experienced by practicing counselors. Counselors working primarily with adolescents and sexual assault/domestic violence survivors experienced more subthreshold PTSD. This study also identified common alleviating factors that decrease vicarious trauma symptoms which were recognized as having a manageable caseload and adequate supervision. Additional educational trainings for counselors related to vicarious trauma and subthreshold PTSD are needed to decrease these symptoms and prepare counselors for engaging in therapeutic relationships with individuals suffering from trauma without developing their own symptomology.

Chapter 5: Manuscript

Introduction and Background of the Problem

All practicing counselors have the possibility of working with clients who have experienced trauma in their lifetime (Trippany, White Kress, Wilcoxon, 2004; Sommer, 2008). Whether the counselor works in a school setting or community mental health center, the likelihood that the counselor will not interact with a client experiencing trauma is slim. Although estimates may differ based on the study at hand, it has been reported that as many as 50% of

counselors are at risk of developing vicarious trauma (National Child Traumatic Stress Network, 2011). Counseling requires an immense amount of empathetic acceptance on part of the counselor which increases the counselors' vulnerability of taking on their clients' traumatic experiences (Jordan, 2010; Finklestien, Stein, Greene, Bronstein, & Solomon, 2015). Empathic acceptance on part of the counselor and increased vulnerability may increase the counselors' likelihood of developing vicarious trauma symptoms. In such, counselor educators are ethically bound to provide counseling students research to understand, detect, and treat vicarious trauma among themselves and peers to protect against the development of vicarious trauma symptoms (Sommer, 2008). Understanding vicarious trauma is essential for counselor educations and practicing counselors as well as developing best practices to decrease the occurrence of vicarious trauma are important components that are needed in counselor preparation programs.

Subthreshold PTSD and Vicarious Trauma

Vicarious trauma and subthreshold PTSD are closely related phenomena's. Many counselors who experience vicarious trauma meet the diagnostic criteria for subthreshold PTSD (Keim, Olguin, Marley, & Thieman, 2008). Symptoms that may occur for counselors experiencing vicarious trauma are similar to those of post-traumatic stress disorder (Jordan, 2010; Finklestien et al., 2015). Counselors who experience vicarious trauma are in essence, experiencing post-traumatic stress symptoms in response to hearing trauma stories from their clients (Bercier & Maynard, 2015). Finklestien et al., (2015) reported that mental health professionals in their study who worked with individuals in the Gaza Strip rocket attacks were at risk for both PTSD and vicarious trauma. Additionally, Finklestein et al., (2015) suggested that PTSD and vicarious trauma were highly correlated. Indicators of vicarious trauma that are comparable to PTSD symptoms are identified by Nelson (2016) as "recurring, distressing

thoughts about work, a specific client or trauma; numbing or dissociative responses (feeling saturated); increased reactivity or hyper vigilance; feeling of guilt; increased irritability; and decreased compassion or empathy.”

Counselor Educator and Supervisor Implications

Counselor educators and supervisors should be aware of the effects vicarious trauma symptoms can play on practicing counselors. As counselor educators are preparing future counselors, they must educate the students on vicarious trauma as well as the possible contributors to vicarious trauma and the development of subthreshold PTSD. In a study on counselors-in-training and vicarious trauma, Keim et al. (2008) found that 12% of their participants who were current counselors-in-training at a CACREP program qualified for a PTSD diagnosis. CACREP (2014) requires accredited counselor preparation programs to educate counselors-in-training on trauma related counseling skills and to prepare counselors-in-training to not only effectively assist their clients in coping, but also take care of themselves to avoid such things as vicarious trauma symptoms and subthreshold PTSD symptoms. To effectively be able to educate students on vicarious trauma and subthreshold PTSD, counselor educators must understand the causes of vicarious trauma and subthreshold PTSD themselves (Keim et al., 2008). According to a study completed by Parker and Henfield (2012), there is an ambiguity of the meaning of vicarious trauma in that the counselors had an idea of what vicarious trauma entailed but could not define it.

Counselor educators and supervisors are ethically bound by The American Counseling Association (2014) as well as by The Council for Accreditation of Counseling and Related Education (2014) to observe student development of counselors-in-training. Specifically, counselor educators and supervisors are to monitor students for impairment (ACA Code F.5.b)

and provide adequate supervision should the counselor-in-training experience vicarious trauma and/or subthreshold PTSD symptoms to address concerns (ACA Code F.8.d). Additionally, ACA Code F.8.c states that counselor educators must provide students with appropriate self-growth experiences that allow for students to process and discuss self-growth experiences in class with peer support if students feel obliged to do so. Keim et al. (2008) suggests that programs should work proactively in the classroom to provide students with ways of preventing burnout and trauma symptoms prior to developing vicarious trauma and subthreshold PTSD symptoms if and when something does happen clinically with a client. In addition, Keim et al. (2008) suggests that counselor educators include modules into their curriculum that focus specifically on counselor self-care, increasing student awareness of safety issues when working with clients, educating students on vicarious trauma, normalizing the experience of vicarious trauma, developing coping strategies with counselors-in-training to cope with vicarious trauma, and have students develop and implement self-care plans (Parker & Henfield, 2012).

Although counselor educators and supervisors are in the perfect position to provide counselors-in-training with adequate skills to cope with vicarious trauma symptoms, there are instances where educators and supervisors may fall short in assisting their students with development. Additionally, although counselor educators may adequately prepare their students, once counselors-in-training become practicing counselors, their roles and responsibilities change which can mean new challenges for the practicing counselor. Not only might practicing counselors experiencing vicarious trauma and subthreshold PTSD leave the profession early, they may also experience emotional and physical disorders, suicidal ideation, strained relationships, increased or continuous burnout, anger, and possibly abuse substances (Keim et al., 2008; Bergman, Kline, Feeny, & Zoellner, 2015). Additionally, vicarious trauma increases

the counselors' potential for clinical error when continuing to counsel clients while experiencing subthreshold PTSD and vicarious trauma symptoms (Trippany, White Kress, & Wilcoxon, 2004). There are numerous variables that may contribute to the vulnerability of practicing counselors developing vicarious trauma symptoms and subthreshold PTSD symptoms that counselor educators and supervisors should be constantly aware of as they prepare counselors-in-training and supervise practicing counselors. These contributors may also be defined as preventive factors if the practicing counselor is utilizing all supports and develops ways to counteract vicarious trauma and subthreshold PTSD symptoms if they are educated on the contributors. A component of this process involves supervisors and counselor educators understanding the factors related to vicarious trauma symptoms and subthreshold PTSD symptoms. Further, this includes consideration of the variables that may decrease and increase vulnerability.

Years of experience

Vicarious trauma and subthreshold PTSD are professional work hazards that can affect any practicing counselor. Although all practicing counselors are at risk, novice counselors are particularly at risk for developing vicarious trauma and subthreshold PTSD symptoms while working with traumatized clients (Michalopoulos & Aparicio, 2012). The risks associated with vicarious trauma have been experienced at a higher rate among those practicing counselors with less clinical experience (Parker & Henfield, 2012). Novice counselors tend to have a lack of experience with high risk cases, may have a lack of life experience related to traumatic experiences, and a lack of training which can all affect how they respond to traumatized clients (Parker & Henfield, 2012; Newell & MacNeil, 2010).). Further, novice counselors may have trouble establishing boundaries during the early stages of professional identity development

which may also contribute to the increase of vicarious trauma symptoms and subthreshold PTSD symptoms among this particular subset of counselors (Howlett & Collins, 2014).

Support

Support from peers and through supervision is of utmost importance for practicing counselors that may be experiencing vicarious trauma (Parker & Henfield, 2012; Whitfield & Kanter, 2014). In order to alleviate the symptomology of vicarious trauma and subthreshold PTSD, practicing counselors require not only collegial support in relation to case conceptualization but also in relation to identification of impairment among each other that may be a consequence of the traumatic material developed through client stories (Newell & MacNeil, 2010).). Collaboration and consultation with peers and supervisors at the workplace are vital to minimize the adverse effects of vicarious trauma and subthreshold PTSD (Jordan, 2010). Unfortunately, there appears to be a lack of clinical supervision at counseling sites which can increase a counselor's risk of developing vicarious trauma symptoms and experiencing subthreshold PTSD symptoms (O'Neill, 2010). Additionally, counselors should seek supervision specific to trauma to ensure they are not developing vicarious trauma symptoms and subthreshold PTSD symptoms while working with traumatized clients (Whitfield & Kanter, 2014).

Unmanageable Caseloads

Large or unmanageable caseloads are a prevalent concern among practicing counselors. Vicarious trauma and subthreshold PTSD symptoms may increase due to a counselors' large caseload as the counselor may not be able to spend adequate amounts of time on each case and may overextend their time to addressing case needs (Whitfield & Kanter, 2014). In addition, counselors with caseloads that are primarily trauma-related are at an increased rate of developing

vicarious trauma and subthreshold PTSD symptoms, especially if they have little clinical experience (Newell & MacNeil, 2010). Those counselors that work specifically with traumatized clients on a regular basis are at higher risk of developing vicarious trauma and subthreshold PTSD symptoms due to the fact they are constantly being inundated with traumatic stories (Trippany, White Kress, & Wilcoxon, 2004; O'Neill, 2010). Further, by working with traumatized clients, counselors are placing themselves at risk of developing negative stress (Bercier & Maynard, 2015). By limiting the counselors load to a reduced number of trauma cases, the counselors' potential for developing vicarious trauma symptoms and subthreshold PTSD symptoms decreases (Trippany, White Kress, & Wilcoxon, 2004).

Lack of Training

Practicing counselors who have experienced vicarious trauma and may identify with subthreshold PTSD symptoms agree that a lack of training related specifically to vicarious trauma and subthreshold PTSD contributed to their development of these symptoms (Parker & Henfield, 2012). Specific training on traumatology is critical for counselors-in-training as well as practicing counselors to reduce the effects of vicarious trauma and subthreshold PTSD (Trippany, White Kress, & Wilcoxon, 2004). Counselors are ethically bound to obtain training specific to the types of counseling they provide and trauma-specific counseling is no different. Counselors must receive training specific to their client's needs in regards to trauma whether this is during their Masters program or provided at their clinical site or conference (Jordan, 2010). Unfortunately, due to a lack of trauma-specific training during their degree program, counselors piece together various trauma trainings to develop their own understanding which can leave holes in the counselors' development of trauma resources (Mailloux, 2014). Counselors need to be trained on the key features of trauma, warning signs, and symptoms as well as self-care

strategies to prevent the development of vicarious trauma and subthreshold PTSD symptoms (Newell & MacNeil, 2010).

Self-Care Implementation

Counselors spend a sizeable amount of their time ensuring that others take care of themselves while neglecting their own personal self-care (Whitfield & Kanter, 2014). In an effort to decrease vicarious trauma and subthreshold PTSD symptoms, practicing counselors must ensure they are incorporating various types of self-care on a regular basis. Self-care activities such as adequate sleep, social interaction, exercise, healthy diet, reading, and journaling may be ways that practicing counselors can incorporate self-care into their routine but all too often, practicing counselors let these activities slip (Jordan, 2010; Nelson, 2016). Counselors that neglect self-care are at an increased rate for developing the negative effects of vicarious trauma and subthreshold PTSD symptoms (Mailloux, 2014).

Statement of the Problem

Vicarious trauma among practicing counselors can be dangerous for both the counselor and the client (Bercier & Maynard, 2015). Counselors experiencing vicarious trauma symptoms can be viewed as an occupational hazard due to the burdens it can place on the employee, the workplace, and the consumer (Howlett & Collins, 2014; Newell & MacNeil, 2010). Continuing to work with clients while experiencing symptoms of vicarious trauma can impede the counselor's judgment, increase risk for the client to be traumatized again by the counselor, increase countertransference, and possibly harm the client (Trippany, White Kress, & Wilcoxon, 2004; Michalopoulos & Aparicio, 2012;). Further, it is possible that counselors who experience vicarious trauma may meet the subthreshold for Post-Traumatic Stress Disorder (PTSD).

Significance of the Study

This study will have a direct impact on counselor preparation programs. Implications related to counselor development will be provided for counselor educators to gain an understanding of aspects that may need to be addressed more thoroughly in counselor preparation programs to decrease vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. The best defense against counselors experiencing vicarious trauma is by providing efficient education on the topic as well as preventive measures to be taken by the counselor (Newell & MacNeil, 2010). By preparing the students more fully while in counselor preparation programs, students can be equipped to cope with challenging clients, heavy caseloads, lack of supervision, and other common factors that increase vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. This study will provide implications that are relatable to both mental health counseling students as well as school counseling students.

Purpose of the Study

The purpose of this study was to gain an understanding of the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. Additionally, in developing implications for counselor educators, the researcher determined common contributing factors among practicing counselors that participants feel contributed to the development of vicarious trauma symptoms and subthreshold PTSD symptoms (i.e. lack of educational training, large caseload, and lack of supervision). Implications have been developed for counselor educators to determine how they best can prepare students to avoid vicarious trauma symptoms and decrease subthreshold PTSD symptoms among practicing counselors' post-degree.

Research Questions

The study presented investigated the following research questions:

1. What symptoms of vicarious trauma and subthreshold PTSD do practicing counselors experience?
2. What is the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors?
3. a. What is the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors on vicarious trauma?
b. What is the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors on subthreshold PTSD?

Participants

The participants for this study were individuals who were either (1) practicing mental health counselors or (2) practicing school counselors. In order to participate in this study, respondents must be at least 19 years of age, have completed a Master's degree in a Counselor Education (ie. School Counseling, Clinical Mental Health Counseling, Rehabilitation Counseling, Family and Marriage Counseling) and have been a practicing counselor for at least 6 months at the time of survey participation. Participants were recruited through counseling association listservs such as Alabama Counseling Association (ALCA), American School Counselors Association (ASCA), and the American Counseling Association (ACA). An invitation to participate in the study was posted on CESNET.

Procedures

Upon approval from Auburn University IRB, participants were recruited via email through listserv solicitation. Participants reviewed an informed consent document and assented to participation. Surveys were sent via Qualtrics and participants could complete surveys online at their convenience. The participants were informed that there was no known risk associated with completing the surveys and that they may withdraw from participation at anytime. Due to

the anonymous nature of the survey, participants may withdraw at any time but their data cannot be retracted as the researcher will not know which survey to remove. All incomplete surveys were removed prior to data analysis. IRB-approval information was attached to the informed consent document for the participant's review. The surveys that were completed by participants were a Brief Demographic Questionnaire the Secondary Trauma Stress Scale, and the PCL-5. Upon completion of data collection from participants, n=220, the surveys were examined for exclusion criteria such as incomplete surveys from participant withdrawal. GPower was calculated utilizing a GPower calculator with 6 predictors at a power of .80 and small effect size that indicated a need for approximately 170-200 participants. After all surveys are completed, the data was analyzed using SPSS software.

Data Analysis

This study was focused on identifying and understanding the presence of symptoms of vicarious trauma and subthreshold PTSD among practicing counselors. The relationship between vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors was also be examined as well as the relationship between years of experience among practicing counselors on vicarious trauma and subthreshold PTSD symptoms. Additionally, this study examined the relationship between work setting and type of cliental among practicing counselors on vicarious trauma and subthreshold PTSD symptoms. The final relationship examined was between the number and type of professional supports utilized by practicing counselors on vicarious trauma symptoms and subthreshold PTSD symptoms. Vicarious trauma symptoms experienced by practicing counselors was established by completion of the Secondary Trauma Stress Scale and subthreshold PTSD symptoms were examined by completion of the PCL-5. Years of experience, work setting, type of cliental, and professional supports were examined

through the Brief Demographic Measure. Data analysis was performed using SPSS. Descriptive statistics and linear regressions were used for this study. Charts and needed graphs have been developed to display data analysis findings.

Results

The purpose of the present qualitative study was to investigate the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms experienced by practicing counselors. Additionally, the present study was interested in developing implications for counselor educators and supervisors that provided needed professional supports for practicing counselors to decrease vicarious trauma symptoms and subthreshold PTSD symptoms. The researcher for this study utilized a brief demographic questionnaire, the Secondary Trauma Stress Scale (STSS), and the Posttraumatic Checklist (PCL5). The present study sought to determine the what vicarious trauma symptoms and subthreshold PTSD symptoms practicing counselors experience, the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms, and the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports utilized by practicing counselors and vicarious trauma symptoms and subthreshold PTSD symptoms. Descriptive analysis was used to determine what symptoms of vicarious trauma and subthreshold PTSD practicing counselors experience (research question 1). A linear regression was used to determine the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms. For research questions 3-5, linear regressions were utilized to determine the relationship years of experience, work setting and type of cliental, and professional supports have on vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors.

Demographics

Two hundred and twenty individuals completed the survey. Of the 220 participants, 219 participants reported their gender; 23 (10.3%) of respondents indicated they identified as male and 196 (87.9%) of respondents indicated they identified as female. Two hundred and fifteen respondents indicated holding a Masters degree (84.8%). Exclusion criteria removed 4 (1.8%) of respondents from the data set for only holding a Bachelors degree as well as one (0.4%) other respondent for not indicating a degree level. Two hundred and seventeen participants (98.6%) reported they were over 19 years of age.

Current work setting was reported by 207 of the respondents. Of the 207 that reported, 137 (62.3%) identified as school counselors, 24 (10.9%) reported working in a community mental health center, 16 (7.35%) reported working in a private practice, 17 (7.7%) reported working in a higher education center, and 13 (5.9%) reported “other” which included settings such as Employee Assistance Programs and Crisis Centers.

Six respondents (2.7%) reported less than one year of cumulative counseling experience, 50 (22.7%) reported 1-3 years of cumulative counseling experience, 31 (14.1%) reported 4-5 years of cumulative counseling experience, 47 (21.4%) reported 6-10 years of cumulative counseling experience, and 72 (32.7%) reported 10 years or more of cumulative counseling experience. Of the 220 respondents, 14 (6.4%) did not report their cumulative years of counseling experience. Participants also reported their reported the number of years they have been in their current position. Of the 220 respondents, 12 (5.5%) did not report how many years they have been in their current position while 8 (3.6%) reported being in their current position less than one year, 103 (10.9%) reported 1-3 years, 31 (14.1%) reported 4-5 years, 30 (13.6%)

reported 6-10 years, and 36 (16.4%) reported being in their current position 10 or more years.

Refer to Table 9 for a summary of the demographic information reported.

The mean, standard deviation, and reliability statistics are reported in Table 10 for the Secondary Trauma Stress Scale (STSS) and the Posttraumatic Checklist (PCL5). The internal consistency for the STSS, PCL-5, and the subscales of the PCL-5 were reliable and supportive ($r > .08$) of use in this study.

Table 9

Demographic Information

Characteristic		N	Percentage
Gender	Male	23	10.5%
	Female	196	89.1%
	Total	219	
Age	19-29	40	18.2%
	30-39	79	35.9%
	40-49	49	22.3%
	50-59	39	17.7%
	60+	10	4.5%
	Total	217	98.6%
Work Setting	School Setting	137	62.3%
	Community Mental Health Center	24	10.9%
	Private Practice	16	7.35%
	Higher Education Center	17	7.7%
	Other	13	5.9%
	Total	220	
Years in Current Position	Less than 1 year	8	3.6%
	1-3 years	103	46.8%
	4-5 years	31	14.1%
	6-10 years	30	13.6%
	10+ years	36	16.4%
	System Missing	12	5.5%
	Total	220	
Years of Experience	Less than 1 year	6	2.7%
	1-3 years	50	22.7%
	4-5 years	31	14.1%
	6-10 years	47	21.4%
	10+ years	72	32.7%
	System Missing	14	6.4%
	Total	220	

Table 10

Scale Reliability Statistics

Scale	N	Mean	SD	Cronbach's Alpha
PCL-5	20	1.758	.224	.954
STSS (Full Scale)	17	2.079	.336	.942
STSS-Intrusion	5	2.005	.502	.804
STSS-Avoidance	7	2.109	.235	.857
STSS-Arousal	5	2.123	.338	.890

Research Question 1: What symptoms of vicarious trauma and subthreshold PTSD do practicing counselors experience?

Descriptive statistics based on participant's responses indicated that there are symptoms of vicarious trauma and subthreshold PTSD being experienced by practicing counselors. On the STSS, all symptoms were experienced by at least 50% of the participants to some degree. Symptoms were rated significant if they scored higher than "Never" on the STSS, indicating they had experienced the symptom to some degree within the past seven days. The most common symptom of vicarious trauma experienced by the participants was thinking about work with clients when not intending to do so (85.5%) as measured by the STSS. Additional symptoms of vicarious trauma symptoms experienced commonly by participants included: feeling emotionally numb (80.5%), becoming easily annoyed (79.1%), difficulty concentrating (75.5%), and feeling discouraged about their future (75.5%) as measured by the STSS. Experiencing disturbing dreams about their clients (49.5%) and feeling jumpy (56.4%) were the least common symptoms experienced by participants, but still 50% of the participants experienced these symptoms. Table 11 outlines the vicarious trauma symptoms measured by the STSS in descending order.

The PCL-5, utilized to measure subthreshold PTSD symptoms, suggested practicing counselors are experiencing subthreshold PTSD symptoms. Symptoms were rated as significant

if they scored higher than “Not at all,” indicating they had experienced the symptom to some degree within the past month. The most common symptom reported to have been experienced by all participants (100%) was repeated, disturbing, or unwarranted memories of the stressful experience. Other symptoms that were reported to have been experienced commonly by practicing counselors included: trouble falling asleep or staying asleep (71.4%), having difficulty concentrating (70.9%), feeling distant or cut off from other people (68.2%), and feeling very upset when something reminded them of the stressful experience (66.8%). Taking too many risks or doing things that could cause you harm (36.8%), feeling or acting as if the stressful experience were actually happening again (42.7%), and experiencing repeated, disturbing dreams of the stressful experience (49.1%) were experienced least commonly by participants. Table 12 outlines the subthreshold PTSD symptoms measured by the PCL-5 in descending order.

Table 11

STSS Symptom Distribution

Item in Descending Order	n (%)
I thought about my work with clients when I didn't intend to	188 (85.5%)
I felt emotionally numb	177 (80.5%)
I was easily annoyed	174 (79.1%)
I felt discouraged about the future	166 (75.5%)
I had trouble concentrating	166 (75.5%)
I had trouble sleeping	165 (75%)
I wanted to avoid working with some clients	162 (73.6%)
I was less active than usual	156 (70.9%)
Reminders of my work with clients upset me	155 (70.5%)
My heart started pounding when I thought about my work with clients	155 (70.5%)
I had little interest in being around others	149 (67.6%)
It seemed as if I was reliving the trauma(s) experienced by my client(s)	133 (60.5%)
I expected something bad to happen	132 (60%)
I avoided people, places, or things that reminded me of my work with clients	126 (57.3%)
I noticed gaps in my memory about client sessions	126 (57.3%)
I felt jumpy	124 (56.4%)
I had disturbing dreams about my work with clients	109 (49.5%)

Table 12

PCL-5 Symptom Distribution

Item in Descending Order	n (%)
Repeated, disturbing, and unwanted memories of the stressful experience?	220 (100%)
Trouble falling or staying asleep?	157 (71.4%)
Having difficulty concentrating?	156 (70.9%)
Feeling distant or cut off from other people?	150 (68.2%)
Feeling very upset when something reminded you of the stressful experience?	147 (66.8%)
Irritable behavior, angry outbursts, or acting aggressively?	139 (63.2%)
Avoiding memories, thoughts, or feelings related to the stressful experience?	139 (63.2%)
Having strong negative feelings such as fear, horror, anger, guilt, or shame?	134 (60.9%)
Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	130 (59.1%)
Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	127 (57.7%)
Being “superalert” or watchful or on guard?	125 (56.8%)
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 with me, no one can be trusted, the world is completely dangerous)?	125 (56.8%)
Loss of interest in activities that you used to enjoy?	123 (55.9%)
Blaming yourself or someone else for the stressful experience or what happened after it?	121 (55%)
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	119 (54.1%)
Feeling jumpy or easily startled?	116 (52.7%)
Trouble remembering important parts of the stressful experience?	113 (51.4%)
Repeated, disturbing dreams of the stressful experience?	108 (49.1%)

Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	94 (42.7%)
Taking too many risks or doing things that could cause you harm?	81 (36.8%)

Research Question 2: What is the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors?

Linear regression models were run to determine the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. In a backward regression, the PCL-5 measuring subthreshold PTSD symptoms was entered as the dependent variable and the subscales of the STSS, measuring subthreshold PTSD symptoms, were entered as the independent variables. Results indicate that the more vicarious trauma symptoms experienced by practicing counselors, the more subthreshold PTSD symptoms experienced. There was a significant relationship between PCL-5 and all three STSS Subscales. The relationship between subthreshold PTSD symptoms and the Intrusion subscale was significant ($r = .676, p < .001$). There was also a significant relationship between subthreshold PTSD symptoms and Avoidance symptoms ($r = .759, p < .001$) and between subthreshold PTSD symptoms and Arousal symptoms ($r = .790, p < .001$). Avoidance vicarious trauma symptoms and Arousal vicarious trauma symptoms were the most predictive variables associated with developing subthreshold PTSD symptoms as evidenced in the restricted model regression summary. In the backward regression model, the Intrusion subscale of the STSS was eliminated as the least significant variable, which indicates the more arousal and avoidance symptoms experienced as vicarious trauma, the more subthreshold PTSD symptoms experienced by the practicing counselors. In the Full Model ($R^2 \text{ Full} = .656, (F = 103.4), p < .001$), results indicate a significant relationship. Through the Restricted Model $R^2 \text{ Restricted} = .655, (F = 155.75), p <$

.001) and the F change test results indicate the restricted model is not worse than the full model due to the Observed F (.00000892), $p=.647$ that does not exceed the Critical F ($df = 1,163$) which is 3.94. Correlation summaries can be viewed in the Table 13. Regression results are outlined in the Table 14.

Table 13

Correlation Summary PCL-5 vs. STSS Subscales

	r	Significance
STSS-Intrusion	.676	<.001
STSS-Avoidance	.758	<.001
STSS-Arousal	.790	<.001

Table 14

Regression Summary

Scale	Full Model		Restricted Model	
	Beta	p	Beta	p
STSS-Intrusion	.037	.647	--	--
STSS-Avoidance	.310	.001	.323	<.001
STSS-Arousal	.501	<.001	.520	<.001

Note: R^2 Full= .656, (F=103.4), $p<.001$ R^2 Restricted= .655, (F=155.75), $p<.001$

Research Question 3a: What is the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors on vicarious trauma?

A backward linear regression model was utilized to determine the relationship between years of experience, work setting and type of cliental, and type of professional supports among practicing counselors on vicarious trauma symptoms. There were two significant relationships within this regression in the Restricted Model of the regression. There was a significant negative

correlation between vicarious trauma symptoms and having a manageable caseload, indicating the more manageable caseload the counselor has, the less vicarious trauma symptoms. In addition, there was a significant negative correlation between vicarious trauma symptoms and having adequate supervision indicating the more supervision received, the less vicarious trauma symptoms experienced. Overall, the two variables (caseload and supervision) correlate with the dependent variable, vicarious trauma symptoms, ($R = .273$, $R^2 = .074$). This overall correlation is unlikely due to chance ($F = 8.159$, $p < .001$). The F Change test indicated the Observed F (2.008), $p = .158$ does not exceed the Critical F ($df = 1, 202$) which is 3.89. The semi-partial correlation between caseload and vicarious trauma symptoms was $-.173$ while the semi-partial correlation between supervision and vicarious trauma symptoms was $-.150$. The semi-partial correlation indicates the uniqueness of the relationship. The squared semi-partial correlation for supervision was, $(-.173)^2 = .029$ and the squared semi-partial correlation for caseload, $(-.150)^2 = .02$. Regression results are outlined in Table 15.

Table 15

Regression Findings – Backward Regression

Factor	<hr/> <hr/>				
	R ²	S.E	Estimate		
			r	Semi-partial	Beta
Full Model	.117	.32497			
Years of Experience			.037	-.043	-.045
Population-Children			-.115	-.064	-.077
Population-F&M			-.172	-.086	-.118
Population-SubAbuse			-.138	-.012	-.021
Population-Adults			-.104	.070	.105
Population-SA/DV			-.075	.094	.151
Population-Prison			-.161	-.115	-.170
Population-Other			-.014	-.004	-.004
Supervision*			-.211	-.111	-.133
Training			-.127	-.013	-.014
Peer Support			-.160	-.037	-.043
Caseload*			-.228	-.155	-.179
Other			.054	.059	.063
Restricted Model	.074	.32350			
Supervision				-.150	-.157
Caseload				-.173	-.182

*p<.05

Research Question 3b: What is the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors on subthreshold PTSD symptoms?

A backward linear regression model was utilized to determine the relationship between years of experience, work setting and type of cliental, and the number and type of professional supports among practicing counselors on subthreshold PTSD symptoms. With subthreshold PTSD as the dependent variable and years of experience, work setting and type of cliental, and type of professional supports as the independent variables, a backward linear regression was run to understand the relationship between the variables in the Restricted Model of the regression. Results indicate a significant relationship between subthreshold PTSD symptoms and those counselors that work primarily with adolescents and those counselors that work primarily with sexual assault/domestic violence clients. Overall, the two variables (adolescents and sexual assault/domestic violence) correlate with our dependent variable, subthreshold PTSD symptoms, ($R = .242$, $R^2 = .059$). This overall correlation is unlikely due to chance ($F = 5.080$, $p = .007$). The F Change test indicated the Observed F (2.255), $p = .135$ does not exceed the Critical F ($df = 1, 162$) which is 3.94. The semi-partial correlation between adolescents and subthreshold PTSD symptoms subthreshold PTSD symptoms was .159 while the semi-partial correlation between sexual assault/domestic violence and subthreshold PTSD was .187. The semi-partial correlation indicates the uniqueness of the relationship. The squared semi-partial correlation for adolescents was, $(.159)^2 = .025$ and the squared semi-partial correlation for sexual assault/domestic violence, $.187^2 = .03$. Regression results are outlined in Table 16.

Table 16

Regression Findings – Backward Regression

Factor	R ²	S.E Estimate			
			r	Semi-partial	Beta
Full Model	.147	.70910			
Years of Experience			-.001	-.038	-.041
Population-Children			.148	.083	.091
Population-Adolescents*			.154	.134	.148
Population-F&M			.016	-.041	-.053
Population-SubAbuse			.001	-.040	-.070
Population-Adults			.083	.120	.181
Population-SA/DV*			.183	.141	.201
Population-Prison			-.015	-.076	-.109
Population-Other			.118	.063	.066
Supervision			-.097	-.057	-.066
Training			-.086	-.063	-.071
Peer Support			-.075	-.053	-.056
Caseload			-.105	-.078	-.090
Self-Care			.063	.086	.092
Other			.137	.124	.133
Restricted Model	.059 ^b	.71448			
Population-Adolescents*				.159	.159

Summary

The current study was developed to gain an understanding of the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms that are experienced by practicing counselors. Further, this study sought to examine the relationship between vicarious trauma symptoms and subthreshold PTSD symptoms as well as contributing factors to these symptoms that practicing counselors may be experiencing. In an effort to retort these research questions, a Brief Demographic Questionnaire, the Secondary Trauma Stress Scale (STSS), and the Posttraumatic Checklist (PCL5) were utilized. Results from this study indicated that vicarious trauma symptoms measured by the STSS were experienced by at least 50% of the participants. There was also a significant correlation between the frequency of vicarious trauma symptoms experienced by practicing counselors and subthreshold PTSD symptoms. Further, having a manageable caseload and adequate supervision decreased participants' vicarious trauma symptoms. Finally, results indicated that working primarily with adolescents and primarily with sexual assault/domestic violence survivors increased participants subthreshold PTSD symptoms.

Discussion

The purpose of this study was to develop an understanding of the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. Additionally, the researcher sought to develop implications for counselor educators by determining common contributing factors that participants felt contributed to the development of vicarious trauma symptoms and subthreshold PTSD symptoms. Results from the Brief Demographic Survey, the Secondary Trauma Stress Scale (STSS), and the Posttraumatic Checklist (PCL5) will be

discussed. Additionally, implications for counselor educators to determine how they best can prepare students to avoid vicarious trauma symptoms and decrease subthreshold PTSD symptoms among practicing counselors' post-degree. Limitations of the current study and recommendations for future research will also be reviewed.

Implications for Counselor Educators and Supervisors

The results of this study provide counselor educators and supervisors with various tools to prepare counselors-in-training to avoid vicarious trauma symptoms and subthreshold PTSD symptoms. The current study established evidence that practicing counselors are experiencing numerous vicarious trauma symptoms and subthreshold PTSD symptoms. In fact, this study found that all vicarious trauma symptoms measured were experienced by at least 50% of the participants and 17 of the 20 PTSD symptoms measured were experienced by participants. Further, in an open-ended question in the Brief Demographic Survey, participants provided the researcher with ideas they felt would decrease vicarious trauma and subthreshold PTSD symptoms. Over 40% of responses indicated more education on vicarious trauma and subthreshold PTSD symptoms. With close to or at 50% of participants reporting vicarious trauma symptoms and subthreshold PTSD symptoms, it is evident that additional education is needed related to these symptoms. Keim et al. (2008) suggested educational trainings and/or workshops be provided to counselors-in-training proactively to decrease vicarious trauma symptoms and subthreshold PTSD symptoms among practicing counselors. Counselor educators and supervisors can also provide trainings on the signs and symptoms of vicarious trauma and subthreshold PTSD experienced by counselors to practicing counselors and supervisors to raise awareness of these symptoms and ways to recognize and alleviate them before causing harm to the counselor.

This study denoted that counselors that work primarily with adolescents and sexual assault/domestic violence survivors are experiencing more subthreshold PTSD symptoms. As counselor educators prepare counselors-in-training for practicum, internship, and employment as counselors, it is vital for counselor educators to acknowledge the unique challenges that may stem with working with adolescents and survivors of sexual assault/domestic violence. It will be imperative that counselor educators and supervisors integrate specific educational material through coursework related to these specific populations in an effort to best prepare counselors-in-training. Evidence-based practices that are sufficient for counseling these populations should be implemented within counselor education programs, supervision practices, and workshops/trainings outside of the degree, such as at conferences (Mailloux, 2014; Whitfield & Kanter, 2014; Alpert & Paulson, 1990).

Education on the significance of professional supports such as adequate supervision and manageable caseloads are fundamental for counselors-in-training to best be prepared to lessen the hazard of developing vicarious trauma symptoms and subthreshold PTSD symptoms. By providing sufficient supervision during practicum and internship, counselor educators and supervisors can prepare counselors-in-training for coping with vicarious trauma and subthreshold PTSD symptoms should they develop. In addition, through modeling appropriate supervision, counselors-in-training will comprehend the supervisory process and seek supervision post-degree.

Limitations

One limitation for this study was the high percentage of school counselors (62.3%) that participated. This could have possibly skewed the primary type of cliental that the practicing counselors worked with that exhibited the most symptoms of vicarious trauma and subthreshold

PTSD. Additionally, this large percentage of school counselors may make the implications suggested in this study not as applicable for counselors in higher education settings.

An additional limitation of this study was the lack of demographics available to identify if counselors were in a rural setting or urban setting. Although the implications suggested are applicable to all counselors, demographic location may serve as an additional barrier to implementing the professional supports suggested.

Future Recommendations for Research

Future studies on vicarious trauma symptoms and subthreshold PTSD symptoms needs to focus solely on clinical mental health or school counselors to develop implications specific to site. Although this study was great for counselor educators and supervisors preparing counselors-in-training, it is important for site specific aspects to be available practicing counselors. Further research devoted to the development of workshops and trainings to educate counselors on vicarious trauma and subthreshold PTSD is needed.

A future study that compares counselors in rural settings and urban settings will be important to understand barriers to coping with and addressing vicarious trauma symptoms and subthreshold PTSD symptoms. For example, in a rural setting, the counselor may not have adequate supervision and may be overloaded with cases which can decrease the amount of self-care they are able to implement. Conversely, counselors in urban settings may be experiencing more cases with traumatic high crime. It will be important for future research to understand what barriers to professional supports counselors face in these different demographic communities.

Due to this study's finding that counselors who work primarily with adolescents and individuals who have experienced sexual assault and/or domestic violence increases the chances of experiencing vicarious trauma symptoms and subthreshold PTSD symptoms, a qualitative

and/or quantitative study focused on vicarious trauma among counselors working with these populations will be desirable. In an effort to best prepare students that may work with these populations, an understanding of what exactly aspects of working with these clients increases the vicarious trauma symptoms and subthreshold PTSD symptoms is essential.

Summary

The current study developed an understanding of the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms experienced by practicing counselors. Further, this study identified the most prevalent vicarious trauma symptoms and subthreshold PTSD symptoms experienced by practicing counselors. Counselors working primarily with adolescents and sexual assault/domestic violence survivors experienced more subthreshold PTSD. This study also identified common alleviating factors that decrease vicarious trauma symptoms which were recognized as having a manageable caseload and adequate supervision. Additional educational trainings for counselors related to vicarious trauma and subthreshold PTSD are needed to decrease these symptoms and prepare counselors for engaging in therapeutic relationships with individuals suffering from trauma without developing their own symptomology.

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Appendix A. IRB Approval

INFORMATION LETTER for a Research Study entitled

"Practicing Counselors, Vicarious Trauma, and Subthreshold PTSD: Implications for Counselor Educators."

You are invited to participate in a research study to investigate if practicing counselors are experiencing trauma symptoms related to their counseling practice. The study is being conducted by Bethany Lanier, a doctoral candidate under the direction of Dr. Jamie Carney, Ph.D. This research is a component of the researcher's doctoral degree requirements. You were selected as a participant because you are a practicing counselor. Participation in this study is restricted to persons age 19 or older and counselors with at least a Masters degree or higher in counselor education or a related counseling field.

What will be involved if you participate? Your participation is completely voluntary. If you decide to participate in this research study, you will be asked to complete an electronic survey. Your total time commitment will be approximately 20-30 minutes.

Are there any risks or discomforts? The risk associated with participating in this study is sharing personal feelings that you might find uncomfortable. If at any time you begin to feel uncomfortable, you may withdraw your participation in the study with no penalty. If you do experience personal feelings that become uncomfortable it is recommended that you seek counseling services.

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 might benefit from an increased awareness related to talking about the vicarious trauma symptoms and subthreshold PTSD symptoms you have experienced. However, we cannot guarantee that you will personally experience benefits from participating in this study. Others may benefit in the future from the information we find in this study.

Will you receive compensation for participating? 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 completion of the study by closing your browser window. Your participation is completely voluntary. Once your data is submitted you will be unable to remove your data since all collected data is unidentifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with the researcher, Auburn University, or the SERC Department.

Add this approval information in sentence form to your electronic information letter!

The Auburn University Institutional
Review Board has approved this
Document for use from
10/28/2016 to 10/27/2019
Protocol # 16-381 EX 1610

Any data obtained in connection with this study will remain anonymous. Data collected in this study is not identifiable and can not be linked to individual participants. All data received will be kept in a secure file on the researcher's computer. Information collected through your participation may be used to fulfill an educational requirement, published in a professional journal, and/or presented at a professional meeting.

If you have questions about this study, please contact Bethany Lanier, MS, NCC at bal0014@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 or IRBChair@auburn.edu.

HAVING READ THE INFORMATION ABOVE, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, PLEASE CLICK ON THE LINK BELOW.
YOU MAY PRINT A COPY OF THIS LETTER TO KEEP.

Bethany Lanier 10/26/16
Investigator Date

J. Carney 10/27/16
Co-Investigator Date

The Auburn University Institutional Review Board has approved this document for use from _____ to _____. Protocol # _____

Add this approval information in sentence form to your electronic information letter!

The Auburn University Institutional Review Board has approved this Document for use from 10/28/2016 to 10/27/2019 Protocol # 16-381 EX 1610

Appendix B. Informed Consent Document

Informed Consent

For a Research Study entitled

Practicing Counselors, Vicarious Trauma, and Subthreshold PTSD: Implications for Counselor Educators

You are invited to participate in a research study to investigate if practicing counselors are experiencing trauma symptoms related to their counseling practice. The study is being conducted by Bethany Lanier, a doctoral candidate under the direction of Dr. Jamie Carney, Ph.D. This research is a component of the researcher's doctoral degree requirements. You were selected as a participant because you are a practicing counselor. Participation in this study is restricted to persons age 19 or older and counselors with at least a Masters degree or higher in counselor education or a related counseling field.

What will be involved if you participate? If you decide to participate in this research study, you will be asked to complete a survey. Your total time commitment will be approximately 20-30 minutes.

Are there any risks or discomforts? The risk associated with participating in this study is sharing personal feelings that you might find uncomfortable. If at any time you begin to feel uncomfortable, you may withdraw your participation in the study with no penalty. If you do experience personal feelings that become uncomfortable it is recommended that you seek counseling services.

Are there any benefits to yourself or others? There are no direct benefits from participating this study. However, if you participate in this study, you might benefit from an increased awareness related to talking about the vicarious trauma symptoms and vicarious trauma symptoms you have experienced. However, we cannot guarantee that you will personally experience benefits from participating in this study. Others may benefit in the future from the information we find in this study.

Will you receive compensation for participating? 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 completion of the study. Your participation is completely voluntary. Once your data is submitted you will be unable to remove your data since all collected data is unidentifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with the researcher, Auburn University, or the SERC Department.

If you decide to participate in this research study, you will be asked to complete a survey through Qualtrics. Your total time commitment will be approximately 20-30 minutes. No

information will be included in publications, presentations, or reports that could be used to personally identify you. The contact email used in recruitment will not be retained.

Your privacy will be protected. Any information obtained in connection with this study will remain anonymous and confidential. Information obtained through your participation may be used to fulfill the requirements of the dissertation process.

If you have questions about this study, *please* contact Bethany Lanier at bal0014@auburn.edu or Dr. Carney at carnejs@edu. You may print a copy of this document for your records.

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

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

- ☐ I AGREE
- ☐ I DO NOT AGREE

Appendix C. Brief Demographic Survey

Please indicate your sex:

- ☐ Male
- ☐ Female
- ☐ Other (please indicate): _____

Please indicate your age: _____

Please select your highest level of completed education:

- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctoral Degree

Please indicate your current job title: _____

Please indicate your current work setting (school, community mental health center, etc):

- ☐ School
- ☐ Community Mental Health Center
- ☐ Private Practice
- ☐ Higher Education setting
- ☐ Other (please indicate): _____

Please indicate the years in your current position: _____

Please indicate the years of experience you have as a practicing counselor: _____

To what extent have you worked with the following populations within the last 6 months (1=not at all, 2=2-4 clients, 3=5-10 clients, 4=more than 10 clients)

- ☐ Children
- ☐ Adolescents
- ☐ Family and Marriage
- ☐ Substance Abuse/Recovery
- ☐ Adults
- ☐ Sexual Assault/Domestic Violence
- ☐ Prison Population
- ☐ Other (please indicate): _____

Do you currently hold any licenses or certifications:

- ☐ Yes
- ☐ No

If yes, please select all current licenses and/or certifications you currently hold:

- Licensed Professional Counselor (LPC)
- Licensed Marriage and Family Therapist
- LPC In Progress (i.e. Associate Licensed Counselor)
- LMFT In Progress
- National Certified Counselor (NCC)
- National Certified School Counselor (NCSC)
- Licensed School Counselor
- Other (Please indicate): _____

Please indicate the professional supports you currently utilize to prevent vicarious trauma and subthreshold PTSD symptoms. For those selected, please indicate on a scale of 1 (less than once a week) to 5 (more than once a day) the extent to which you utilize each type of support:

- Supervision
1 2 3 4 5
- Trauma-specific training
1 2 3 4 5
- Peer Support
1 2 3 4 5
- Manageable Caseloads
1 2 3 4 5
- Years of experience as a counselor
1 2 3 4 5
- Self-care implementation
1 2 3 4 5
- Other (please identify): _____
1 2 3 4 5

Please indicate the which professional supports you need additional support in your current role as counselor:

- Supervision
- Trauma-specific training
- Peer Support
- Manageable Caseloads
- Years of experience as a counselor
- Self-care implementation
- Other (please identify): _____

Please describe ways in which you feel counselors could be better supported to deal with symptoms of vicarious trauma and symptoms of subthreshold PTSD:

Appendix D.

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 **seven (7) days** 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

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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 E.

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